STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	**514 OLD MOUNT HOLLY ROAD** **STANLEY, NC 28164**

(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 construction, one story, with a complete automatic sprinkler system and using delayed egress system. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the: Total Certified Bed Count 106 Census 98 The deficiencies determined during the survey are as follows:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: the left leaf fire door in fire rated wall going into special care unit, did not close an latch properly.	K 011	The left leaf fire door in the fire rated wall going into the special care unit (400 unit) was repaired to properly close and latch on 8/12/16. All fire doors were assessed to ensure each properly closes and latches with no further concerns noted on 8/16/16.	9/9/16

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

Electronically Signed | 08/16/2016

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K 011	Continued From page 1 2000 NFPA 101, 19.1.1.4.1 This deficiency affected one of seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 011	The Fire Program policy and procedure in the Environmental Services Manual was revised to include that fire doors (fire barriers having at least a 2 hour fire resistance rating constructed of materials as required) will properly close and latch and that all fire doors will be checked on a monthly basis to ensure proper function (closing/latching). All maintenance staff were educated by the Environmental Services Director on this policy revision on 8/18/16. An assigned maintenance employee will check each fire door to ensure each properly closes and latches on a monthly basis—this assignment will be made with completion documented each time through the PM Worx preventative maintenance system. Assignments for this monthly check will begin in September 2016. The Environmental Services Director will assign one maintenance employee (different from the employee assigned for the routine scheduled monthly check) through the PM Worx preventative maintenance system to verify that each fire door properly closes and latches weekly X 4 weeks, followed by every other week X 1 month, and finally monthly X 4 months for the purposes of quality assurance beginning in September 2016. Any concerns noted with each check will be corrected immediately. The Environmental Services Director will	

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K 011	Continued From page 2	K 011	verify each quality assurance check has been completed as assigned and will randomly check different fire doors to ensure proper closing/latching each month X 6 months. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: The smoke wall going into 500 hall, (front and back smoke walls) have holes and/or penetrations that were not sealed in accordance with an approved fire rated assemble in order to maintain the fire resistance rating of the wall. There are multiple cable and conduit penetrations in the walls that are not sealed in accordance with an approved and listed fire stop assembly and/or fire stop assembly method. 2000 NFPA 101 Section 5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of	K 025	The smoke barrier wall going into the 500 hall (front and back smoke walls) had all holes and/or penetrations properly sealed by 8/25/16. All smoke barrier walls were assessed to ensure no other holes and/or penetrations were present by 8/25/16. The Fire Program policy and procedure in the Environmental Services Manual was revised to include that smoke barriers/walls will have any holes/penetrations properly sealed in accordance with an approved fire rated assemble in order to maintain the fire resistance rating of the wall as well as maintenance staff to check behind any contract staff who are working in areas that may affect smoke barriers/walls to	9/9/16

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K 025	Continued From page 3 protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. 2000 NFPA 101, 8.3.2* Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 NFPA 101, 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: 1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be	K 025	ensure no holes/penetrations are made —any discovered will be immediately corrected. All maintenance staff were educated by the Environmental Services Director on this policy revision on 8/17/16. Beginning on 8/26/16, an assigned maintenance employee will check each smoke barrier/wall to ensure there are no holes or penetrations following any contractor who has worked in areas with smoke barriers/walls and corrective action will be taken immediately. (D) The Environmental Services Director will assign one maintenance employee to verify that there are no holes/penetrations in smoke barriers/walls monthly X 6 months for the purposes of quality assurance through the PM Worx preventative maintenance system beginning in September 2016. Any concerns noted with each assessment will be corrected immediately. The Environmental Services Director will verify each quality assurance check has been completed as assigned and will randomly check different smoke barriers/walls each month X 6 months to ensure no holes/penetrations are noted. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	

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K 025	Continued From page 4 solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. This deficiency affected one of seven smoke compartments . Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025		
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 483.70 (a)	K 029	The door to the oxygen storage room on	9/9/16

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K 029	Continued From page 5 Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: door to oxygen storage room on special care unit, did not close and latch. 2000 NFPA 101, 19.3.5.3/8.4.1 This deficiency affected special unit only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 029	the special care unit (400 unit) was properly closed and latched on 7/26/16. The only other oxygen storage room (500 unit) was noted to be properly closed and latched upon inspection on 7/26/16. No other areas were affected. The Fire Program policy and procedure in the Environmental Services Manual was revised to include that rooms in which oxygen is stored will properly close and latch—these doors will be closed when the room is not in immediate use. Any doors where oxygen is being stored that are discovered to be open when not in use will be immediately corrected. All maintenance and nursing staff were educated by the Environmental Services Director on this policy revision by 8/22/16. The Fire Program policy and procedure in the Environmental Services Manual was revised to include that individual departments will be trained upon orientation and at least annually specifically to their own assigned areas as to how each relates differently to fire safety including nursing staff for training specific to oxygen storage safety. A nursing supervisor will check both oxygen storage rooms (400 and 500 units) on each shift to ensure each is properly closed/latched when the room is not in immediate use daily X 2 weeks, followed by weekly X 4 weeks, and then finally monthly X 4 months for the purposes of quality assurance beginning	

