PRINTED: 04/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345264	345264 B. WING		07/26/2016	
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
K 000 K 011 SS=E	at 42CFR 483.70(a); Health Care section of publications. This built one story, with a come system and using delexit conference all dediscussed and acknown time of survey the: Total Certified Bed Common Census 98 The deficiencies deteare as follows: NFPA 101 LIFE SAFE	e Code of Federal Register using the 2000 Existing of the LSC and its referenced ding is Type III construction, plete automatic sprinkler ayed egress system. In the ficiencies noted were wledged with administration. Ount 106 Trained during the survey	K 00		9/9/16	
	barrier having at least rating constructed of a addition. Communicate corridors and shall be self-closing fire doors resistance rating 18.1.1.4.1, 18.1.1.4.2 19.1.1.4.2 This STANDARD is resistance ration approximately 9:00 A deficiencies were not non-compliant, specifical fire door in fire racare unit, did not clos	ng, the common wall is a fire a two hour fire resistance materials as required for the ting openings occur only in protected by approved with at least 1 1/2 hour fire 1, 18.2.3.2, 19.1.1.4.1, not met as evidenced by: as, on 07/26/2016 at M onward, the following ed: The standard was ic findings include: the left ted wall going into special		The left leaf fire door in the fire rated we going into the special care unit (400 unwas repaired to properly close and late on 8/12/16. All fire doors were assessed to ensure each properly closes and latches with a further concerns noted on 8/16/16.	it) h	

Electronically Signed 08/16/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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 011	Continued From page	e 1	ΚO	11				
	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.			The Fire Program policy the Environmental Service revised to include that fire barriers having at least a resistance rating construe as required) will properly and that all fire doors will monthly basis to ensure p (closing/latching). All may were educated by the Enservices Director on this 8/18/16. An assigned maintenance check each fire door to e properly closes and latch basis—this assignment we completion documented through the PM Worx premaintenance system. As this monthly check will be September 2016. The Environmental Service assign one maintenance (different from the employ the routine scheduled month through the PM Worx premaintenance system to we fire door properly closes weekly X 4 weeks, follow week X 1 month, and final months for the purposes assurance beginning in Sent Any concerns noted with be corrected immediately.	tes Manual was te doors (fire 2 hour fire 2 hour fire 2 hour fire cted of materials close and latch be checked on a proper function intenance staff vironmental policy revision or the employee will near each time eventative esignments for egin in the expension of the expension o			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345264	B. WING _	B. WING		07/26/2016	
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K 011	Continued From page		K	verify each quality been completed a randomly check densure proper clomonth X 6 months and corrective active active monthly	y assurance check has as assigned and will different fire doors to osing/latching each s. All checks, finding tions taken will be to the QA&A Committ	ıs, tee.	
K 025 SS=E	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.		KO	The smoke barrier hall (front and back holes and/or peneroty 8/25/16. All smoke barrier ensure no other holes and holes have present by 8. The Fire Program the Environmental revised to include barriers/walls will holes/penetration accordance with a assemble in order resistance rating maintenance staff contract staff who	n policy and procedure al Services Manual wa e that smoke	all led to ons e in as	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345264 B. WING 07/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 OLD MOUNT HOLLY ROAD** STANLEY TOTAL LIVING CENTER STANLEY, NC 28164 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 3 K 025 protection, or any other feature is required for holes/penetrations are made ensure no compliance with the provisions of this Code, such -any discovered will be immediately device, equipment, system, condition, corrected. All maintenance staff were arrangement, level of protection, or other feature educated by the Environmental Services shall thereafter be maintained unless the Code Director on this policy revision on 8/17/16. exempts such maintenance. Beginning on 8/26/16, an assigned 2000 NFPA 101, 8.3.2* Smoke barriers required maintenance employee will check each by this Code shall be continuous from an outside smoke barrier/wall to ensure there are no wall to an outside wall, from a floor to a floor, or holes or penetrations following any from a smoke barrier to a smoke barrier or a contractor who has worked in areas with combination thereof. Such barriers shall be smoke barriers/walls and corrective action continuous through all concealed spaces, such as will be taken immediately. those found above a ceiling, including interstitial (D) The Environmental Services Director Exception: A smoke barrier required for an will assign one maintenance employee to occupied space below an interstitial space shall verify that there are no holes/penetrations not be required to extend through the interstitial in smoke barriers/walls monthly X 6 space, provided that the construction assembly months for the purposes of quality forming the bottom of the interstitial space assurance through the PM Worx provides resistance to the passage of smoke preventative maintenance system equal to that provided by the smoke barrier. beginning in September 2016. Any concerns noted with each assessment will 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 be corrected immediately. NFPA 101, 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and The Environmental Services Director will verify each quality assurance check has ducts, and similar building service equipment that pass through floors and smoke barriers shall be been completed as assigned and will protected as follows: randomly check different smoke 1) The space between the penetrating item and barriers/walls each month X 6 months to the smoke barrier shall meet one of the following ensure no holes/penetrations are noted. conditions: All checks, findings, and corrective actions taken will be reported monthly to a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke the QA&A Committee. 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

