STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	**968 EAST WAIT AVENUE** **WAKE FOREST, NC 27587**

(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: V (111) Constructed: 1992 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 150 Census = 145 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 482.41(a) Based on the observations, and staff interviews on 8/17/2016 at approximately 9:15 AM onward, the following deficiencies were noted: The facility maintenance and inspection of the door release mechanism for the speical locking systems was non-compliant the specific items include: The facility door release mechanism for the locking system at the entrance of speical care unit of the facility did not release the	K 038	Plan of Correction: K-038 #1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility door release mechanism for the locking system at the entrance of special care unit did not release the electromagnetic locked door when tested on 8-17-16. The door release mechanism at the entrance of the special care unit was repaired on 8-19-16 by the	8/29/16

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

Electronically Signed | 08/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	**968 EAST WAIT AVENUE** **WAKE FOREST, NC 27587**

(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 038	Continued From page 1 electromagnetically locked door when tested. The door did release with activation of the fire alarm system and the door release mechanism at the nurses station. Ref: 2000 NFPA 101 Section 19.2.1; 7.2.1.6 This deficiency affected one of approximately ten smoke zones in the facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	Maintenance Supervisor and operating correctly releasing on activation. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All door release mechanisms in the facility were inspected by the Maintenance Supervisor on 8-19-16 and found to be operating properly releasing on activation. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The quarterly maintenance schedule will be revised to include checking door release mechanisms that release when activated. The Maintenance Supervisor will be responsible to check door release mechanisms to ensure that they are functioning properly. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The quarterly maintenance schedule will be performed by the Maintenance Supervisor, monitored by the Administrator, and reported to the quality assurance committee for review and recommendations.	
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 482.41(a) Based on the observations, and staff interviews	K 147	Plan of Correction: K147 #1. Address how corrective action will be accomplished for those residents found to	8/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	**968 EAST WAIT AVENUE** **WAKE FOREST, NC 27587**

(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 147	Continued From page 2 on 8/17/2016 at approximately 9:15 AM onward, the following deficiencies were noted: The facility maintenance and inspection of the electrical system was non-compliant, specific findings include: 1. The facility has a circuit breaker box number 3 in the unit two electrical / hot water heater room that the plank space plate near the top of the box that did not sit properly and exposed the electrical circuitry. 2. The facility has a circuit breaker box number 1 in the unit two electrical / hot water heater room that the box is off center and exposed the electrical circuitry. 3. The small dining room in the speical care unit does not have a unitary light on the emergency circuit that does not have the ability to be switched of. This current condition may leave that room in darkness in case of a power outage. Ref: 2000 NFPA 101 Section 19.5.1; 9.1.2 This deficiency affected one of approximately ten smoke zones in the facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 147	have been affected by the deficient practice; 1. The circuit breaker box number 3 in the unit two electrical/hot water heater room was adjusted to sit properly and not expose the electrical circuitry. This was completed on 8-19-16 by the Maintenance Supervisor. 2. Circuit breaker box number 1 in the unit two electrical/hot water heater room was adjusted to sit properly and not expose the electrical circuitry. This was completed on 8-19-16 by the Maintenance Supervisor. 3. The unitary light in the small dining room in the special care unit was corrected on 8-19-16 by the Maintenance Supervisor and cannot be switched off. The unitary light remains on the emergency generator circuit. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All circuit breaker panels in the facility were inspected by the Maintenance Supervisor on 8-19-16 and adjusted if required. All dining rooms in the facility were inspected by the Maintenance Supervisor on 8-19-16 and all unitary lights were working properly. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The Maintenance Supervisor on the quarterly maintenance schedule will include checking all circuit breaker panels to ensure that they sit properly and do not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	**968 EAST WAIT AVENUE** **WAKE FOREST, NC 27587**

(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 147	Continued From page 3	K 147	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 that solutions are sustained. The quarterly maintenance schedule will be conducted by the Maintenance Supervisor, monitored by the Administrator, and reported to the quality assurance committee for review and recommendations.	