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K 029	Continued From page 6	K 029	the week of 8/22/16. Any concerns noted with each check will be corrected immediately and any staff with continued non-compliance will be addressed through disciplinary action up to and including termination for the safety of residents. The Environmental Services Director will verify each quality assurance check has been completed and will randomly check to ensure oxygen storage rooms to ensure doors are properly closed/latched when not in immediate use monthly X 6 months. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	
K 060 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: when staff was ask if they knew how to activated the Ansul fire system under the kitchen hood, they did not know nor location of pull. 2000 NFPA 101, 19.3.4.2/9.6.2.1 This deficiency affected kitchen only. Failure to comply with minimum standards as	K 060	All dietary staff including dietary managers were trained on the proper use/activation of the Ansul fire system under the kitchen hood by the Environmental Services Director by 8/18/16. No other areas were affected—there is only one kitchen in the facility. The Fire Program policy and procedure in the Environmental Services Manual was revised to include that individual departments will be trained upon orientation and at least annually	9/9/16

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K 060	Continued From page 7 referenced increases the risk of death or injury due to fire and/or smoke.	K 060	specifically to their own assigned areas as to how each relates differently to fire safety including dietary staff for training specific to the use of the Ansul fire system under the kitchen hood and how to properly use/activate it. Specific directions on the use of the Ansul fire system under the kitchen hood were also included in the Dietary Services Manual for future reference as needed by dietary staff. The Kitchen Manager will have (4) random dietary staff members verbally explain the proper use of the Ansul fire system under the kitchen hood weekly X 4 weeks, then every two weeks X 1 month, and finally monthly X 4 months for the purposes of quality assurance beginning the week of 8/22/16. The Environmental Services Director will verify each quality assurance check has been completed and will randomly have dietary staff members on each shift verbally explain the proper use of the Ansul fire system under the kitchen hood, including dietary managers, monthly X 6 months. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	
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,	K 062		9/9/16

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K 062	Continued From page 8 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: no sprinkler wrench was in spare head sprinkler box in riser room. 2000 NFPA 101, 19.7.6.12 NFPA 25, 9.7.5 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	A sprinkler head wrench was ordered from Simplex Grinnell and was placed in the spare head sprinkler box in the riser room by 8/22/16. A sprinkler head wrench was present in all other spare sprinkler head boxes in each of the remaining two riser rooms upon inspection as of 8/19/16. The Fire Program policy and procedure in the Environmental Services Manual was revised to include that a sprinkler wrench will be kept in the spare head sprinkler box in the riser room for immediate use at all times. All maintenance staff were educated by the Environmental Services Director on this policy revision by 8/17/16. (D) The Environmental Services Director will assign one maintenance employee to verify that each spare head sprinkler box in each riser room has a sprinkler wrench present weekly X 2 months followed by monthly X 4 months for the purposes of quality assurance through the PM Worx preventative maintenance system beginning in September 2016. Any concerns noted with each assessment will be corrected immediately. The Environmental Services Director will verify each quality assurance check has been completed as assigned and will randomly check each spare head sprinkler box in each riser room monthly X 6 months to ensure sprinkler wrenches	

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K 062	Continued From page 9	K 062	are present for immediate use. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: the K type fire extinguisher in the Kitchen did not have the required placard/signage indicating the use order of the Ansul hood extinguishing system and K type fire extinguisher installed near it. Reference: 2000 NFPA 101 19.3.5.6, 9.7.4.1, 1998 NFPA 10 2-3.2.1, 1998 NFPA 96 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. This deficiency affected kitchen only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke	K 064	The K-type fire extinguisher in the kitchen was identified with the required placard/signage indicating it to be used as a secondary back-up means to the automatic fire suppression system (Ansul hood extinguishing system) on 8/11/16. No other areas were affected—there is only one kitchen in the facility. Dietary services staff were trained on the placement of the placard/signage as well as the use of the extinguisher as a secondary back-up means to the automatic fire suppression system (Ansul hood extinguishing system) by the Environmental Services Director by 8/18/16. The Environmental Services Director will assign one maintenance employee to verify that the appropriate placard/signage indicating the K-type fire extinguisher is present in the kitchen weekly X 2 months followed by monthly X 4 months for the purposes of quality assurance through the	9/9/16

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K 064	Continued From page 10 This deficiency affected *** of *** smoke compartments *** of Resident rooms*** Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 064	PM Worx preventative maintenance system beginning in September 2016. Any concerns noted with each assessment will be corrected immediately. The Environmental Services Director will verify each quality assurance check has been completed as assigned and will randomly check for the appropriate placard/signage in the kitchen indicating use of the K-type fire extinguisher as a secondary back-up means to the automatic fire suppression system monthly X 6 months to ensure proper placement. All checks, findings, and corrective actions taken will be reported monthly to the QA&A Committee.	
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 07/26/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: facility could not provide proper documentation that a 4 year fire/smoke damper test had been performed. 2000 NFPA 101, 19.5.2.1 NFPA 90A	K 067	All heating, ventilation, and air conditioning dampers for the facility were tested by a contract company on 8/10/16 with documentation of such testing provided. All heating, ventilation, and air conditioning dampers for the facility will be tested by a contract company every 4 years for fire/smoke damper testing—the next date due will be August 2020. The Environmental Services Director will	9/9/16

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K 067	Continued From page 11 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	maintain proper documentation for the 4-year fire/smoke damper testing upon completion and will report as well as any areas requiring corrective action related to such testing to the QA&A Committee when conducted.	