| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345429 | A. BUILDING **01 - BUILDING 0101**<br>B. WING _____ | **08/26/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PEAK RESOURCES - PINELAKE** | **801 PINEHURST AVENUE**<br>**CARTHAGE, NC 28327** |

| (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 |
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| K 000 | INITIAL COMMENTS<br><br>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 V(III) 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.<br><br>At time of survey the:<br>Total Certified Bed Count 110<br>Census 79<br><br>The deficiencies determined during the survey are as follows: | K 000 | | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70 (a)<br><br>Based on observations, on 08/26/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: door to | K 029 | Filing of this plan of correction<br>Does not constitute admission that<br>The deficiencies alleged did in fact<br>Exist. The plan of correction is filed in<br>Evidence of the facilities desire to comply<br>With the requirements and to continue to | 9/16/16 |

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

Electronically Signed | 09/14/2016

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| K 029 | Continued From page 1<br>dry storage room in kitchen would not latch. Tape was covering strike plate.<br><br>2000 NFPA 101,19.3.2.1<br><br>This deficiency affected kitchen area only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. | K 029 | Provide high quality care.<br><br>K029<br><br>No residents were affected by this alleged deficiency<br><br>Residents with potential to be affected<br><br>The following was accomplished:<br><br>1.Tape was removed from storage door and a new door handle lock was added on 8-26-16.<br><br>2.All doors in the facility were checked to ensure that they closed properly on 8-26-16. No further issues were identified with any door in the facility.<br><br>3.All staff will be inserviced by the SDC on how to recognize if doors are working properly, to utilize TELS system to report if a door is not working properly and that no modifications have been made to a facility door by 9-16-16.<br><br>Monitoring:<br><br>An audit tool was developed to check functionality of all doors in the facility. All facility doors will be monitored to ensure that they close properly by the Maintenance Supervisor weekly for four weeks and monthly for 6 months.<br><br>QA:<br><br>All audit information will be brought to the | |

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| K 029 | Continued From page 2 | K 029 | QA committee by the Maintenance Supervisor; the QA Committee will make changes as needed. | |
| K 072 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br>This STANDARD is not met as evidenced by:<br>Based on observations, on 08/26/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: B/P machine was plugged into electrical outlet on 100 Hall at fire doors blocking egress path and handrails. B/P machine was not moved during the survey.<br><br>2000 NFPA 101, 19.2.1/7.1.10<br><br>This deficiency affected two of six smoke compartments.<br>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. | K 072 | Filing of this plan of correction<br>Does not constitute admission that<br>The deficiencies alleged did in fact<br>Exist. The plan of correction is filed in<br>Evidence of the facilities desire to comply<br>With the requirements and to continue to<br>Provide high quality care.<br><br>K072<br><br>No residents were affected by this alleged deficiency<br><br>Residents with potential to be affected<br><br>The following was accomplished:<br><br>1.Blood Pressure machines were moved off the hall on 8-26-16.<br><br>2.Facility was checked to see if any other items were blocking egress for our residents on 8-26-16. None were found.<br><br>3.All staff will be inserviced by the SDC on | 9/16/16 |

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| K 072 | Continued From page 3 | K 072 | how to ensure that all residents have egress to hand rails and fire exits by 9-16-16.<br><br>Monitoring:<br><br>An audit tool was developed to monitor the halls in the facility to ensure that no items were blocking egress. The hallways will be monitored by the maintenance director for any items that would block egress for residents, daily for 4 weeks, weekly for four weeks and monthly for 6 months.<br><br>QA:<br><br>All audit information will be brought to the QA committee by the Maintenance Supervisor; the QA Committee will make changes as needed. | |
| K 144 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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)<br>This STANDARD is not met as evidenced by:<br>Based on observations, on 08/26/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include:The generator annunciator panel located at the nurse station did not show generator running when power was transferred from normal to emergency connected load. | K 144 | Filing of this plan of correction<br>Does not constitute admission that<br>The deficiencies alleged did in fact<br>Exist. The plan of correction is filed in<br>Evidence of the facilities desire to comply<br>With the requirements and to continue to<br>Provide high quality care.<br><br>K144 | 9/1/16 |

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| K 144 | Continued From page 4<br>NFPA 99. 3-4.1.1.15<br><br>This deficiency affected entire facility.<br>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. | K 144 | No residents were affected by this alleged deficiency<br><br>Residents with potential to be affected<br><br>The following was accomplished:<br><br>1.Generator was checked by a licensed professional and the transfer light was corrected on 9-1-16.<br><br>Monitoring:<br><br>Maintenance Supervisor will monitor that the transfer light is working properly weekly for four weeks and monthly thereafter.<br><br>QA:<br><br>All audit information will be brought to the QA committee by the Maintenance Supervisor; the QA Committee will make changes as needed. | |