STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING **02 - WHITE OAK MANOR-SHELBY** 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 New 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 with administration. Stories: One and basement is mechanical space Construction Type II (111) Constructed: 2015 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 160 Census - 124	K 000		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96 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 hood suppression system in the new rehab building was non-compliant the specific items include: The facility hood suppression system must be inspected at least semiannually. The new rehab area has a hood system installed and the facility does not have a tag or label securely attached indication the month and year the maintenance was preformed and the identification of the person performing the maintenance.	K 069	White Oak Manor-Shelby ensures cooking facilities shall be protected. The Rehab building facility hood suppression system was inspected on 8-2-16. An audit of the other hood suppression system was conducted by the Maintenance Supervisor on 7-19-16 to ensure inspection completed semiannually and ensure compliance to K069. No other issues were identified. Semiannual inspections of facility hood suppression systems will be completed by	8/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		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 069	Continued From page 1 Ref: 2000 NFPA 101 Sections 19.3.2.6, 9.6; 9.2.3; NFPA 17A Section 7.3.2.6* 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 069	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 K069.	