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

AND DI AN OF CORRECTION INTERPRETATION NUMBERS		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345166 B. WING			06	06/22/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME				157	REET ADDRESS, CITY, STATE, ZIP CODE 70 NC 8 AND 89 HIGHWAY NBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
K 000	at 42CFR 483.70(a) Health Care section publications. This bu construction, two sto sprinkler system. In deficiencies noted w acknowledged with a At time of survey the NF Total Certified Bed 0 Census 40 NF The deficiencies det are as follows:	de(LSC) survey was the Code of Federal Register the using the 2000 Existing of the LSC and its referenced dilding is Type II(222) ory, with a complete automatic the exit conference all there discussed and dadministration. The licensed bed capacity = 40 Count 40 NF The ermined during the survey	K 0		DEFICIENCY)		
K 012 SS=F	Building construction of the following: 19.1.6.2, 19.1.6.3, 1 This STANDARD is 42 CFR 483.70 (a) Based on observation approximately 11:30 deficiencies were no non-compliant, spectom of the are holes in the assembly behind first located in ice machine NFPA 101, 19.1.6.2,	ons, on June 22, 2016 at AM onward, the following ted: The standard is iffic findings include: the rated floor/ceiling at floor nurse's station -	K 0	J12	Corrective action plan to be accomplished by the facility to correct deficient practice: Maintenance staff replaced the ceiling tiles in the rated floor/ceiling assembly behind the first floor nurses station-located in the ice machine room. How will other life safety issues having potential to affect residents by the sam deficient practice be identified: Maintenance staff inspected the		7/6/16
ABOBATORY	NIDECTOR'S OR BROVINER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	 DE		TITLE		(X6) DATE

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.

Electronically Signed

07/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		345166	B. WING			06/22/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME				15	TREET ADDRESS, CITY, STATE, ZIP CODE 570 NC 8 AND 89 HIGHWAY ANBURY, NC 27016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 012	Continued From page 1 compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.		K	012	remaining floor/ceiling assembly for the unit and no additional holes were identified. Maintenance staff will inspect all floor/ceiling assembly for the unit for he and replace as needed on a monthly basis. Measures to be put in place or systemi changes made to ensure that deficient practice will not occur: Maintenance staff inspected the remaining floor/ceiling assembly for the unit and no additional holes were identified. Maintenance staff will inspect all floor/ceiling assembly for the unit for he and replace as needed on a monthly basis. Checking the floor/ceiling assembly for the unit will be completed per the mont maintenance checklist. How will the facility monitor performance to make sure that solutions are sustain. Maintenance director will add checking and repair of the floor/ceiling assembly holes to the monthly safety rounds of maintenance and repairs. Any holes on needed repair will be corrected when it noted on inspection. This will be completed monthly for one year and longer if indicated.	oles c hly eed:	

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		345166 B. WING			06/22/2016
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STOKES	COUNTY NURSING HOM	E		570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				D BE COMPLETION
K 012	Continued From page	÷ 2	K 012	All findings will be reported on safety survey monthly and in quarterly Environment of care and monthly Housewide QI meeting.	,
K 144 SS=E	Generators inspected under load for 30 min in accordance with Ni 3-4.4.1 and 8-4.2 (NF 110) This STANDARD is r 42 CFR 483.70 (a) Based on observation approximately 11:30 deficiencies were not non-compliant, specif 1. Visual indicator for functioning on automal located in main electr 2. There are no documented in main electricated in main electricated in the generator of the complete documents to not contain alternative allowance standard. 3. There are no specific hecks in accordance documents did not should be simple to the container of the	normal power is not atic transfer switch CMPA - ical/mechanical room. ments confirming test of stem in accordance with The documented monthly irty percent of combined ratings(800KW); the firm compliance with s permitted by referenced fic gravity and electrolyte with NFPA 110 - available ow specific gravity gravity lls; and did not document ecordance with	K 144	Corrective action plan to be accomplished by the facility to corrected deficient practice: Item 1- Maintenance director repairs visual indicator for normal power on automatic transfer switch CMA- locathe main electrical/mechanical room 7-5-16. Item 2- The weekly internal testing a monthly on site testing had been completed and documented but not components were included. The test emergency power system in accorda with NFPA 110 Chapter 6 had not be completed by an outside vendor with capability to complete this test. The has been scheduled with Carolina Generator for August 1, 2016. Item 3- Generator battery cell tester purchased with weekly testing and documentation of specific gravity an electrolyte levels on 7-1-2016.	ed the the ted in on and all ting of ance een n test

