## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/08/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<del>J. 0938-039 <u>I</u></del>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED 07/14/2011	
		345284	B. WING				
NAME OF PROVIDER OR SUPPLIER  THE OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA RD 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	CTION SHOULD BE COMPLETION DATE	
F 000	INITIAL COMMENTS  The facility is in com	pliance with the FR Part 483, Subpart B for		000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A BUILDING B. WING\_ 08/11/2011 345284 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 901 BETHESDARD THE OAKS WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) NFPA 101 LIFE SAFETY CODE STANDARD K 061 K 061 NEPA 101 Life Safety Code Standard SS≃E 9/20/2011 Required automatic sprinkler systems have Tug#K 061 This requirement will be met as follows: valves supervised so that at least a local alarm The facility has taken correctly action for the will sound when the valves are closed. residents affected by this practice by: 72, 9,7,2.1 Mechanism to facilitate electrical supervision of the valves on the accelerator line will be installed by September 20, 2011. The facility will identify other life exfety issues having the potential to affect residents by the same deficient practice; This STANDARD is not met as evidenced by: Based on the observations and staff Interview A local alarm will sound when valves are closed. during the tour on 8/11/2011 the facility is utilizing a dry pipe sprinkler system with an accelerator The following measures/systemic changes will be put in place to ensure that the deficiont installed to increase performance to the sprinkler practice does not recur; system. The accelerator has valves installed if closed would affect the sprinkler system in a Maintenance Director will assure that accelerator valves are electrically supervised. negative way. These valves installed on the accelerator line must be electrically supervised. The facility will monitor its performance to ensure that solutions are achieved and CFR#: 42 CFR 483.70 (a) gustained. The facility will evaluate the plan's NFPA 101 LIFE SAFETY CODE STANDARD K 147 K 147 effectiveness by: SSHE Maintenance Director will monitor the installed Electrical wiring and equipment is in accordance mechanism which electrically supervises the with NFPA 70, National Electrical Code, 9.1.2 valves on the accolerator line. This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/11/2011 during the testing of the emergency power system the generator was supplying load to the life safety branch of the facility. The generator annunciator panel located at stallon # 1 was not giving an indication that the generator was running nor supplying power to the life safety branch of the facility. (X6) DATE LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S GIGNATURE TITLE tellit

THE OAKS AT FORSYTH

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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No. 1/4/FOR 3PROVED

Aug. 26. 2011 3:46PM

AUE. ZO. ZVII J:40PM INC DAKS AT FORSYTH DEPARTMENT OF HEALTH AND HUWAN SCRVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1/4/1016 49 10/2011 OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 B. WING \_ 08/11/2011 345284 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 901 BETHESDARD THE DAKS WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 147 K 147 Continued From page 1 NFPA 101 Life Safety Code Standard CFR#; 42 CFR 483,70 (a) 9/20/2011 Tog# K 147 This requirement will be met as follows: The fucility has taken corrective action for the residents affected by this practice by: Anunciator panel will be checked and repaired as needed to appropriately indicate that the good ator is moning or supplying power to the life sufety branch of the facility by September 20, 2011. The facility will identify other life talety issues having the potential to affect residents by the same deficient practice; Annunciator panel will work correctly. The following measures/systemic changes will he put in place to ensure that the deficient practice does not recur: Annunciator panel will indicate that the generator is running or supplying power to the life safety brauch of the facility by September 20, 2011. The facility will monitor its performance to ensure that solutions are achieved and. gustained. The facility will evaluate the plan's effectiveness by: Maintenance Director will text panel by turning on the generator and assuring that the annunciator panel indicates that generator is running or supplying power to the life safety branch of the facility.

FORM CMS-2567(02-99) Previous Versions Obsolete

Eyent ID: X1A421

Facility IO; 923497

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