STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING **02 - 24-BEDROOM & THERAPY SUITE ADDITION** B. WING _____	**05/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	**111 HARRILSON STREET** **CHERRYVILLE, NC 28021**

(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 New Health Care section of the LSC and its referenced publications. This building is Type V(211) construction, one story, with a complete automatic sprinkler system and utilizing special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. The new addition is for private rooms and new Therapy area. This addition is not a bed increase. At time of survey the: Total Certified Bed Count =107 Census =97 The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 05/25/2016 at approximately 1:00 PM onward, the following	K 018	Carolina Care ensures doors protecting corridor openings are constructed to prevent passage of fire and/or smoke.	7/9/16

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

Electronically Signed | 06/08/2016

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K 018	Continued From page 1 deficiencies were noted: The standard was non-compliant, specific findings include: residents rooms doors 312 and 316 that open to corridor will not resist the passage of smoke(opening at top of frame greater than 1/2 inch). 2000 NFPA 101, 18.3.6.3.1 This deficiency affected new addition only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 018	Corrective action for alleged deficient practice was corrected by contractor contacted on 5-25-16 to inspect and repair/replace doors on rooms 312 and 316 to resist passage of smoke. Contractor inspected doors 6-3-16. Contractor scheduled door repairs to be initiated 6-8-16 scheduled to be completed 6-17-16. All other corridors were inspected during survey to ensure prevention of smoke passage to protect other residents having potential to be affected by alleged deficient practice. Measures put into place to ensure alleged deficient practice does not recur include: weekly door checks for any problems by maintenance department documented and notification of contractor of any problems. Results will be submitted to Administrator. Monitors put into place to ensure alleged deficient practice does not recur include: Weekly door inspections will be submitted to monthly Quality Assurance and Assessment committee to identify problems noted and evaluate for effectiveness of plan for a period of one year.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by:	K 038		7/9/16

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K 038	Continued From page 2 42 CFR 483.70 (a) Based on observations, on 05/25/2016 at approximately 1:00 PM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: 1. The emergency release switches (for 2 mag -locked doors) located at nurse station and at each locked exit door were not two-way (on/off) switches. The exisiting switches were momentary switches and would automatically relock after 15 seconds. Also switch has to be properly identified at nurse station. . 2000 NFPA 101, 7.2.1.6 This deficiency affected new addition. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	Carolina Care Center provides exit access to be readily accessible at all times. Corrective action for alleged deficient practice was corrected by contacting vendor on 6-3-16 to replace existing release switch with toggle switches in new addition. Toggle switches are scheduled to be replaced by vendor on 6-9-16 Signage to identify emergency release switch was placed on day of survey 5-25-16 All other exits in facility were inspected during survey to allow exit access for other residents with potential to be affected by alleged deficient practice. All other exits were readily accessible. Measure put into place to ensure alleged deficient practice does not recur include: new unit exits operate properly by replacing switches with toggle scheduled by vendor for installation on 6-9-16. System is tested and documented each month with fire drills and as needed by maintenance and submitted to Administrator. Monitors put into place to ensure alleged deficient practice does not recur include: Test results of mag lock release in new unit switches are submitted to monthly Quality Assurance and Assessment for review for any problems noted and to evaluate effectiveness of plan for a period of one year.	

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