PRINTED: 01/31/2018 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345441	B. WING			01	/05/2018	
	ROVIDER OR SUPPLIER	1	1		,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE	
K 000	National Fire Protect Life Safety Code (LS NFPA 99 - Health Ca and its referenced poplan/construction ap 5, 2016. The facility systems. In the exit deficiencies noted w acknowledged with A Stories: one Construction Type: Constructed: 7/7/198 Fully Sprinkled YES At time of survey the Total Certified Bed Co Census = 88 Fire Alarm System - CFR(s): NFPA 101 Fire Alarm System i components approve accordance with NFI and NFPA 72, Nation provide effective wan building. In areas no detection is installed unit. In new occupan at notification applian and supervising stati	de(LSC) survey was ne 2012 edition of the tion Association (NFPA) 101 - SC) and 2012 edition of the are Facilities Code (HCFC) ublications. The facility proval occurred prior to July v is utilizing special locking conference all LSC ere discussed and Administration. 3(211) 33 a Licensed bed capacity 100 count = 100 Installation Installation Installed with systems and ed for the purpose in PA 70, National Electric Code, nal Fire Alarm Code to ming of fire in any part of the t continuously occupied, at each fire alarm control acy, detection is also installed ince circuit power extenders, ion transmitting equipment. iring or other transmission for integrity.		341			1/19/18	
ADODATODY	DIRECTOR'S OR BROVINER	/SUPPLIER REPRESENTATIVE'S SIGNATUR) DE		TITI F		(X6) DATE	

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.

Electronically Signed

01/17/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JLTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345441	B. WING _			01/	05/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
K 341	Continued From page	e 1	К3	41			
	by: Based on observation documentation on 0° through 2:00 PM the noted: The standard findings include: 1.The facility had two mounted closure that return and/or supply and #13. 2. The facility was mile every 2 year smoke of NFPA 101, 19, 9.6, Note that the transfer of	following deficiencies were I is non-compliant, specific ceiling smoke detectors a 3 feet to a ceiling HVAC grilles Smoke detector # 32 ssing documentation of detector sensitivity test.			ALEXANDRIA PLACES RESPONSE THIS REPORT OF SURVEY DOES NO DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NO DOES IT CONSTITUTE AN ADMISSIO THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE PO BECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct deficient practice and what led to the deficient practice: Alexandria Place will move Smoke detector #32 and #13 three feet away from a ceiling HVAC return and/or sup grilles. It has been determined that wh he smoke detectors were installed, Ni egulations were not properly maintain The two year smoke detector sensitivity est was completed on 1/16/18. How will you identify other life safety assues having the potential to affect esidents by the same deficient practic and what corrective action will be take full residents have the potential to be affected by this practice. All smoke detectors were checked for compliance to at least three feet away from ceiling HVAC returns and/or supply grilles. The vas completed on 1/11/18. The two est smoke detector sensitivity test was completed and revealed no concerns. accility determined that all other smoke	OT R ON OC the ply en FPA led. ty ce n: e to G is ar The	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3	(X3) DATE SURVEY COMPLETED	
		345441	B. WING _			01/05/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ALEXAND	RIA PLACE			1770 OAK HOLLOW ROAD			
	0.11.41.51.4.51.4.51.4.51.4.51.4.51.4.51	TATEMENT OF DEFINITION		GASTONIA, NC 28054	-071011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 341	Continued From pag	e 2	К3	detectors were in compliance at What measures will be put into p what systemic changes will you rensure that the deficient practice recur: The maintenance supervisor will smoke detectors monthly for one then annually thereafter to ensur are in proper compliance for K34 maintenance supervisor will also future installations of smoke detectors complete annual audits of docum for the two year smoke detector test to ensure it is completed every years. When a smoke detector not be replaced, the maintenance su will ensure that it is in compliance. How the corrective action(s) will monitored to ensure the deficient will not recur, i.e., what quality as program will be put into place. The monthly an annual maintenare ports will be turned into the Quant Assurance committee on a quart for review and determination if a action or amended action is necessaries prompt follow up and/or recompletion. The Quality Assurance committee with be charged with responsibility to ensure that correactive and sustained.	lace or make to addit all a year and e they 1. The audit ectors to ance for sor will nentation sensitivity two eeds to apervisor e. be t practice assurance ality erly basis dditional essary to epair ce the	,	
K 363 SS=D	CFR(s): NFPA 101		K 3	63		1/19/18	
	Corridor - Doors Doors protecting corr	idor openings in other than					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345441	B. WING			01/	05/2018
	ROVIDER OR SUPPLIER		•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 363	hazardous areas resi and are made of 1 3/4 wood or other materia at least 20 minutes. It is smoke compartments the passage of smoke to rooms containing finaterials have positive latches are prohibited requirements do not do not contain flamm Clearance between the covering is not exceed complying with 7.2.1. with a device capable when a force of 5 lbf impediment to the cloth devices that release to pulled are permitted. Of unlimited height are meeting 19.3.6.3.6 and shall be labeled and in materials in compliant smoke compartment window assemblies a sprinklered compartment restrictions in area or frames in window assembles as 19.3.6.3, 42 CFR Parand 485 Show in REMARKS of protection ratings, au etc. This REQUIREMENT by:	of vertical openings, exits, or ist the passage of smoke 4 inch solid-bonded core al capable of resisting fire for Doors in fully sprinklered is are only required to resist e. Corridor doors and doors dammable or combustible we latching hardware. Roller do by CMS regulation. These apply to auxiliary spaces that able or combustible material. Softom of door and floor and floor and gore are permissible if provided to of keeping the door closed is applied. There is no osing of the doors. Hold open when the door is pushed or Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Door frames made of steel or other are allowed per 8.3. In ments there are no	K	363	ALEXANDRIA PLACES RESPONSE	ΓΟ	
	documentation on 0				THIS REPORT OF SURVEY DOES NO	_	

