STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**06/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	**401 N MORGAN STREET** **SHELBY, NC 28150**

(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 Existing Health Care section of the LSC and its referenced publications. This building is Type II(222) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. At time of survey the: Total Certified Bed Count = 160 Census = 104 The deficiencies determined during the survey are as follows:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 6/1/2015 at approximately 8:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 011	White Oak Manor-Shelby does provide required fire barriers and two-hour fire resistance rating where required. 1.) White Oak Manor-Shelby has a new Rehab addition. White Oak Manor-Shelby is awaiting occupancy approval. Life	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2015

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.

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

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K 011	Continued From page 1 1. There is no fire separation between incomplete new addition and existing facility with occupied beds and spaces adjacent to entry to new addition. The new addition had not been recommended for use at time of on-site survey. 2. Renovations within existing occupied zones are not separated from occupied patient room wings by fire barrier as required for renovations and modernization projects. Resident rooms 75, and 56 are adjacent to renovation area. This deficiency affected two of four smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 011	Safety Systems are in place. The facility and Project Manager have been in regular communication with DHSR Construction Section staff regarding occupancy approval and would anticipate occupancy approval on or by 6-30-15. The facility does not anticipate any future additions to the existing building. 2.) Renovations have been completed in the area referenced. The area was given recommendation for use as of 6-5-15 by DHSR Construction Section, Engineering Plan Reviewer. This area has reopened and is in current use. Any future renovation areas will be reviewed and if needed, will have smoke tight partitions/separation, along with maintaining all life safety systems. Review of any future smoke tight partitions/separation will be discussed at the Quarterly QA Committee Meeting. The Administrator and Maintenance Director are responsible for compliance to K011.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012		6/18/15

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K 012	Continued From page 2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 6/1/2015 at approximately 8:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. Hole in the rated roof/ceiling assembly of resident room #1. Area is being renovated with lay-in ceiling tile removed from grid - smoke resistance rating of roof/ceiling assembly is not maintained between adjacent areas. 2. Hole in roof/ceiling assembly above Cat Cable system box - located in room near room #20. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	White Oak Manor-Shelby does maintain building construction that is in compliance with K012. 1.) The ceiling tile in resident room #1 was replaced on 6-1-15. The ceiling tile had been removed for work in a room that was undergoing renovation. 2.) The hole in the roof/ceiling assembly above Cat Cable system box located in the ice room near room #20 was sealed by Telco on 6-18-15. An audit of other ceiling assemblies in the facility has been completed to ensure all other ceilings are in compliance with K012. All ceiling assemblies are in compliance with K012 as of June 18, 2015. Monthly inspections of all ceilings in the facility will be conducted by the Maintenance Director (or a Maintenance Assistant as directed by the Maintenance Director)to ensure ongoing compliance to K012. The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the Quarterly QA Committee Meeting. The Maintenance Director and the Administrator are responsible for compliance to K012.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		6/22/15

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K 046	Continued From page 3 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 6/1/2015 at approximately 8:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: The exit discharge light is not functioning at temporary exit located near resident room #15. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 046	White Oak Manor-Shelby does maintain emergency lighting of at least 1 hour duration. The exit discharge light at temporary exit located near resident room #15 was replaced on 6-22-15. An audit of other emergency lighting was completed to ensure compliance to K046. No other issues were identified. Monthly inspections of emergency lighting will be completed by the Maintenance Director (or Maintenance Assistant under the direction of the Maintenance Director). The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the Quarterly QA Committee Meeting. The Maintenance Director and Administrator are responsible for compliance to K046.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		6/24/15

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K 072	Continued From page 4 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 6/1/2015 at approximately 8:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. There are impediments in the means of egress corridor near resident rooms #73, and #74 - trash and linen carts are stored in corridor area and not in fire rated enclosures designed for such carts. 2. The audio/visual nurse patient call panel is located on corridor wall with sharp edges protruding into required headroom clearance of corridor area - panel is located on wall near room #82. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 072	White Oak Manor-Shelby does maintain means of egress that are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 1.) The Nursing Department (which includes Nursing Assistants and Nurses) have received, or will receive, inservicing on keeping corridors free of objects (such as trash and linen carts). Inservicing was initiated on 6-18-15. Additional inservicing for the Nursing Department is scheduled for 6-22-15 and 6-23-15. This inservicing included review of equipment temporarily in corridors must be kept in use, and if not in use, equipment should be moved off corridors. The inservicing was initiated by the Administrator, with follow up inservicing conducted by the Director of Nursing and the Staff Development Coordinator. Inservicing will be completed with new hires, as well as on an as needed basis. 2.) The temporary audio/visual nurse patient call panel (temporary due to construction renovations) located in the corridor area near room #82 was corrected and placed further back into the wall on 6-1-15. The temporary audio/visual nurse patient call panel was	

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K 072	Continued From page 5	K 072	removed entirely on 6-4-15, as the permanent audio/visual nurse patient call panel was placed back in use. In the future, should a temporary audio/visual nurse patient call panel be needed, the Administrator and/or Maintenance Director will ensure it does not protrude from the corridor wall (nor have sharp edges). The Administrator, Director of Nursing, and/or Maintenance Supervisor will observe corridors being kept free of objects during daily rounds. The findings from rounds will also be reviewed at the Quarterly QA Committee Meeting. The Administrator and Maintenance Director are responsible for compliance to K072.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are 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, 19.3.2.4	K 076		6/18/15

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K 076	Continued From page 6 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 6/1/2015 at approximately 8:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is a oxygen cylinder located less than five feet from combustible storage in housekeeping supply storage room - room is near room #9. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 076	White Oak Manor-Shelby does ensure medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. The oxygen cylinder located in the housekeeping supply storage room near room #9 was removed on 6-1-15. An audit of storage for oxygen cylinders was completed by the Maintenance Director to ensure compliance to K076. No other issues were identified. The Housekeeping/Laundry Supervisor was inserviced on proper storage of oxygen cylinders. This was completed on 6-18-15. The Housekeeping/Laundry Supervisor is to check the housekeeping supply storage room each working day to ensure there are no oxygen cylinders. The Maintenance Director is to conduct monthly inspections of oxygen cylinder storage to ensure ongoing compliance to K076. The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the Quarterly QA Committee Meeting. The Maintenance Director and Administrator are responsible for compliance to K076.	