STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING **01 - MAIN BLDG 01** B. WING _____	**06/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE** **FUQUAY VARINA, NC 27526**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The facility utilizes Special Locking through-out. All deficiencies were discussed and acknowledged by facility management and staff. Total number of beds 100 Census at time of Survey 81 The deficiencies determined during the survey are as follows:	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		7/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/02/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 027	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70 Based on observation and staff interview, 6/17/2015, at 1: 00 am onward, the following item was non compliant; specific findings include: the Cross Corridors fire/smoke doors at/near Nsg Station #3 had kick-down hardware installed that would impede closing of the doors in a fire/emergency. NFPA 101, 2000 Ed: Sect 18.3.7.3, Sect 18.3.7.6 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Doors in Smoke barrier walls shall be self closing or automatic closing. The deficiency affected 2 of 5 smoke compartments.	K 027	1. Kick-down hardware was removed from the door by the maintenance director on 6/26/15. 2. All other doors in the facility were viewed by the maintenance director, and no others were found with the deficient practice. Completed on 6/26/15. 3. Maintenance director will be inserviced by the administrator about the need to assure all smoke barrier doors automatically close, without impediment in a fire/emergency. To be completed by 6/30/15. 4. All smoke barrier doors will be checked weekly times 4 weeks; then twice monthly thereafter by the maintenance director. Results will be submitted to the monthly QA committee for review.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 Based on observation and staff interview, 6/17/2015, at 1: 00 am onward, the following item	K 029	1. Self-closing hardware was installed by the maintenance director on 6/26/15. 2. All other hazardous areas in the	7/8/15

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K 029	Continued From page 2 was non compliant; specific findings include: the required self-closing hardware for Hazardous Storage room corridor doors had been removed: 1. Medical Supply Room 2 Equipment Storage Room Reference NFPA 101, 2000 Ed, Sect 19.3.2.1 The def(s) affected 1 of 5 smoke compartments.	K 029	building were checked by the maintenance director on 6/30/15 for self-closing devices and no other deficient practice was found. 3. Maintenance staff will be in-serviced by the administrator by 6/30/15 about the need for fire-rated doors to have devices that allow for automatic closing in the event of fire or emergency. 4. Doors will be checked by the maintenance director weekly time 4 weeks to assure that closing devices allow for automatic closing; then twice monthly thereafter. Results will be presented at the monthly QA meeting. Need for additional checks will be identified by the committee members.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 Per Staff Interview and documentation review on 6/17/2015, the facility was not having the required Fire Alarm system required inspections/maintenance as required by NFPA 72 and NFPA 70 . They did have the annual inspection per documentation.	K 052	1. Quarterly inspection of fire system will be completed by Pye Barker on 7/1/15. 2. All other required fire inspections (such as ansul and fire extinguishers) were reviewed on 6/30/15. No other deficient practice was found. 3. Maintenance director will be inserviced	7/8/15

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K 052	Continued From page 3 Reference NFPA 101, 2000 Ed, Sect 9.6.1.7 The deficiency affected the entire facility, 5 of 5 smoke compartments.	K 052	about the requirement for quarterly and annual fire inspections throughout the facility, by 6/30/15. 4. Fire inspection reports will be submitted by the maintenance director to the monthly QA committee for review. Additional reports will be determined by the committee.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 Per Staff Interview and documentation review on 6/17/2015, the facility was not having the sprinkler system required inspections/maintenance (Quarterly and Semi-Annual) as required. They did have the required Annual Inspection. Reference NFPA 101, 2000 Ed, Sect 9.7.5, Sect 4.6.12.1, NFPA 25, Sect 2-2 and table 2-1 The deficiency affected the entire facility, 5 of 5 smoke compartments.	K 062	1. Quarterly inspection of the sprinkler system will be arranged by the maintenance director and completed by Pye Barker on 7/1/15. 2. No other deficient practice was identified. 3. Maintenance director will be inserviced by the administrator about the requirement for quarterly and annual sprinkler inspections throughout the facility, by 6/30/15. 4. Sprinkler inspection reports will be submitted by the maintenance director to the monthly QA committee for review. Additional reports will be determined by the committee. Beginning in July 2015.	7/8/15
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are	K 076		7/8/15

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K 076	Continued From page 4 protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/17/2015 at approximately noon, the oxygen storage was non-compliant, specific findings include; Oxygen storage near the nurses station: Oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] The deficiency affected 1 of 5 smoke compartments.	K 076	1. The plastic storage rack was removed by the maintenance director on 6/26/15. 2. All other oxygen storage was checked by the maintenance director on 6/26/15, and no other deficient practice was discovered. 3. Maintenance and central supply staff will be in-serviced by the administrator by 6/30/15 concerning appropriate methods for storing oxygen tanks (chained, or metal stand or cart). 4. Maintenance director will check oxygen storage twice weekly times 4 weeks; then weekly times for 4 weeks; then monthly thereafter. Deficient practice will be immediately corrected by the maintenance staff. Results will be submitted by the maintenance director to the QA committee monthly. Need for additional checks or interventions will be determined by the committee.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		7/8/15

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K 144	Continued From page 5 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70 Based on documentation and staff interview - 6/17/2015: The staff could not substantiate that the emergency generator was exercised under full load for a minimum of 30 minutes per month. They had only been conducting weekly run tests. Reference NFPA 99, 1999 Ed, Sect 3.4.4.1 The deficiency affected the entire facility, 5 of 5 Smoke compartments.	K 144	1. The generator will be tested under full load by the maintenance director by 7/1/14. 2. No other requirements for full-load generator testing exist. Weekly testing has been completed as required. 3. Maintenance director will be in-serviced by the administrator by 6/30/15 concerning the requirements for generator testing, including the requirement for monthly testing under full load circumstantes. 4. Results of generator testing will be submitted monthly by the maintenance director to the QA committee. Need for additional testing or interventions will be determined by the committee.	