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	
		345441	B. WING _			01/	05/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
K 363	noted: The standard findings include: 1. One of the fire rate corridor doors near rent NFPA 101, 19.3.6.3, This deficiency affect compartments. Failure to comply with	following deficiencies were lis non-compliant, specific d doors in the pair of cross shab would not self latch.	K	363	DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POBECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: Alexandria Place repaired the fire rated door in the pair of cross corridor doors near rehab. The deficient door will self latch to comply with NFPA 101, 19.3.6.7.2, 8.3. The repair was completed on 1/9/18 by N2 Fire Protection. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taker All residents have the potential to be affected by this practice. All fire doors if the facility were tested to ensure they selated on 1/11/18. It was determined that other fire doors were in compliance with NFPA 101, 19.3.6.3, 7.2, 8.3. It was also determined that the deficient door did reself latch due to a lapse in fire rated do audits. What measures will be put into place of what systemic changes will you make the ensure that the deficient practice does recur: The maintenance supervisor will audit after rated doors to ensure they self latch comply with NFPA 101, 19.3.6.3, 7.2, 8.3. On a monthly basis the maintenance supervisor will audit all fire rated doors.	oN oC he I 3, en: nelf tall no not or onot all to .3.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345441	B. WING			01/	05/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALEXAND	RIA PLACE				770 OAK HOLLOW ROAD ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 363	CFR(s): NFPA 101 Subdivision of Buildin Construction 2012 EXISTING Smoke barriers shall fire resistance rating pe permitted to termin Smoke dampers are repenetrations in fully dan approved sprinkler smoke compartments barrier. 19.3.7.3, 8.6.7.1(1)	ng Spaces - Smoke Barrie ng Spaces - Smoke Barrier be constructed to a 1/2-hour per 8.5. Smoke barriers shall nate at an atrium wall.		363	ensure they are self latching. This will it done along with monthly fire drills. Any door needing corrective action will be corrected at the time of the audit. The maintenance supervisor will record his findings and bring them to the quarterly Quality Assurance meetings. How the corrective action(s) will be monitored to ensure the deficient pract will not recur, i.e., what quality assurant program will be put into place: The quarterly maintenance reports will turned into the Quality Assurance committee on a quarterly basis for revie and determination if additional action of amended action is necessary to ensure prompt follow up and or repair. The Quality Assurance committee with be charged with the responsibility to ensure that correction is achieved and sustains.	ce be ew r	1/19/18
	in REMARKS.	is not met as evidenced					

