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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	**07/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	**401 N MORGAN STREET** **SHELBY, NC 28150**

(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: II (222) Constructed: 1972 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 160 Census = 128 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
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 482.41(a) Based on the observations, and staff interviews on 7/19/2016 at approximately 9:00 AM onward,	K 029	White Oak Manor-Shelby does provide an approved automatic fire extinguishing system.	7/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/04/2016

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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K 029	Continued From page 1 the following deficiencies were noted: The facility maintenance and inspection of the rated ceiling in hazardous areas was non-compliant the specific items include: The facility has unsealed penetrations in the rated ceiling of the mechanical room of the older section. The penetrations in this space must be maintained with approved materials to maintain the integrity of the rated ceiling in the space. Ref: 2000 NFPA 101 Sections 19.1.6.2, 8.2.3.2.4.2* 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 029	The unsealed penetrations in the rated ceiling of the mechanical room of the main building were sealed on 7-21-16. The penetrations were sealed with Hilti firestop material. The Maintenance Director has inspected the ceilings throughout the facility to identify and correct any other unsealed penetrations to ensure compliance to K029. This was completed on 7-22-16. Monthly inspections of facility ceilings for any unsealed penetrations will be completed by the Maintenance Director (or Maintenance Assistant under the direction of the Maintenance Director). The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the monthly QA Committee Meeting. The Maintenance Director and the Administrator are responsible for compliance to K029.	
K 038 SS=F	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 7/19/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The facility maintenance and inspection of the	K 038	White Oak Manor-Shelby does ensure exit access is arranged so that exits are readily accessible at all times. The door release mechanism for the special locking system near room 112 was	8/2/16

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K 038	Continued From page 2 door release mechanism for the speical locking systems was non-compliant the specific items include: The facility door release mechanism for the speical locking system in the order section of the facility near room 112 did not release when tested. 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	replaced by a fire protection contractor on 8-2-16. An audit of the facility's other door release mechanisms for the special locking system was completed by the Maintenance Director on 7-19-16 to ensure compliance to K038. As of 8-2-16, all facility door release mechanisms for the special locking system are functional. At least monthly inspections of the facility's door release mechanisms for the special locking system will be completed by the Maintenance Director (or Maintenance Assistant under the direction of the Maintenance Director). The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the monthly QA Committee Meeting. The Maintenance Director and the Administrator are responsible for compliance to K038.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating 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 482.41(a) Based on the observations, and staff interviews on 7/19/2016 at approximately 9:00 AM onward,	K 062	White Oak Manor-Shelby does ensure required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and	8/9/16

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K 062	Continued From page 3 the following deficiencies were noted: The facility maintenance and inspection of the sprinkler system in the was non-compliant the specific items include: 1. The sprinkler system has dust and lint debris on the heat sensitive element of the sprinkler heads at the following locations: A. Laundry department B. Dietary department near the kitchen hood 2. The sprinkler heads at the required exit near room 216 were noted to be out of date and in need of replacement by the facility sprinkler contractor dated June 2016. Ref: 2000 NFPA 101 Sections 19.3.5.1, 19.7.6; NFPA 25 These deficiencies affect the two smoke zones and the required exit egress. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	tested periodically. 1.) The sprinkler heads at the A.) Laundry department and B.) Dietary department near the kitchen hood were cleaned by the Maintenance Supervisor on 7-21-16 and are free of dust and/or debris. An audit of other sprinkler heads in the facility was completed by the Maintenance Director on 7-22-16 to ensure compliance to K062. The Maintenance Director has implemented a quarterly preventative maintenance schedule for checking all sprinkler heads to ensure there is no dust and/or debris. This will be completed by the Maintenance Director (or Maintenance Assistant under the direction of the Maintenance Director). The inspection findings will be reported to the Administrator by the Maintenance Director. The inspection findings will also be reviewed at the Monthly QA Committee Meeting. 2.) The sprinkler heads at the required exit near room 216 that were noted to be in need of replacement were ordered and are scheduled to be installed by a qualified contractor on 8-9-16. Any other sprinkler heads needing replacement were also reviewed and ordered on 7-28-16 and will also be installed on 8-9-16 to ensure compliance to K062.	

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K 062	Continued From page 4	K 062	The Maintenance Director will be responsible for ensuring reviews of the facility sprinkler contractor audits when completed and ensuring any needed sprinkler heads are ordered and installed promptly. The review findings will be reported to the Administrator by the Maintenance Director. The findings will also be reviewed at the Monthly QA Committee Meeting. The Maintenance Director and the Administrator are responsible for compliance to K062.	