PRINTED: 10/15/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - Main Building 01	(X3) DATE SURVEY COMPLETED		
		345321	B. WING _		08/14/2015		
NAME OF PROVIDER OR SUPPLIER KERR LAKE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1245 PARK AVENUE HENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION		
K 000	-	S (LSC) survey was conducted Federal Register at 42CFR	KO	00			
	483.70(a); using the section of the LSC a publications. In the edeficiencies noted wacknowledged with a	exit conference all ere discussed and					
	Stories:1 Construction Type II Constructed: *** Fully Sprinkled - Yes At time of survey the Total Certified Bed C Census = 86	3 3:					
K 012 SS=F	NOT MET as evider NFPA 101 LIFE SAF Building construction	42 CFR, Subpart 483.70(a) is ice by: EETY CODE STANDARD 1 type and height meets one 1.6.2, 19.1.6.3, 19.1.6.4,	KO	12	8/28/15		
	Based on observation approximately 8:00 and deficiencies were not 1) In the kitchen the of the room is not motion (ceiling area above)	ons, on Friday 8/14/15 at AM onward the following oted: e ceiling in the center an area aintained in good condition. Orep table/assemble table) ary closet has wood covering		1. Kitchen ceiling above prep table repaired by Hillco Support Services 8/26/15. Dietary Closet areas that wood were covered in sheetrock an ceiling sealed by Hillco Support Ser on 8/25/15. Clean Linen room #20 repaired and holes sealed by Hillco Support Services on 8/26/15. Elect water heater closet wall finished by	on were id vices ceiling		
ARORATORY	of the room is not m (ceiling area above 2) The kitchen dieta	aintained in good condition. orep table/assemble table)		repaired and holes sealed by Hillco Support Services on 8/26/15. Elect	ric		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(- /

Electronically Signed 08/28/2015

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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345321 B. WING 08/14/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1245 PARK AVENUE KERR LAKE NURSING AND REHABILITATION CENTER HENDERSON, NC 27536 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 012 | Continued From page 1 K 012 the left side of the closet. Ceiling was not sealed Support Services on 8/26/15. and/or maintained in order to maintain the 2. Audit completed of 100% of building by required fire resistance rating of the area. The facility maintenance staff on 8/20/15 to closet also has hole that were not sealed in order ensure all areas sealed and maintained to maintain the required rating of the room. as required with repairs completed as 3) The clean linen room # 20 has holes in the needed. ceiling and wood was used to seal a hole in the 3. Maintenance staff trained on 8/19/15 ceiling. regarding sealing holes and penetration 4) The electric water heater closet for the kitchen areas. Maintenance will inspect 50% of did not have a finished interior on the wall facilng ceiling walls monthly during rounds to the corridor. (Wall was open to exposed stud ensure compliance with maintenance and wall.) sealing as required. NFPA 101: 19.1.6.2 4. Monthly rounds will be reviewed at Executive Quarterly QI meeting to ensure These deficiency affected four of approximately continued compliance. six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 8/25/15 SS=D Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 134 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
345321		345321	B. WING		08/14/2015	
NAME OF PROVIDER OR SUPPLIER KERR LAKE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1245 PARK AVENUE HENDERSON, NC 27536	·	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
K 018	Continued From pag	ge 2	К0	18		
K 025 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Friday 8/14/15 at approximately 8:00 AM onward the following deficiencies were noted: 1) The right had set of corridor doors the the electric water heaters for the kitchen did not close and latch smoke tight when checked. Ref: NFPA 101, 19.3.6.3 This deficiency affected one of approximately six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4		K 02	1. Corridor doors to the electric was heaters were repaired to close and smoke tight on 8/17/15 by facility maintenance staff 2. Audit completed of 100% of build facility maintenance staff on 8/21/18 ensure doors closed and latched wirepairs completed as needed. 3. Maintenance staff trained 8/19/18 regarding ensuring doors close and smoke tight. Maintenance to insped doors during monthly rounds to ensclose and latch smoke tight. 4. Monthly rounds will be reviewed Executive Quarterly QI meetings to ensure continued compliance.	latch ling by 5 to th latch ct ure	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345321 B. WING 08/14/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1245 PARK AVENUE KERR LAKE NURSING AND REHABILITATION CENTER HENDERSON, NC 27536 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 025 Continued From page 3 K 025 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) 1. Wall located in therapy office evaluated and is not a smoke wall. Self latching Based on observations, on Friday 8/14/15 at door removed from hallway. approximately 8:00 AM onward the following 2. All smoke walls inspected 8/25/15 by deficiencies were noted: facility maintenance staff to ensure 1) The smoke wall located in Therapy office was complete with repairs as needed. not complete between the top of the wall and roof 3. Maintenance staff trained on 8/19/15 deck. regarding ensuring smoke walls remain NFPA 101, 19.3.7.3 sealed with no holes, cracks or NFPA 101, 8.3.6.1 penetrations. Maintenance to inspect smoke walls during monthly rounds to This deficiency affected two of approximately six ensure complete with no holes or cracks. smoke compartments. 4. Monthly rounds will be reviewed at Failure to comply with minimum standards as Executive Quarterly QI meetings to referenced increases the risk of death or injury ensure continued compliance. due to fire and/or smoke. K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 9/1/15 SS=D One hour fire rated construction (with 3/4 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) 1. Supply/ Storage room ceiling repaired

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		345321	B. WING _			08/	14/2015	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
KERRIA	CE NURSING AND REHA	BII ITATION CENTER		12	245 PARK AVENUE			
KERR LAKE NURSING AND REHABILITATION CENTER				HENDERSON, NC 27536				
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K 130	Failure to comply with	ed the kitchen staff only. n minimum standards as the risk of death or injury	K 1	130	ensure continued compliance.			