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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 345441 B. WING 01/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD **ALEXANDRIA PLACE** GASTONIA, NC 28054 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (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 6 K 372 by: Based on observations, staff interview, and/or ALEXANDRIA PLACES RESPONSE TO documentation on 01/05/2018 at 9:30 AM THIS REPORT OF SURVEY DOES NOT through 2:00 PM the following deficiencies were DENOTE AGREEMENT WITH THE noted: The standard is non-compliant, specific STATEMENT OF DEFICIENCIES: NOR findings include: DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS 1. The facility had unsealed penetrations in the ACCURATE. WE ARE FILING THE POC smoke fire barrier wall in the attic above the cross BECAUSE IT IS REQUIRED BY LAW corriodr doors near room 122. What corrective action(s) will be NFPA 101, 19.3.7.3, 8.6.7.1, 8.5 accomplished by the facility to correct the deficient practice and what led to the This deficiency affected 8 of 8 smoke deficient practice: compartments. Alexandria Place repaired the unsealed Failure to comply with minimum standards as penetrations in the smoke fire barrier wall referenced increases the risk of death due to in the attic above the cross corridor doors smoke and or fire. near room 122 on 1/12/18 with NFPA approved foam sealer. It was determined that after new camera wires were run that the penetrations were not re-sealed. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All smoke fire barrier walls were audited on 1/12/18 to ensure they are in compliance and do not have an unsealed penetrations. At that time all other smoke fire barrier walls were in compliance with K372 and did not have any unsealed penetrations. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		01/05/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		
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K 372	Continued From page	• 7	K 372	smoke fire barrier walls monthly for one year and quarterly thereafter to ensure that all smoke fire barrier walls do not have any unsealed penetrations and all in compliance with K372. Any future we requiring penetration of the fire barrier walls in the attic will be monitored by the maintenance supervisor and all holes we be sealed with approved foam once we has been completed. Any smoke barrie wall needing corrective action will be corrected at the time of the audit. The maintenance supervisor will record his findings and present them to the quarter Quality Assurance meeting. How the corrective action(s) will be monitored to ensure the deficient pract will not recur, i.e., what quality assurant program will be put into place: The quarterly maintenance reports will turned into the Quality Assurance meetion a quarterly basis for review and determination if additional action or amended action is necessary to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correction is achieved and sustain	re pork de vill pork er erly ice ce be ting	
K 521 SS=D	CFR(s): NFPA 101 HVAC	manufacturer's	K 521		1/19/18	

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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 345441 B. WING 01/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD **ALEXANDRIA PLACE** GASTONIA, NC 28054 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (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) K 521 Continued From page 8 K 521 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or ALEXANDRIA PLACES RESPONSE TO documentation on 01/05/2018 at 9:30 AM THIS REPORT OF SURVEY DOES NOT through 2:00 PM the following deficiencies were DENOTE AGREEMENT WITH THE noted: The standard is non-compliant, specific STATEMENT OF DEFICIENCIES; NOR findings include: DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS 1. The facility was missing documentation of ACCURATE. WE ARE FILING THE POC every 4 year fire/smoke damper test and BECAUSE IT IS REQUIRED BY LAW maintenance. NFPA 101, 19.5.2.1, 9.2, NFPA 90 What corrective action(s) will be accomplished by the facility to correct the This deficiency affected 8 of 8 smoke deficient practice and what led to the compartments. deficient practice: Failure to comply with minimum standards as On 1/15/18 the 4 year fire/smoke damper referenced increases the risk of death due to test was completed by N2 Fire Protection. smoke and or fire. The fire/smoke damper test has been scheduled to be completed every 4 years with N2 Fire Protection. It was determined that turnover in the maintenance position caused a lapse in paperwork follow through. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. The fire/smoke damper test was completed by N2 Fire Protection on 1/15/18 as required. The fire/smoke damper test has been scheduled to be completed every 4 years with N2 Fire Protection. The Maintenance Supervisor will keep logs of the 4 year

