STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	**1245 PARK AVENUE** **HENDERSON, NC 27536**

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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. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories:1 Construction Type III (211) Constructed: *** Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 92 Census = 86 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 012 SS=F	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 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) In the kitchen the ceiling in the center an area of the room is not maintained in good condition. (ceiling area above prep table/assemble table) 2) The kitchen dietary closet has wood covering	K 012	1. Kitchen ceiling above prep table repaired by Hillco Support Services on 8/26/15. Dietary Closet areas that were wood were covered in sheetrock and ceiling sealed by Hillco Support Services on 8/25/15. Clean Linen room #20 ceiling repaired and holes sealed by Hillco Support Services on 8/26/15. Electric water heater closet wall finished by Hillco	8/28/15

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

Electronically Signed | 08/28/2015

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K 012	Continued From page 1 the left side of the closet. Ceiling was not sealed and/or maintained in order to maintain the required fire resistance rating of the area. The closet also has hole that were not sealed in order to maintain the required rating of the room. 3) The clean linen room # 20 has holes in the ceiling and wood was used to seal a hole in the ceiling. 4) The electric water heater closet for the kitchen did not have a finished interior on the wall facilng the corridor. (Wall was open to exposed stud wall.) NFPA 101: 19.1.6.2 These deficiency affected four 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.	K 012	Support Services on 8/26/15. 2. Audit completed of 100% of building by facility maintenance staff on 8/20/15 to ensure all areas sealed and maintained as required with repairs completed as needed. 3. Maintenance staff trained on 8/19/15 regarding sealing holes and penetration areas. Maintenance will inspect 50% of ceiling walls monthly during rounds to ensure compliance with maintenance and sealing as required. 4. Monthly rounds will be reviewed at Executive Quarterly QI meeting to ensure continued compliance.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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.	K 018		8/25/15

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K 018	Continued From page 2 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.	K 018	1. Corridor doors to the electric water heaters were repaired to close and latch smoke tight on 8/17/15 by facility maintenance staff 2. Audit completed of 100% of building by facility maintenance staff on 8/21/15 to ensure doors closed and latched with repairs completed as needed. 3. Maintenance staff trained 8/19/15 regarding ensuring doors close and latch smoke tight. Maintenance to inspect doors during monthly rounds to ensure close and latch smoke tight. 4. Monthly rounds will be reviewed at Executive Quarterly QI meetings to ensure continued compliance.	
K 025 SS=D	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 025		9/28/15

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K 025	Continued From page 3 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 smoke wall located in Therapy office was not complete between the top of the wall and roof deck. NFPA 101, 19.3.7.3 NFPA 101, 8.3.6.1 This deficiency affected two 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.	K 025	1. Wall located in therapy office evaluated and is not a smoke wall. Self latching door removed from hallway. 2. All smoke walls inspected 8/25/15 by facility maintenance staff to ensure complete with repairs as needed. 3. Maintenance staff trained on 8/19/15 regarding ensuring smoke walls remain sealed with no holes, cracks or penetrations. Maintenance to inspect smoke walls during monthly rounds to ensure complete with no holes or cracks. 4. Monthly rounds will be reviewed at Executive Quarterly QI meetings to ensure continued compliance.	
K 029 SS=D	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	1. Supply/ Storage room ceiling repaired	9/1/15

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K 029	Continued From page 4 Based on observations, on Friday 8/14/15 at approximately 8:00 AM onward the following deficiencies were noted: 1) The supply storage room/office has holes and/or penetration in the ceiling that were not sealed in order to maintain the required rating of the room. NFPA 101: 19.2.1 This deficiency affected one of approximately smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 029	and sealed by Hillco Support Services on 8/24/15 2. Ceilings in facility audited by facility maintenance staff for holes and /or penetrations on 8/24/15 with repairs completed to seal as needed. 3. Maintenance staff trained 8/19/15 regarding ensuring ceilings/ walls remain sealed with no holes, cracks or penetrations. Maintenance to monitor 50% of facility ceilings monthly for holes, cracks, penetrations during rounds to ensure remain sealed. 4. Monthly rounds will be reviewed at Executive Quarterly QI meetings to ensure continued compliance.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 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) Staff in the kitchen when questioned were not familiar on how to operate the Ansul System in case of an emergency. NFPA 96: 8-1.4 "Instructions for manually operating the fire-extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed periodically with employees by the management."	K 130	1. Instructions on how to operate Ansul system posted in kitchen. 2. All dietary staff inserviced by 9/1/15 on how to operate the Ansul system in case of emergency. Inservice will be completed during dietary orientation and annually by dietary manager. 3. Dietary manager will monitor monthly to ensure instructions are posted and will interview 50% of dietary staff monthly to ensure staff is knowledgeable of how to operate Ansul system. 4. Monthly audits will be reviewed at Executive Quarterly QI meetings to	9/4/15

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K 130	Continued From page 5 This deficiency affected the kitchen staff only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 130	ensure continued compliance.	