STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345101	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	**208 CARY STREET** **ENFIELD, NC 27823**

(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. The facility is utilizing speical locking systems. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories: One Construction Type: III (211) Constructed: 7/1/1973 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 63 Census = 41 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 012 SS=D	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, and documentation review on 6/9/2016, at approximately 9150 AM onward, the following deficiencies were noted: The facility maintenance and inspection of the rated ceilings was non-compliant, specific findings include: The facility rated ceiling in the copier room has a fire barrier pass through device installed. This fire rated passway has fire stop foam and fire	K 012	Enfield Oaks Nursing and 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 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 written allegation of compliance. Enfield Oaks Nursing and Rehabilitation	7/1/16

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

Electronically Signed | 06/23/2016

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K 012	Continued From page 1 barrier calk inside the interior cavity of the pass through device. The fire rated listing device by design does not require additional fire stop material. This deficiency affects 1 of approximately 4 smoke zones in the facility. Ref: 2000 NFPA 101 Section 19.1.6.2 2000 NFPA 101 Section 8.2.3.2.4.2	K 012	Center's response to this Statement of Deficiencies nor does it constitute an admission that any deficiencies is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeals procedure and/or any other administrative or legal proceeding. K012 Maintenance Supervisor will replace the current fire barrier pass through device without the use of fire barrier caulk in the interior cavity of the pass through device by 6/24/16. Maintenance Supervisor conducted 100% audit to ensure no other pass through devices are affected under this standard with no other areas identified on 6/22/16. Maintenance Supervisor was in-serviced on 6/21/16 by the Administrator related to fire barrier passthroughs do not require the use of additional fire barrier caulk in the interior of the device. Maintenance Supervisor will audit all fire barrier pass through devices weekly x 4 weeks, then biweekly x 4 weeks, then monthly on Preventative Maintenance rounds. Any negative findings will be addressed and repaired upon discovery. Results of the on-going audits will be brought to the monthly QI/QA committee meeting with modifications made to the POC as needed based on result findings x	

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K 012	Continued From page 2	K 012	4 months.	
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 and document review on 6/9/2016 at approximately 9:15 AM onward, the following deficiencies were noted: The facility failed to meet the requirement for preventive maintenance for hazardous areas. The specific items include: The facility has a build up of dust and lint in the upper portion of the combustion chamber of the gas fired dryers in the laundry department making higher risk of fire in the laundry. The deficiency affects all of the gas fired dryers in the laundry department. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1	K 029	K029 Maintenance Supervisor cleaned dryer #1 and dryer #2 on 6/09/16. Maintenance Supervisor was In-serviced by the Administrator on 6/20/16 to ensure that both dryers are being cleaned on a set cleaning schedule. Maintenance Supervisor will utilize a Clothes Dryer Check List to check/clean the combustion chambers of both dryers Monday-Friday x 4 weeks, then 2 times per week x 4 weeks and then weekly for on-going preventative maintenance. Results of the audit will be brought to the QI/QA Committee meeting monthly and recommend any changes to the POC at that time x 4 months.	7/1/16
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		7/1/16

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K 054	Continued From page 3 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, and documentation review on 6/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted: The facility location of smoke detectors was non-compliant and the specific items include: The smoke detector near the required exit leading to the facility generator room is not spaced more than minimum requirement of 36 inches from air supply or return air diffusers. All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. NFPA 101, Sect 9.6.1.3 The deficiency affected 1 of approximately 5 smoke zones in the facility. Ref: 2000 NFPA 101 Sections 19.3.4;	K 054	K054 Contract services, BFPE, came out to the facility on 6/16/16 to correct the placement of the detector located near the exit leading to the generator room. This detector meets the minimum requirement of 36 inches from air supply or return air diffusers. Maintenance completed 100% audit of all smoke detectors in the facility to ensure that all other detectors in the facility meet this standard. Maintenance Supervisor was in-serviced on 6/21/16 by the Administrator in regards to the requirement that all smoke detectors must be spaced 36 inches from air supply or return air diffusers. Maintenance Supervisor will audit all facility smoke detectors to ensure that each meets this regulation weekly x 4 weeks, then every two weeks x 4 weeks then monthly on-going with the preventative maintenance program. The results of the audits will be brought to the monthly QI/QA Committee meeting monthly and any changes to the POC will be made at that time based on the results x 4 months.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		7/1/16

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K 062	Continued From page 4 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, and documentation review on 6/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted: The facility maintenance and inspection of sprinkler heads was non-compliant, specific findings include: The facility dry storage room inside the dietary department is currently protected by an approved fire suppression sprinkler system. The sprinkler head in this space is a quick response green color glass bulb sprinkler. The facility must verify that the space protected is greater than an ordinary hazard sprinkler classification. This deficiency affects 1 of approximately 4 smoke zones in the facility. Ref: 2000 NFPA 101 Section 19.3.2.1; 9.7.5	K 062	L062 Contract company, BFPE, came out to the facility on 6/16/16 and replaced the green sprinkler head with an appropriate red sprinkler head located in the facility dry storage room inside the dietary department. 100% audit was completed by the Maintenance Supervisor on 6/23/16 to ensure all sprinkler heads in the facility is complaint with this standard. Corporate Office staff in-serviced the Maintenance Supervisor on 6/23/16 on how to determine what type of sprinkler heads are needed in given areas of the facility. Sprinkler heads will be audited every week x 4 weeks, then every 2 weeks x 4 weeks, then monthly with preventative maintenance program. Audits will be taken to the QI/QA Committee Meeting monthly x 4 months to determine if any change in the POC is needed.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with	K 072		7/1/16

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K 072	Continued From page 5 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, and documentation review on 6/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted: The facility failed to have its required means of egress corridors clear of obstructions., specific findings include: The facility has bug lights that protruded into the corridor past the hand rails. The bug lights are below the six feet eight inch requirement for items protruding into the egress corridor. The locations are: 1. Between rooms 6 and 8 2. Between rooms 13 and 15 3. Between rooms 26 and 27 This deficiency affects 2 of approximately 4 smoke zones in the facility. Ref: 2000 NFPA 101 Section 19.2.1; 7.1.5	K 072	L 072 Contract company, Steritech, came out to the facility on 6/20/16 and raised the fly lights between room 6 and 8, rooms 13 and 15 and rooms 26 and 27 to the required six feet eight inch requirement for items that protrude into the corridor past the handrails. 100% audit was conducted by the Maintenance Supervisor on 6/22/16 to ensure that all means of egress were free from obstructions or impediments to include the interior and exterior of the building with negative findings Maintenance Supervisor was in-serviced on 6/20/16 to ensure no objects are to protrude past the handrails and means of egress corridors are clear from all obstructions. Maintenance Supervisor will audit all means of egress weekly x 4, then bi-weekly x4 and then monthly on prevention maintenance monitoring. All audit results will be taken to the monthly QI/QA meeting and changes to the POC made at that time x 4 months.	