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
	345449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**04/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	**115 WHITE ROAD** **KING, NC 27021**

(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 III(211) construction, one story, with a complete automatic sprinkler system. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = 120 = 96 NF + 24 AC Total Certified Bed Count 96 Census 86 The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=E	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: 42 CFR 483.70 (a) Based on observations, on April 28, 2016 at approximately 10:45 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 029	F0000 This Plan of Correction is required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the	6/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/13/2016

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 Listed self-closing hardware is missing from rated fire door to maintenance shop - shop contains flammable aerosols and combustible material. NFPA 101, 19.3.2.1 This deficiency affects all 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	part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. 1. Self-closing hardware was installed on the Maintenance Shop door on 5/9/16. 2. All residents at the facility have the potential to be affected by the alleged deficient practice. All doors in the facility will be audited by the Maintenance Director by 5/20/16 to assure self-closing hardware is installed where applicable. Any doors requiring self-closing hardware will by installed by 6/11/16. No negative outcome was identified by the alleged deficient practice. 3. The Maintenance Director will audit all doors one time weekly for three months to assure all self-closing hardware has been installed and functioning properly. The audit results will be recorded on a Quality Assurance Monitoring Tool weekly. 4. The audit findings will be reported monthly by the Maintenance Director to the Quality Assurance/Performance Improvement Committee for three months for further review and the Committee's recommendations to assure proper compliance. The Administrator will be responsible to assure compliance of all audits.	

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K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on April 28, 2016 at approximately 10:45 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. Recent sprinkler inspection reports reveal that no ten year sample testing of dry-pipe sprinklers have occurred based on NFPA 25 requirements. 2. Sprinkler heat sensitive elements are covered with grease and debris - located between kitchen range hood and entrance to kitchen from dining room. NFPA 101, 19.7.6, 9.7.5, 4.6.12, NFPA 13, NFPA 25 This deficiency affects all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	1. A 10 year sampling of dry-pipe sprinklers was completed by Salisbury Fire and Appliance on 5/10/16 and it was noted the sprinkler heads used in the facility were recalled by the Inspector and needed to be replaced. The sprinkler heads will be measured and ordered to complete repair. All sprinkler head repairs will be made no later than 9/12/16 and the Division of Health Service Regulation will be notified when installation will begin and the facility will remain on a fire watch as long as the Fire Alarm System is not operational. The debris has been removed from the two sprinkler elements that were noted in the kitchen and cleaned and two new sprinkler elements have been ordered from Salisbury Fire and Appliance on 5/10/16. The two new sprinkler element replacements in the kitchen will be installed no later than 6/11/16 by Salisbury Fire and Appliance. 2. All residents at the facility have the potential to be affected by the alleged deficient practice. Salisbury Fire and Appliance has the 10 year sampling of dry-pipe sprinklers inspection scheduled for the facility 10 years in the future and the Maintenance Director has future inspections also planned for the 10 year inspection to be completed. An audit was	6/12/16

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K 062	Continued From page 3	K 062	completed by the Maintenance Director on 5/4/16 to assure all sprinkler heads were clean and in proper working condition. The results of his findings were noted on a Quality Monitoring tool. 3. The Maintenance Director will audit all sprinkler heads one time weekly for three months to assure all sprinkler heads are clean and free of debris. The Maintenance Director will clean all sprinkler heads a minimum of weekly if needed. The audit results will be recorded on a Quality Assurance Monitoring Tool weekly by the Maintenance Director. 4. The audit findings will be reported monthly to the Quality Assurance/Performance Committee by the Maintenance Director for three months for further review and the Committee's recommendations to assure proper compliance. The Administrator will be responsible to assure compliance of all audits.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: 42 CFR 483.70(a) Based on observations, on April 28, 2016 at approximately 10:45 AM onward, the following	K 144	1. The 2 hour loadbank test of the diesel powered generator will be completed by Atlantic Cummins no later than 6/11/16.	6/12/16

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K 144	Continued From page 4 deficiencies were noted: The emergency generator operational inspection and testing was non-compliant, specific findings include; documentation for monthly load test was conducted without recording percent rated load for 125 KW generator or temperature rise as indicated in item (a) or (b) as follows: NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144	2. All residents at the facility have the potential to be affected by the alleged deficient practice. The Maintenance Director will annually have a 2 hour loadbank test of the diesel powered generator scheduled with Atlantic Cummins. The facility has signed a contract with Atlantic Cummins to automatically have 2 hour loadbank test scheduled annually for the facility. 3. The Maintenance Director will ensure all inspections are performed as scheduled and record his findings on the Quality Improvement Monitoring Tool form. 4. The audit findings will be reported monthly by the Maintenance Director to the Quality Assurance/Performance Improvement Committee for further review and the Committee's recommendations to assure proper compliance. The Administrator will be responsible to assure compliance of all audits.	

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K 147	Continued From page 5	K 147		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on April 28, 2016 at approximately 10:45 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: Room air conditioner is rated for single use receptacle and dedicated branch circuit in activity office - unit as installed, is connected to a duplex receptacle that serves other equipment. NFPA 101, 19.9.1, 9-1.2 This deficiency affects 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 147	1. A 120 amp dedicated circuit was installed on 5/2/16 to supply power for the activity room air conditioner. 2. All residents of the facility have been identified as having the potential to be affected by the alleged deficient practice. An audit will be completed by the Maintenance Director no later that 5/20/16 of the facility to assure no electrical devices rated for a single use receptacle is connected to a duplex receptacle. 3. An audit of all electrical devices at the facility will be completed one time weekly for three months by the Maintenance Director to assure electrical devices rated for a single use receptacle is not connected to a duplex receptacle. Any issues requiring repair will be completed by 6/11/16. The audit results will be recorded on a Quality Improvement Monitoring Tool weekly. 4. The audit findings will be reported monthly by the Maintenance Director to the Quality Assurance/Performance Improvement Committee for three months for further review and the Committee's recommendations to assure proper compliance. The Administrator will be responsible to assure compliance of all audits.	6/12/16

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