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		345441	B. WING		01/	05/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		
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K 521	Continued From page	9	K 52	fire/smoke damper test. What measures will be put into place of what systemic changes will you make ensure that the deficient practice does recur: The Maintenance Supervisor will complete monthly audits of all fire/smodamper test documentation for one ye and then will audit the documentation annually thereafter. A separate log will maintained, as a back up for documentation, in the Administrators office. The maintenance director will maintain logs of documentation audits will report them in the quarterly Quality Assurance meetings. How the corrective action(s) will be monitored to ensure the deficient pract will not recur, i.e., what quality assurant program will be put into place: The completed monthly audits logs will reviewed in the quarterly Quality Assurance meetings to ensure the fire/smoke damper test is completed a required. The Quality Assurance Committee will be charged with the responsibility to ensure that correction achieved and sustained.	to not like ar libe and libe libe s	
K 712 SS=D	Fire Drills CFR(s): NFPA 101		K 71	12		1/19/18
	signal and simulation conditions. Fire drills unexpected times und least quarterly on each	transmission of a fire alarm of emergency fire are held at expected and der varying conditions, at h shift. The staff is familiar s aware that drills are part of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		345441	B. WING		(01/05/2018		
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K 712	established routine. between 9:00 PM and announcement may be alarms. 19.7.1.4 through 19.7 This REQUIREMENT by: Based on observation documentation on 0° through 2:00 PM the noted: The standard findings include: 1. The facility was minguarter for 2017, they Nov. and December of NFPA 101, 19.7.1 This deficiency affect compartments. Failure to comply with	Where drills are conducted d 6:00 AM, a coded be used instead of audible of 1.1.7 is not met as evidenced ons, staff interview, and/or 1/05/2018 at 9:30 AM following deficiencies were this non-compliant, specific only had fire drills 1 per shift per only had fire drills for Sept., of 2017.	K 71	ALEXANDRIA PLACES RESPO THIS REPORT OF SURVEY DO DENOTE AGREEMENT WITH T STATEMENT OF DEFICIENCIE DOES IT CONSTITUTE AN ADI THAT ANY STATED DEFICIENCY ACCURATE. WE ARE FILING T BECAUSE IT IS REQUIRED BY K712 What corrective action(s) will be accomplished by the facility to of deficient practice and what led to deficient practice: On 1/10/18 The maintenance so created a new log for fire drills of once per shift per quarter to bet and keep track of required fire of missing fire drill was completed 1/12/18 and added to the log. To be maintained monthly by the maintenance supervisor. It was determined that turnover in the maintenance position caused a paperwork follow through. How will you identify other life so issues having the potential to aff residents by the same deficient and what corrective action will be All residents have the potential of affected by this practice. The maintenance supervisor will aud	DES NOT THE ES; NOR MISSION CY IS THE POC T LAW correct the to the upervisor completed ter reflect lirills. The on he log will lapse in afety fect practice te taken: to be			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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K 712	Continued From page	÷ 11	K 7	drill log monthly to ensure completed as required. A to be missed will be composed from the audit. What measures will be purchast systemic changes we ensure that the deficient recur: The maintenance superve monthly audits of the fire separate long will be main Administrators office as a documentation. The fire of reviewed by the quarterly Assurance meeting. How the corrective action monitored to ensure the will not recur, i.e., what a program will be put into purchast monitored to ensure the completed monthly find the completed monthly find the completed are as required. The Quality of Committee will be charged responsibility to ensure the achieved and sustained.	any fire drill no pleted at the ti ut into place o will you make t practice does risor will completed in the pack up for drill audits will y Quality (a) will be deficient practice drill audits erly Quality (b) Quality (c)	ted ted me r o not ete be ice ce will all	
K 912 SS=D	CFR(s): NFPA 101 Electrical Systems - F Power receptacles ha highly dependable grumaintaining low-conta plug. In pediatric loca	Receptacles at least one, separate, bunding pole capable of act resistance with its mating tions, receptacles in patient ay rooms, and activity	KS	12			1/19/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC. 28054				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
K 912	tamper-resistant or er If used in patient care interrupters (GFCI) ar 6.3.2.2.6.2 (F), 6.3.2.2 This REQUIREMENT by: Based on observation documentation on 01 through 2:00 PM the fronted: The standard findings include: 1. The med refrigerate emergency powered adjacent the beauty so NFPA 101, NFPA 70 This deficiency affects compartments. Failure to comply with referenced increases	mploy a listed cover. room, ground-fault circuit re listed. 2.4.2 (NFPA 99) is not met as evidenced rus, staff interview, and/or /05/2018 at 9:30 AM following deficiencies were is non-compliant, specific rus was not plugged into an recepticle in the med room hop. ed 8 of 8 smoke ruminimum standards as the risk of injury and/or of medication not being	К	912	ALEXANDRIA PLACES RESPONSE THIS REPORT OF SURVEY DOES NO DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOF DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POBECAUSE IT IS REQUIRED BY LAW K912 What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: The emergency power receptacle in the med room will be replaced by Alexandre Place on 1/17/18. It was determined the when the refrigerator was placed in the med room that there was a failure to complete an assessment for compliance with K912. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by this practice. All medication refrigerators in the facility will be audited to ensure they are plugged into emergency power receptacles. If an emergency power receptacle is warranted, it will be completed by 1/17/17/18/15/19/19/19/19/19/19/19/19/19/19/19/19/19/	DT R N DC he e ia at ee e 1: 1 d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345441	B. WING _		01	/05/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054			
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K 912 K 918 SS=D	CFR(s): NFPA 101	Essential Electric Syste	K 9	what systemic changes will you nensure that the deficient practice recur: The maintenance supervisor will medication refrigerators are pluggan emergency power receptacle. He will record his findings and repto the quarterly Quality Assurance meeting. If any receptacle is foun need repair or replacement, it will repaired or replaced at the time of finding. How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e., what quality as program will be put into place: The monthly audits will be turned Quality Assurance committee for and determination if additional act amended action is necessary and ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correachieved and sustained.	audit all ged into monthly. port them e d to l be of the practice surance into the review stion or d to ce ne	1/19/18	
	Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s	Essential Electric System sting er alternate power source oment is capable of supplying onds. If the 10-second uring the monthly test, a rided to annually confirm this safety and critical branches. ting of the generator and					

