STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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
F 000	INITIAL COMMENTS The facility was in compliance with the requirement of the 42 CFR part 483, Subpart B for Long Term Care Facilities , and complaint investigation Intake # NC 00081622.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

DW

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

PRINTED: 08/04/2012
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
	345172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II Fire Resistive construction, is utilizing North Carolina Special Locking arrangements. The facility is equipped with a complete automatic sprinkler system.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Triad Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 012 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/31/2012 the following item was observed as noncompliant, specific findings include: There was a hole in the rated wall in the laundry room linen closet adjacent to the hot water heater room where repairs to the wall were not finished.	K 012	K 012 1. The hole in the rated wall in the laundry room linen closet adjacent to the hot water heater room was repaired on 8/2/12 by the Maintenance Director. 2. An audit was completed by the Maintenance Director on 8/2/12 to assure there were no holes in other rated walls throughout the facility. Any areas found were repaired.	
K 038 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	3. Maintenance Director was re-educated by the Administrator on 8/1/12 related to holes in rated walls.	

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

A Hopgood | Administrator | 8/17/12

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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
K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/31/2012 the following item was observed as noncompliant, specific findings include: The interior courtyards on the second floor do not have single motion of the hand exiting if the dead bolts for the doors are locked from the corridor side. CFR#: 42 CFR 483.70 (a)	K 038	4. Maintenance Director will perform random checks of rooms to assure there are no holes in rated walls 1 x weekly x 4 weeks then 1 x monthly x 2 months. Results will be submitted to Performance Improvement Committee 1 x monthly x 3 months. Date of Compliance: 8/17/12 K 038 1. The interior courtyard door locks will be replaced with One-Step leaver locks by Mid-State Lock Company with installation scheduled for 8/17/12. 2. An audit was completed by the Maintenance Director on 8/2/12 to assure there were no other doors requiring One-Step leaver locks. Any doors required to have One-Step leaver locks will be replaced. 3. The Maintenance Director was re-educated by the Administrator on 8/1/12 related to One Step leaver locks on doors. 4. The Maintenance Director will perform random checks of the doors with One-Step leaver locks to assure there are no issues identified with the doors unlocking 1 x weekly x 4 weeks then 1 x monthly x 2 months. Results will be submitted to Performance Improvement Committee 1x monthly x3 months. Date of Compliance: 8/17/12	