Facility ID: 953470

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K 025	between the item and of the following cond a. It shall be filled with of maintaining the small barrier. b. It shall be protected is designed for the small be protected into consideration, and meet one of the following. It shall be made on barrier.	ke barrier, and the space d the sleeve shall meet one itions: h a material that is capable noke resistance of the smoke d by an approved device that pecific purpose. Ke transmission of vibration ny vibration isolation shall wing conditions: n either side of the smoke	KO	25			
K 029 SS=E	compartments. Failure to comply wit referenced increases due to fire and/or sm NFPA 101 LIFE SAF One hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3.5.4 protes the approved automa option is used, the arother spaces by smo doors. Doors are selfield-applied protective 48 inches from the beautomatical permitted.	onstruction (with o hour n approved automatic fire in accordance with 8.4.1 acts hazardous areas. When atic fire extinguishing system reas are separated from ke resisting partitions and if-closing and non-rated or replates that do not exceed outom of the door are	К0	The door to the oxygen storage re	oom on	9/9/16	

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NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				5′	TREET ADDRESS, CITY, STATE, ZIP CODE 14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
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K 029	deficiencies were note non-compliant, specif oxygen storage room close and latch. 2000 NFPA 101, 19.3 This deficiency affecte Failure to comply with	ns, on 07/26/2016 at M onward, the following ed: The standard was ic findings include: door to on special care unit, did not .5.3/8.4.1 ed special unit only. In minimum standards as the risk of death or injury	K	029	the special care unit (400 unit) was properly closed and latched on 7/26/16. The only other oxygen storage room (5 unit) was noted to be properly closed a latched upon inspection on 7/26/16. No other areas were affected. The Fire Program policy and procedure 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/ The Fire Program policy and procedure 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 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 not in immediate use daily X 2 weeks, followed by weekly X 4 weeks, and the finally monthly X 4 months for the purposes of quality assurance beginning	00 nd o e in s d e in s s as g is n	

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K 029 K 060 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD		KO	the week of 8/22/16. Any conwith each check will be correct immediately and any staff with non-compliance will be address disciplinary action up to and intermination for the safety of restraining to the Environmental Services I verify each quality assurance been completed and will rand to ensure oxygen storage roomensure doors are properly clowhen not in immediate use months. All checks, findings, corrective actions taken will be monthly to the QA&A Commit Managers were trained on the	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.	
				use/activation of the Ansul fire under the kitchen hood by the Environmental Services Direct 8/18/16. No other areas were affected-only one kitchen in the facility	tor by there is	
	2000 NFPA 101, 19.3 This deficiency affect	5.4.2/9.6.2.1		The Fire Program policy and puthe Environmental Services Marevised to include that individude partments will be trained up	orocedure in Ianual was ual	
		n minimum standards as		orientation and at least annua		

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K 060	Continued From page referenced increases due to fire and/or smo	the risk of death or injury	K	060	specifically to their own assigned areas to how each relates differently to fire safety including dietary staff for training specific to the use of the Ansul fire systunder the kitchen hood and how to properly use/activate it. Specific directions on the use of the Anfire system under the kitchen hood wer also included in the Dietary Services Manual for future reference as needed 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 weeks, then every two weeks X 1 mon and finally monthly X 4 months for the purposes of quality assurance beginning the week of 8/22/16. The Environmental Services Director werify 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 how including dietary managers, monthly X months. All checks, findings, and corrective actions taken will be reportemonthly to the QA&A Committee.	tem sul re by X 4 th, ng vill is e od, 6		
K 062 SS=E	Required automatic s continuously maintair condition and are insp	ed in reliable operating	K	062			9/9/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED				
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K 062	9.7.5 This STANDARD is r 42 CFR 483.70 (a) Based on observation approximately 9:00 A deficiencies were not non-compliant, specif sprinkler wrench was in riser room. 2000 NFPA 101, 19.7 NFPA 25, 9.7.5 This deficiency affect Failure to comply with	not met as evidenced by: ns, on 07/26/2016 at M onward, the following ed: The standard was ic findings include: no in spare head sprinkler box 1.6.12 ed entire facility. In minimum standards as the risk of death or injury	K 06	A sprinkler head wrench was order from Simplex Grinnell and was place the spare head sprinkler box in the room by 8/22/16. A sprinkler head wrench was preser other spare sprinkler head boxes in of the remaining two riser rooms up inspection as of 8/19/16. The Fire Program policy and proced the Environmental Services Manual revised to include that a sprinkler will be kept in the spare head sprink box in the riser room for immediate all times. All maintenance staff were ducated by the Environmental Services Dirwill assign one maintenance employ verify that each spare head sprinkle in each riser room has a sprinkler will present weekly X 2 months followed monthly X 4 months for the purpose quality assurance through the PM V preventative maintenance system beginning in September 2016. Any concerns noted with each assessment be corrected immediately. The Environmental Services Director verify each quality assurance check been completed as assigned and w randomly check each spare head sprinkler box in each riser room mo 6 months to ensure sprinkler wrence.	ed in riser Int in all each on dure in was rench der use at e vices 17/16. Rector yee to er box rench d by es of Vorx ent will chas ill inthly X			

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K 067		ed entire facility. n minimum standards as the risk of death or injury	КО	maintain proper documenta 4-year fire/smoke damper to completion and will report a areas requiring corrective a such testing to the QA&A C when conducted.	esting upon as well as any action related to	