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	
		345441	B. WING			01/	05/2018	
NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE				17	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD ASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 918	with NFPA 110. Generator sets are in under load 30 minuted day intervals, and exmonths for 4 continuounder load conditions simulated cold start atransfer of all EES locompetent personne stored energy power accordance with NFF circuit breakers are in program for periodica components is estab manufacturer require maintenance and tes readily available. EEs circuits are marked, is separate from normathe possibility of dams source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (N 111, 700.10 (NFPA 7 This REQUIREMENT by: Based on observation documentation on 0 through 2:00 PM the noted: The standard findings include:	performed in accordance aspected weekly, exercised as 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test as include a complete and automatic or manual ads, and are conducted by I. Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a fally exercising the lished according to aments. Written records of atting are maintained and as electrical panels and are adily identifiable, and all power circuits. Minimizing age of the emergency power ansideration for new FPA 99), NFPA 110, NFPA and and and and and breadily identifiable, and and and and are adily identifiable, and and and and are adily identifiable, and and and and are adily identifiable, and and are adily and a series and are adily and and are adily and a series and are adily and are adil	К	918	ALEXANDRIA PLACES RESPONSE THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOT DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POBECAUSE IT IS REQUIRED BY LAW	OT R DN		
	generator 4 hour run time every 3 years. 2. The facility was missing documentation of annual load bank test.				K918 What corrective action(s) will be accomplished by the facility to correct t deficient practice and what led to the	he		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	X2) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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K 918	Continued From page	K	918	18				
	3. The facility was mi generator transfer sw each month and doct battery voltage or spe and documented each. 4. The facility generations when generator batter turned off. NFPA 101, 19, NFPA This deficiency affect compartments. Failure to comply with	ssing documentation of vitches being exercisesed umentation of generator ecific gravity being checked th month. tor annunciator panel did not or battery charger AC power ery charger breaker was			deficient practice: The 4 hour generator run was complet by Kraft Power on 1/9/18. The annual I bank test was also completed by Kraft power on 1/9/18. Transfer switches we assessed and the generator battery was checked along with the battery voltage and specific gravity on 1/9/18. The generator annunciator panel will be serviced and complaint by 1/19/18. How will you identify other life safety issues having the potential to affect residents by the same deficient practic and what corrective action will be taken All residents have the potential to be affected by this practice. The 4 hour generator run, annual load bank test, transfer switches, generator battery, battery voltage and specific gravity and the generator annunciator panel will be audited to be sure they are in compliar for K918 and to ensure they are being checked monthly. The audit will be completed by 1/19/18. If any repairs or replacements are needed, they will be done at the time of the audit. What measures will be put into place of what systemic changes will you make ensure that the deficient practice does recur: The maintenance supervisor will compannual checks for the 4 hour generator run and as well and the annual load battest. This will be added to the generator switches, generator battery voltage and specific gravity and the generator	e en:		