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		345166	B. WING _			06/	22/2016	
NAME OF P	1E		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			, 00:22:20:0		
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K 144	compartments. Failure to comply wit	FPA 110 Chapter 6 Intially affects all smoke In minimum standards as as the risk of death or injury	K.	144	How will other life safety issues having potential to affect residents by the sam deficient practice be identified: Item 1- Maintenance director repaired visual indicator for normal power on the automatic transfer switch CMA- located the main electrical/mechanical room or 7-5-16. Inspection will be completed weekly to verify visual indicator is work. Item 2- The weekly internal testing and monthly on site testing had been completed and documented but not all components were included. Due to the monthly loads being less than thirty percent of combined generator namep ratings, outside load bank testing is required. The testing of emergency power system in accordance with NFP. 110 Chapter 6 had not been completed an outside vendor with capability to complete this test. The test has been scheduled with Carolina Generator for August 1, 2016. This outside testing we be scheduled and completed annually required. Item 3- Generator battery cell tester was purchased with weekly testing and documentation of specific gravity and electrolyte levels started on 7-1-2016. This testing has been added to the we checklist for completion and documentation. Measures to be put in place or system changes made to ensure that deficient practice will not occur:	e the e d in ing. late A d by rill as ekly		

NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME SUBMENT SUPPLIES SOLD SHIGHWAY DANBURY, NC 27016 SUBMENT SUPPLIES SOLD SHIGHWAY DANBURY, NC 27016 SUBMENT SUPPLIES SOLD SHIGHWAY DANBURY, NC 27016 K 144 Continued From page 4 K 144 K 144 Continued From page 4 K 144 K 144 Item 1- Maintenance director repaired the visual indicator for normal power on the automatic transfer switch CMA- located in the main electrical/mechanical room on 7-5-16. Inspection will be completed weekly to verify visual indicator for normal power on the normal power on the automatic transfer switch CMA- located in the main electrical/mechanical room on 7-5-16. Inspection will be completed weekly to verify visual indicator switch switch growth and monthly on site testing had been completed and documented but not all components were included. Due to the monthly loads being less than thirty percent of combined generator nameplate ratings, outside load bank testing is required. The testing of emergency power system in accordance with NFPA 110 Chapter 6 had not been completed by an outside vendor with capability to complete this test. The test has been scheduled with Carolina Generator for August 1, 2016. This outside testing will be scheduled and completed and on 7-1-2016. This testing has been added to the weekly checklist for completion and documentation. How will the facility monitor performance to make sure that solutions are sustained:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
STOKES COUNTY NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR I.SC. IDENTIFYING INFORMATION) PREFIX TAG			345166	B. WING	 	06/22/2016	
CASTOR C	NAME OF PR	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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Item 1- Maintenance director repaired the visual indicator for normal power on the automatic transfer switch CMA- located in the main electrical/mechanical room on 7-5-16. Inspendicular on 7-1-2016. This testing and on 7-1-2016. This testing on 7-1-2016. This testing on 7-1-2016. This testing of machine of specific gravity and electrolyte levels started on 7-1-2016. This testing has been added to the weekly checklist for completion and documentation.	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
visual indicator for normal power on the automatic transfer switch CMA- located in the main electrical/mechanical room on 7-5-16. Inspection will be completed weekly to verify visual indicator is working. Item 2- The weekly internal testing and monthly on site testing had been completed and documented but not all components were included. Due to the monthly loads being less than thirty percent of combined generator nameplate ratings, outside load bank testing is required. The testing of emergency power system in accordance with NFPA 110 Chapter 6 had not been completed by an outside vendor with capability to complete this test. The test has been scheduled with Carolina Generator for August 1, 2016. This outside testing will be scheduled and completed annually as required. Item 3- Generator battery cell tester was purchased with weekly testing and documentation of specific gravity and electrolyte levels started on 7-1-2016. This testing has been added to the weekly checklist for completion and documentation. How will the facility monitor performance	K 144	Continued From page	2 4	K 14	14		
Maintenance director will add weekly, monthly and annual checks and testing to					visual indicator for normal power on the automatic transfer switch CMA- located the main electrical/mechanical room of 7-5-16. Inspection will be completed weekly to verify visual indicator is work litem 2- The weekly internal testing and monthly on site testing had been completed and documented but not all components were included. Due to the monthly loads being less than thirty percent of combined generator namer ratings, outside load bank testing is required. The testing of emergency power system in accordance with NFF 110 Chapter 6 had not been complete an outside vendor with capability to complete this test. The test has been scheduled with Carolina Generator for August 1, 2016. This outside testing we scheduled and completed annually required. Item 3- Generator battery cell tester we purchased with weekly testing and documentation of specific gravity and electrolyte levels started on 7-1-2016. This testing has been added to the we checklist for completion and documentation. How will the facility monitor performant to make sure that solutions are sustain. Maintenance director will add weekly,	ne d in n n king. d l e blate PA d by vill as as ekkly ce ned:	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345166 B. WING 06/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY STOKES COUNTY NURSING HOME DANBURY, NC 27016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 144 Continued From page 5 K 144 completed and documented by maintenance staff and reported monthly for one year and longer if indicated. Failure to complete all testing will be addressed and corrected immediately. All testing and completed checklists will be provided to the Quality of Life and Housewide QI meeting monthly. K 145 NFPA 101 LIFE SAFETY CODE STANDARD K 145 7/14/16 SS=E The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99) This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Corrective action plan to be accomplished by the facility to correct the Based on observations, on June 22, 2016 at deficient practice: approximately 11:30 AM onward, the following deficiencies were noted: The standard is Maintenance director contacted electrical non-compliant, specific findings include: vendor, who will be on site to install a new electrical feed from the Life Safety 1. The fire control panel is connected to the generator to the fire alarm panel at the normal power distribution panel instead of the Life entrance. The generator annunciator Safety Branch system of the essential electrical panel will be connected to read the EPS supplying load during testing of the system. emergency power supply system. Upon 2. The generator annunciator panel is not reading completion, testing will be completed with EPS supplying load during test of emergency loss of normal power to ensure the power supply system. During loss of normal annunciator indicates the generator is power to ATS(CMPA), the generator annunciator supplying load through the transfer switch. did not read connection of generator supplying load through transfer switch. How will other life safety issues having potential to affect residents by the same NFPA 99, 3-4.2.2.2, 3-5.2.2 deficient practice be identified: This deficiency potentially affects all smoke Maintenance director contacted electrical

