DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION IG 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		345417	B. WING _		08/17/2016	
	ROVIDER OR SUPPLIER NURSING CENTER OF V	WAK		STREET ADDRESS, CITY, STATE, ZIP CODE 968 EAST WAIT AVENUE WAKE FOREST, NC 27587		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
K 000	INITIAL COMMENTS	;	K 0	00		
K 038 SS=E	as per The Code of F 483.70(a); using the 3 section of the LSC are publications. The face locking systems. In the deficiencies noted we acknowledged with a stories: One Construction Type: \Constructed: 1992 Fully Sprinkled - Yes At time of survey the Total Certified Bed Consus = 145 The requirement at 4 NOT MET as evidence NFPA 101 LIFE SAFE Exit access is arrange accessible at all times 7.1. 19.2.1 This STANDARD is 142 CFR 482.41(a) Based on the observation 8/17/2016 at apport the following deficien The facility maintenant door release mechant systems was non-coinclude: The facility door release	cility is utilizing speical ne exit conference all ere discussed and dministration. (1111) (KO	Plan of Correction: K-038 #1. Address how corrective action w accomplished for those residents for have been affected by the deficient practice; The facility door release mechanism the locking system at the entrance of special care unit did not release the electromagnetic locked door when to on 8-17-16. The door release mechanism the entrance of the special care unit was repaired on 8-19-16 by the	for f ested	
		CLIDDLIED DEDDECENTATIVE'S SIGNATUS		TITLE	(YE) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

08/29/2016 **Electronically Signed**

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION . BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345417	B. WING _			08/17/2016	
NAME OF PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP C			
HILLSIDE	NURSING CENTER OF	WAK		968 EAST WAIT AVENUE			
				WAKE FOREST, NC 27587		T	
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K 038	Continued From pag	e 1	K 0	38			
	The door did release alarm system and the the nurses station. Ref: 2000 NFPA 10° This deficiency affects smoke zones in the failure to comply with	h minimum standards as s the risk of death or injury		Maintenance Supervisor ar correctly releasing on active #2. Address how the facility other residents having the paffected by the same deficiental door release mechanism were inspected by the Main Supervisor on 8-19-16 and operating properly releasing #3. Address what measures place or systemic changes ensure that the deficient pracecur; The quarterly maintenance be revised to include check release mechanisms that reactivated. The Maintenance will be responsible to check mechanisms to ensure that	ation. y will identify cotential to be ent practice; ns in the facility ntenance d found to be g on activation. s will be put in made to actice will not schedule will sing door elease when e Supervisor a door release		
K 147 SS=D	Electrical wiring and accordance with Nat (NFPA 99) 18.9.1, 19 This STANDARD is 42 CFR 482.41(a)	ETY CODE STANDARD equipment shall be in ional Electrical Code. 9-1.2 9.9.1 not met as evidenced by: ations, and staff interviews	K 1	functioning properly. #4. Indicate how the facility monitor its performance to solutions are sustained. The quarterly maintenance be performed by the Mainte Supervisor, monitored by th Administrator, and reported assurance committee for re recommendations.	plans to make sure that schedule will enance ne I to the quality eview and	8/29/16	

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		345417	B. WING _		_	08/	17/2016
NAME OF PROVIDER OR SUPPLIER HILLSIDE NURSING CENTER OF WAK			STREET ADDRESS, CITY, ST. 968 EAST WAIT AVENUE WAKE FOREST, NC 275				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 147	the following deficient. The facility maintenal electrical system was findings include: 1. The facility has a 3 in the unit two electrom that the plank the box that did not selectrical circuitry. 2. The facility has a din the unit two electrical circuitry. 3. The facility has a din the unit two electrical circuitry. 3. The small dining redoes not have a unital circuit that does not h	cies were noted: Ince and inspection of the sonon-compliant, specific circuit breaker box number trical / hot water heater space plate near the top of it properly and exposed the circuit breaker box number 1 cal / hot water heater room of the special care unit any light on the emergency have the ability to be rent condition may leave as in case of a power outage. Section 19.5.1; 9.1.2 ed one of approximately ten acility. In minimum standards as the risk of death or injury	К-	have been affected practice; 1. The circuit breathe unit two electric room was adjusted expose the electric completed on 8-19-Supervisor. 2. Circuit breaker unit two electrical/h was adjusted to sit expose the electrical completed on 8-19-Supervisor. 3. The unitary light room in the special corrected on 8-19-Supervisor and car The unitary light relemergency general #2. Address how the other residents have affected by the sam All circuit breaker pwere inspected by Supervisor on 8-19 required. All dining rooms in inspected by the Mon 8-19-16 and all working properly. #3. Address what in place or systemic of ensure that the defirecur; The Maintenance Squarterly maintenant include checking all	aker box number 3 is cal/hot water heater to sit properly and real circuitry. This was also hot water heater room properly and not al circuitry. This was also hot water heater room properly and not al circuitry. This was also hot in the small dining care unit was also the Maintenant was also to the Maintenant heater circuit. The facility will identify wing the potential to the deficient practice wanels in the facility the Maintenance also and adjusted if the facility were aintenance Supervisunitary lights were measures will be put changes made to icient practice will not supervisor on the	not s nce e m s	

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K 147	Continued From page	. 3	K 14	expose electrical circuitry. The Maintenance Supervisor on the quarterly maintenance schedule will include checking unitary lighting in the dining rooms to ensure that they are working properly and corrected as needed. #4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The quarterly maintenance schedule who be conducted by the Maintenance Supervisor, monitored by the Administrator, and reported to the qualessurance committee for review and recommendations.	that vill		