DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	05/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MOCKSVILLE	**1007 HOWARD STREET** **MOCKSVILLE, NC 27028**

(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 A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. The facility is utilizing speical locking systems. In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type III (211) Constructed: 1976 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 96 Census - 75 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)	K 029	Preparation and submission of this plan	6/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/12/2015

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 029	Continued From page 1 Based on observations and document review on 5/28/2015 at approximately 9:30 AM onward, the following deficiencies were noted: The facility failed to have properly protection for currently used storage rooms. 1. Resident room 108 2. Resident room 112 3. Resident room 122 The facility has converted resident room into storage rooms on the Maple Hallway. This condition changes the room from a ordinary hazard and requires a self closing or automatic-closing device installed to keep the door closed. This deficiency affected one smoke zone on the Maple Hallway. Ref: 2000 NFPA 101 Sections 19.3.2.1	K 029	of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under states and federal laws. Resident rooms 108, 112, and 122 have self closing devices as of 6/16/2015. An audit of the facility was performed and all resident rooms requiring self closing devices and all resident rooms requiring self closing devices have self closing devices. Resident rooms requiring self closing devices will be audited monthly by the Maintenance Director or Administrator for three months to ensure compliance. The Maintenance Director or Administrator will report compliance to the QA Committee monthly for three months.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations and document review on 5/28/2015 at approximately 9:30 AM onward, the	K 038	The crush and run at the end of Maple Hallway is being added 6/19/2015 has been added and is in proper condition. An audit of the other exits has been	6/19/15

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K 038	Continued From page 2 following deficiencies were noted: The facility failed to have properly exit discharge maintained. The facility does not have proper exit discharge path maintained at the required exit from the long Maple hallway exit discharge. The crush and run material at the end this exit is not properly maintained and in good repair This deficiency affected one of the required exits on the Maple Hallway. Ref: 2000 NFPA 101 Sections 7.1; 19.2.1	K 038	completed and all exits are properly maintained. All ramps are audited monthly by the Maintenance Director or Administrator to ensure that they are maintained properly. Results of these monthly audits will be presented to the QA Committee monthly for three months by the Maintenance Director or Administrator.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations and document review on 5/28/2015 at approximately 9:30 AM onward, the following deficiencies were noted: The facility failed to have properly working fire/ radiation dampers at the following location in building 0102. 1. Resident room 108	K 067	The radiation damper fusible link are being replaced by 6/24/2015. All radiation damper fusible links have been audited by the Maintenance Director. The Maintenance Director or Administrator will audit the radiation damper fusible links monthly for three months and will be reported to the QA Committee monthly for three months.	6/24/15

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K 067	Continued From page 3 The facility could not verify that the integrity of the radiation damper fusible link was maintained to deploy at the proper temperature as the damper was fully deployed in the closed position. This deficiency affected one resident room on the Maple Hallway. Ref: 2000 NFPA 101 Sections 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		