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K 918 K 923 SS=E	CFR(s): NFPA 101 Gas Equipment - Cyli Greater than or equal Storage locations are ventilated in accordar 5.1.3.3.3. >300 but <3,000 cubi Storage locations are within an enclosed in limited- combustible of gates outdoors) that of gases are not stored.	nder and Container Storage to 3,000 cubic feet designed, constructed, and nce with 5.1.3.3.2 and c feet outdoors in an enclosure or rerior space of non- or construction, with door (or can be secured. Oxidizing with flammables, and are ustibles by 20 feet (5 feet if	K 918	annunciator panel will be audited mont to ensure they are in proper working condition and are in compliance with K918. These audits will be added to th monthly generator documentation and audit form to ensure they are in proper working condition and in compliance w K918. How the corrective action(s) will be monitored to ensure the deficient pract will not recur, i.e., what quality assurar program will be put into place: The monthly documentation reports wi be turned into the Quality Assurance committee monthly for review and determination if additional action or amended action is necessary to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensu that correction is achieved and sustain	e ith ice ice il	19/18		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE				1	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD BASTONIA, NC 28054	1 011	00/2010	
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K 923	1/2 hr. fire protection Less than or equal to In a single smoke co cylinders available for care areas with an a or equal to 300 cubic stored in an enclosur handled with precaut A precautionary sign each door or gate of where the sign include minimum "CAUTION STORED WITHIN N Storage is planned so of which they are rec Empty cylinders are cylinders. When fact integral pressure gate considered empty is are marked to avoid in the open are prote 11.3.1, 11.3.2, 11.3.3 This REQUIREMEN' by: Based on observation documentation on 0 through 2:00 PM the noted: The standard findings include: 1. The facility had Of an enclosed shed; the separate full and em the shed. 2. The cylinders were	struction having a minimum rating. o 300 cubic feet impartment, individual or immediate use in patient ggregate volume of less than cleet are not required to be re. Cylinders must be tions as specified in 11.6.2. readable from 5 feet is on a cylinder storage room, des the wording as a li OXIDIZING GAS(ES) O SMOKING." oo cylinders are used in order ceived from the supplier. segregated from full ility employs cylinders with uge, a threshold pressure established. Empty cylinders confusion. Cylinders stored ected from weather. 3, 11.3.4, 11.6.5 (NFPA 99) T is not met as evidenced ons, staff interview, and/or 1/05/2018 at 9:30 AM following deficiencies were d is non-compliant, specific 2 cylinders stored outdoors in the facility did not label and pty cylinder(s) locations in	K	923	ALEXANDRIA PLACES RESPONSE THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOT DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POBECAUSE IT IS REQUIRED BY LAW K923 What corrective action(s) will be accomplished by the facility to correct to deficient practice and what led to the	OT R ON OC		
	findings include: 1. The facility had Of an enclosed shed; the separate full and emithe shed. 2. The cylinders were electrical recepticle as	2 cylinders stored outdoors in ne facility did not label and pty cylinder(s) locations in			DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POBECAUSE IT IS REQUIRED BY LAW K923 What corrective action(s) will be	ON OC		

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		345441	B. WING _			01/	05/2018
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K 923	standing upright and safe storage racks. NFPA 101, 19, NFPA This deficiency affect compartments. Failure to comply with	several smaller O2 I unsecured in the shed just not in a proper individual	K	923	The O2 cylinder shed was labeled with separate full and empty signs on 1/11/7 The O2 cylinders were moved 5 feet at from the electrical receptacle and panel/breaker box on the right side of the shed on 1/11/18. The small O2 cylinder and E cylinder were secured and store proper individual safe storage racks on 1/11/18 and 1/12/18. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taker All residents have the potential to be affected by this practice. All O2 cylinder and the O2 cylinder shed was audited the ensure it was in compliance with K923. The cylinders were properly labeled, 5 feet away from the electrical receptacle and panel/breaker box, and securely stored in individual safe storage racks. This audit was completed on 1/12/18. If any repairs or replacements were need it was completed at the time of the aud on 1/12/18. What measures will be put into place of what systemic changes will you make the ensure that the deficient practice does recur: The maintenance supervisor will audit at O2 Cylinder storage for correct signs, and panel/breaker box, and safe storage racks monthly and record and report findings to the quarterly Quality Assural meeting. If any repairs or replacements are warranted, they will be completed as warranted.	tale. the rest of the ded, it reconditions of the conditions of t	

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G 01 - Main Building 01		(X3) DATE SURVEY COMPLETED			
		345441	B. WING			01/05/2018			
NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054					
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K 923	Continued From page	÷ 19	K 92	the time of the monthly audit How the corrective action(s) monitored to ensure the defivill not recur, i.e., what quality program will be put into place. The monthly reports will be to Quality Assurance committee monthly basis for review and determination if additional action amended action is necessary ensure prompt follow up/reports completion. The Quality Assurance will be charged were sponsibility to ensure that achieved and sustained.	will be cient practice ity assurance e: urned into the e on a d ction or y and to air urance ith the				