STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	**128 SNOW HILL ROAD** **AYDEN, NC 28513**

(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. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories: 1 Construction Type V (111) Constructed: 2/14/1999 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 82 Census =74 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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: Based on observations, on Tuesday 6/14/2016 at approximately 10:00AM onward, the following deficiencies were noted: The doors to hazardous area were non-compliant, specific findings include:	K 029	Ayden Court Nursing & Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually	6/22/16

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

Electronically Signed | 06/24/2016

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 1. The door to the storage room in the kitchen was blocked from closing. NFPA 101, 19.3.2.1 Doors are self-closing. This deficiency affected one 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 029	correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Ayden Court Nursing & Rehabilitation Center's response to the statement of deficiencies does not denote agreement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further Ayden Court Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on this statement through informal dispute resolution, formal appeal procedure and or any other administrative legal proceedings. An inservice with 100% of dietary staff regarding the door to the storage room in the kitchen remaining unblocked from closing. All new staff will be educated during orientation. The storage room door was unblocked from closing on 6/14/16. The storage room door closed and latched properly. A 100% audit of all kitchen storage doors was conducted on 6/14/16 by Administrator to identify any other doors that may have been blocked from closing. No other issues found. The maintenance director, housekeeping supervisor, administrator or designee will conduct weekly audits of all kitchen storage doors for three months as part of the preventive maintenance program. All	

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K 029	Continued From page 2	K 029	audits will be taken to the Quarterly QI meeting for review. Adjustments to the audit schedule are to be made as needed. Corrective action will be completed by 6/22/16.	
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: Based on observations, on Tuesday 6/14/2016 at approximately 10:00AM onward, the following deficiencies were noted: The smoke duct detector is the HVC unit was non-compliant, specific findings include: 1. Thw smoke duct detector located in the HVAC unit in the attic on 100 hall was not maintained clean and in good condition. NFPA 101 19.5.2.1, 9.2, NFPA 90A This deficiency affected one 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 067	The smoke duct detector located in the HVAC unit in the attic on 100 hall was cleaned and ensured to be in good working condition on 6/23/16 by maintenance director and representative from BFPE. The maintenance director, housekeeping supervisor, administrator or designee will conduct random weekly audits of the smoke duct detectors in the attic for three months as part of the preventive maintenance program. All audits will be taken to the Quarterly QI meeting for review. Adjustments to the audit schedule are to be made as needed. Corrective action will be completed by 06/24/16.	6/24/16