

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2016
NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	
(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 arrangements. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = 90 NF Total Certified Bed Count 90 NF Census 74 NF The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	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 July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is a hole in the rated roof/ceiling assembly in the D.O.N. office - located behind the ceiling mounted mechanical unit. NFPA 101, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	K-12 1) The hole in the ceiling in the DON office was appropriately covered with fire rated sheet rock. 2) The Maintenance Director will complete a facility wide audit for any holes penetrating the ceiling. All holes will be filled with fire calk. 3) Education will be provided to the Maintenance Director by the Administrator. Education will include ensuring that all holes penetrating the ceiling are filled with sheet rock and/or fire	9/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/05/2016

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 012	Continued From page 1 This deficiency potentially affected 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 012	calk. 4) The facility Maintenance Director will monitor the facility weekly for twelve weeks to ensure compliance. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) 1. Door closing path is obstructed by privacy curtain - resident room door 107. 2. Door to employee lounge will not latch. NFPA 101, 2000 ed, Section 19.3.6.3	K 018	K-18 1) The privacy curtain in room 107 was pulled back to allow the door to close. The door to the employee lounge was fixed so that it would latch by itself. 2) The Maintenance Director will complete a facility wide audit for any doors that do not latch on their own or any doors that are obstructed by privacy curtains.	9/2/16	

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K 018	Continued From page 2 This deficiency potentially affected 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 018	3) Education will be provided to the Maintenance Director and staff. Education will include ensuring that all doors latch on their own and also that nothing should be in the way of the doors to prevent them from closing. 4) The facility Maintenance Director will monitor five doors per week for twelve weeks to ensure compliance. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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 July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: The fire door to the laundry area would not self close and latch without manual intervention. NFPA 101, 19.3.2.1, NFPA 80	K 029	K-29 1) The door to the laundry room was fixed so that it would latch upon closing. 2) The Maintenance Director will complete a facility wide audit for any doors that do not latch on their own or any doors that are obstructed by privacy curtains. 3) Education will be provided to the Maintenance Director and staff. Education will include ensuring that all doors latch on their own and also that nothing should be in the way of the doors	9/2/16	

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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	to prevent them from closing. 4) The facility Maintenance Director will monitor five doors per week for twelve weeks to ensure compliance. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The ceiling radiation damper, located in public restroom near dining room, is covered with sprayed on textured ceiling compound. 2. There are no ceiling radiation dampers in rectangular mechanical outlets in main dining room. NFPA 101, 19.5.2.2, 19.5.2.1, 9.2, NFPA 90A This deficiency affects one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury	K 067	K-67 1) The ceiling radiation damper had the sprayed on textured ceiling compound removed. The rectangular mechanical outlets in main dining room were removed. 2) The Maintenance Director will complete a facility wide audit for any dampers with sprayed ceiling texture compound. 3) Education will be provided to Maintenance Director. Education will include that all vents have dampers and that no sprayed on textured compound is present on dampers 4) The facility Maintenance Director will monitor 3 dampers per week to ensure compliance. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.	9/2/16

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K 067	Continued From page 4 due to fire and/or smoke.	K 067			
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There are staff lockers, and linen carts stored in the corridor area adjacent to laundry room. NFPA 101, 19.2.1, 7.1.10 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 072	K-72 1) The staff lockers and linen carts adjacent to the laundry room were removed. 2) The Maintenance Director will complete a facility wide audit to ensure that any other areas of the facility are not obstructed from means of egress. 3) Education will be provided to staff by the Administrator. Education will include that all areas of the facility shall remain free of obstruction from means of egress. 4) The facility Maintenance Director will monitor 3 halls per week for twelve weeks to ensure means of egress is free of obstructions. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.	9/2/16	
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:	K 144		9/2/16	

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K 144	Continued From page 5 42 CFR 483.70 (a) Based on observations, on July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is no generator annunciator panel serving updated automatic transfer switch for emergency power system. The annunciator panel shall be located in the vicinity of the supervised nurse's station. NFPA 101, 9.1.2, NFPA 99, NFPA 110 This deficiency potentially affected 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	K-144 1) An annunciator panel is being placed in the facility at the nurses station. 2) The Maintenance director completed a facility wide audit and ensured that the annunciator panel was placed at the nurses station. 3) Education will be provided to all staff by the Administrator. Education will include that an annunciator panel was placed in the building to let the staff know that the generator is under power. 4) The Maintenance Director will monitor the annunciator panel weekly for twelve weeks to ensure that it is working properly. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.	
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 483.70 (a) Based on observations, on July 22, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: Armored cable assembly doesn't terminate in an electrical junction box - located in main mechanical/electrical equipment room.	K 147	K-147 1) The armored cable assembly located in the main mechanical room was fixed. 2) The Maintenance Director completed a facility wide audit to locate any other flawed armored cables. 3) Education will be provided to the Maintenance Director by the Administrator. Education will include that armored cable assembly in the facility are	9/2/16

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K 147	Continued From page 6 NFPA 101, 9.1.2, NFPA 70 This deficiency potentially affected 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 147	fixed to facility protocol. 4) The Maintenance Director will monitor the three armored cables weekly to ensure compliance. The monitoring tools will be brought to QAPI and presented by the Maintenance Director monthly for three months.		