STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	**811 SNOWBIRD ROAD** **ROBBINSVILLE, NC 28771**

(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 This 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. This building is Type III(211) construction, one story, with a complete automatic sprinkler system and using special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = Total Certified Bed Count = 80 Census = 74 The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is a mechanical supply outlet that is not equipped with a ceiling fire damper - located in the kitchen pantry roof/ceiling assembly. Note: Ceiling fire damper shall be installed in accordance with the manufacturer's installation instructions.	K 012	K012 SS=E A ceiling fire damper will be installed in the mechanical supply outlet located in the kitchen pantry in accordance with the manufacturer's installation instructions on or before Sept 11, 2016. An audit was performed by the Maintenance Supervisor and all fire dampers in the storage rooms, except for one mentioned above are working properly.	9/11/16

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

Electronically Signed | 08/22/2016

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K 012	Continued From page 1 NFPA 101, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This deficiency affects one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure all smoke dampers to include the kitchen pantry weekly X 4 weeks, then a monthly audit will be conducted by Maintenance Supervisor or designee to ensure all smoke dampers are working properly. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There are holes in the cross corridor smoke barrier doors - located near room 22. NFPA 101, 19.3.7.5, 19.3.7.6. 19.3.7.7	K 027	K027 SS=D The holes in the cross corridor smoke barrier doors located near room 22 were repaired with fireproofing caulking on August 5,2016. A audit of all doors has been completed and no holes were found in any other doors.	8/22/16

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K 027	Continued From page 2 This deficiency potentially affects two of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 027	A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure all doors are free of holes weekly for 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure no holes are found in any doors. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	
K 029 SS=D	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 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: Fire door to central supply would not self latch without manual intervention - located beside front entrance conference room. NFPA 101, 19.3.2.1	K 029	K=029 SS=D Fire Door to central supply closet was repaired by the Maintenance Supervisor on 8-5-16, so that it self latches without manual interventions. An audit was conducted by Maintenance Supervisor to check all fire doors to ensure they latch properly without manual intervention.	8/22/16

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K 029	Continued From page 3 This deficiency affects one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 029	A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure all doors are latching properly and not requiring manual interventions weekly x 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure all doors are latching properly and not requiring manual interventions. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	
K 032 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: The chain link fence with gate assembly creates an enclosed courtyard with travel distance exceeding fifty feet; also, the area is using outdoor furniture in the required means of egress from exit discharge near resident room #60.	K 032	K032 SS=E Chain link fence and gate was removed on 8-5-16 located in back courtyard near room #60 by Maintenance Supervisor. An audit was conducted by the Maintenance Supervisor to check all areas around the facility to ensure areas are free of fencing and gates. A weekly audit will be conducted by	8/22/16

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K 032	Continued From page 4 NFPA 101, 19.2.4.1, 19.2.4.2, 7.1.10 This deficiency potentially affects one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 032	Maintenance Supervisor or designee to ensure areas around the facility are free of fences and gates weekly for 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure areas around facility are free of fences and gates. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	
K 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There are two main sprinkler control valves without electrical supervision in the outside sprinkler vault - located to the left of front entrance area. NFPA 101, 9.7.2.1 This deficiency potentially affects all smoke compartments.	K 061	K061 SS=E Two main sprinkler control valves in the outside sprinkler vault are to be removed on or before Sept. 11, 2016 by Pye Barker Fire & Safety Inc. An audit was conducted by Maintenance Supervisor to ensure no other sprinkler control valves were outside around facility. A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure areas around facility are free of sprinkler control valves weekly X 4 weeks, then a monthly audit will be conducted by	9/11/16

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K 061	Continued From page 5 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 061	the Maintenance Supervisor or designee to ensure areas around facility are free of sprinkler control valves. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is an exposed element, high temperature, portable space heater with temperature of heating elements exceeding 212 degrees Fahrenheit - located in medical records office. NFPA 101, 19.7.8 This deficiency affects one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 070	K070 SS=E The portable space heater was removed from Medical Records Office on 8-4-16 and discarded. An audit was conducted by the Maintenance Supervisor to ensure no space heaters were in the facility. A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure areas in the facility are free of space heaters weekly X 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure areas in the facility are free of space heaters. The results of the audit will be reviewed	8/22/16

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K 070	Continued From page 6	K 070	by the Administrator in the monthly QI Committee Meeting.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. There is no emergency task lighting covering emergency generator access panels inside fenced enclosure - existing emergency light is located outside enclosure and fails to provide illumination due to obstructions by wood fence. 2. There is no documentation of weekly checks of generator battery electrolyte levels and specific gravity readings. NFPA 101, 9.1.2, NFPA 99, 3-4-4-1, 8-4.2, NFPA 110, Chapter 6 This deficiency potentially affects all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144	K144 SS=E 1. Emergency task lighting to be installed by S & S Electrical co. on or before Sept. 11, 2016 to cover the emergency generator area. A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure task lighting at the emergency generator is working properly weekly X 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor of designee to ensure emergency task lighting is working properly to cover generator area. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting. K144 SS=E The Maintenance Supervisor will document generator battery testing on the corrected form weekly on or before Sept.	9/11/16

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K 144	Continued From page 7	K 144	11, 2016 and documented correctly. Weekly audits will be conducted by the Maintenance Supervisor or designee to ensure generator battery testing has been done on a weekly basis. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.	