## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION		.serri to month trompen	A. BUILDING		G		
345315		B. Wil	B. WING			12/15/2011	
NAME OF PROVIDER OR SUPPLIER HIGHLAND ACRES NURSING AND REHABILITATION CENTER				11	REET ADDRESS, CITY, STATE, ZIP CODE 170 LINKHAW ROAD UMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER'S PLAN OF CORRECT PROVIDER'S			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
		CFR Part 483, Subpart B for acilities (General Health					
	i e e e e e e e e e e e e e e e e e e e	re cited as a result of the tion Event ID# W82M11					
				***************************************			
				Construction of the constr			
LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

RINTED: 01/13/2012 RTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ENTERS FOR MEDICARE & MEDICAID SERVICES 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 345315 01/11/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1170 LINKHAW ROAD HIGHLAND ACRES NURSING AND REHABILITATION CENTER LUMBERTON, NC 28358 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 029 NFPA 101 LIFE SAFETY CODE STANDARD Principle LTC acknowledges receipt of the Statement of Deficiencies and proposes this SS=D One hour fire rated construction (with 1/4 hour Plan of Correction to the extent that the summary of findings is factually correct and fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 in order to maintain compliance with and/or 19.3.5.4 protects hazardous areas. When applicable rules and provisions of quality of the approved automatic fire extinguishing system care of residents. The Plan of Correction is option is used, the areas are separated from submitted as a written allegation of other spaces by smoke resisting partitions and compliance. doors. Doors are self-closing and non-rated or Principle LTC's response to this Statement field-applied protective plates that do not exceed of Deficiencies does not denote agreement 48 inches from the bottom of the door are with the Statement of Deficiencies nor does 19.3.2.1 permitted. it constitute an admission that any deficiency is accurate. Further, Principle LTC reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute This STANDARD is not met as evidenced by: Resolution, formal appeal procedure and /or A, Based on observation on 01/11/2012 the any other administrative or legal proceeding. storage rooms located near rooms 506 A& B and room 522 did not have a closer on the doors. K 029 B. The doors to the ADON's office and the Social Workers office require more than one (1) motion Storage rooms located near rooms 506 A&B 1/18/12 of the hand in order to exit the room. and room 522 now have self closer's on the K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 doors. SS=D Exit access is arranged so that exits are readily Will inspect storage room doors weekly for accessible at all times in accordance with section one month then monthly thereafter to assure 1/20/12 7.1. 19.2.1 self closing. Door knobs replaced in ADON and Social Worker's offices. All office door knobs 1/12/12 through out facility were inspected to assure they only require one motion of the hand to This STANDARD is not met as evidenced by: exit room. A. Based on observation on 01/11/2012 the staff interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a) (X8) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE THEN RN LNHA

Any deficiency statement ending with an asterisk (1) 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 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONST A. BUILDING 01 - (			(X3) DATE SURVEY COMPLETED	
345315		B. WII	B. WING			01/11/2012	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	₹	1	REET ADDRESS, CITY, STATE, ZIP CODE 170 LINKHAW ROAD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI.L SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			JLD BE	(X5) COMPLETION DATE
			***************************************		K 038  All staff in-serviced about location master door release switch located nurses station.	of the	01/23/12
					All new staff will be in-serviced in orientation about the location of m release switch located at the nurse.	aster door	1/19/12
		·	Andrew - * * * * * * * * * * * * * * * * * *				
		_					
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
****	M <sub>erc</sub>						
The state of the s							
						Topodella collegación de la	

FAX NO. :9106711625

Jan. 24 2012 03:12PM P2/3

~ 1/					and profit of the			
		HAND HUMAN SERVICES E & MEDICAID SERVICES			JAM & Chall	FORM	): 01/13/2012 /IAPPROVED ): 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDEN (IFICATION NUMBER;				(X2) MULTIPLE CONSTRUCTION A. UUILÜING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345315	B. WING	} <u></u>	——————————————————————————————————————	01 <i>/</i> ·	11/2012	
	PROVIDER OR SUPPLIER ND ACRES NURSING	AND REHABILITATION CENTER		117	ET ADDRESS, CITY, STATE, ZIP CODE TO LINKHAW ROAD MBERTON, NC 28358			
(X4) IO PREFIX ING	SUMMARY STATUMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BUT PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I SHOULD HE COMPLETION		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ 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		K 02		t of the oses this the creet and huality of ction is tement or does ciple of the			
K 038 SS≂D	A. Based on obserstorage rooms local room 522 did not hat B. The doors to the Workers office requof the hand in order NFPA 101 LIFE SA Exit access is arran accessible at all tim 7.1. 19.2.1	FETY CODE STANDARD  ged so that exits are readily es in accordance with section  s not met as evidenced by:	K 030	8	deficiencies on this Statement of Deficiencies through Informal Disparation, formal appeal procedure any other administrative or legal procedure and rooms 522 now have self closer's doors.  Will inspect storage room doors were one month then monthly thereafter a self closing.  Door knobs replaced in ADON and Worker's offices. All office door known through out facility were inspected they only require one motion of the exit room.	and/or occoding.  Of A&B s on the occidence of the contract of	1/18/12	
	A. Based on observation on 01/11/2012 the staff interviewed did not know about the master door							

I ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Any deficiency statement entiting with an asterisk (Odertotes 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 noteing homos, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For noteing 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.

FORM CMS-2567(U2-89) Previous Versions Obsoleie

42 CFR 483.70 (a)

Event ID: W82M21

Facility ID: 923071

If continuation shoot Page 1 of 2

		HAND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 01/13/2012 MAPPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(XX) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345315	B. WI	ING	01/	11/2012	
J	PROVIDER OR SUPPLIER  ND ACRES NURSING	AND REHABILITATION CENTE	:R	STREET ADDRESS, CITY, STAYE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	1	\$10.00 American (see 1 - c 4	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREF TAG	TIX (FACH CORRECTIVE ACTION SHO	ULO DE	(X5) COMPLETION DATE		
				K 038  All staff in-serviced about locatio master door release switch located nurses station.		01/23/12	
The second secon				All now staff will be in-serviced is orientation about the location of n release switch located at the nurse	naster door	1/19/12	
Those are a second as a se					,		