Facility ID: 943474

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		345166	B. WING _			06/22/2016	
	NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, I 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	ZIP CODE	00/22/2010	
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K 145	compartments. Failure to comply with	n minimum standards as the risk of death or injury	K	vendor, who will be on electrical feed from the generator to the fire ala entrance. The generator panel will be connected supplying load during the emergency power supplying load through loss of normal power to annunciator indicates the supplying load through. The maintenance direct all required weekly and components from the Notesting and inspection of generator and added at the checklist. These would and documented at the weekly or monthly interesting made to ensure practice will not occur. Maintenance director convendor, who will be on electrical feed from the generator to the fire ala entrance. The generator panel will be connected supplying load during the emergency power supply completion, testing will loss of normal power to annunciator indicates the supplying load through. The maintenance directors of the fire ala entrance indicates the supplying load through.	Life Safety arm panel at the or annunciator It to read the EPS esting of the oly system. Upon be completed with or ensure the the generator is the transfer switch tor has reviewed monthly IFPA guidelines for of the Life Safety II components to iill be completed or appropriate vals. Is place or systemic appropriate vals. In the safety arm panel at the or annunciator of to read the EPS esting of the or system. Upon be completed with or ensure the		

l' '		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345166	B. WING _			06/	22/2016	
NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE				
K 145	Continued From page	97	K	145	all required weekly and monthly components from the NFPA guidelines testing and inspection of the Life Safety generator and added all components to the checklist. These will be completed and documented at the appropriate weekly or monthly intervals. Maintenance director will verify that the new electrical feed and annunciator are working properly upon installation on J 14, 2016. The maintenance staff will test and document monthly load testing and that the generator is supplying load through the transfer switch. How will the facility monitor performance to make sure that solutions are sustain. The maintenance staff will test and document monthly load testing and that the generator is supplying load through the transfer switch. This will be completed and documented on checklists and reported monthly for one year and long if indicated. All findings will be reported monthly to Safety committee and Housewide QI meeting.	t e e e e e e e e e e e e e e e e e e e		