STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed adequately provide housekeeping and maintenance services for 2 of 2 common use bath/shower rooms, 1 of 2 common resident halls, 3 of 34 resident rooms, and 1 of 1 laundry service room. The findings include: 1) On 02/17/2013 at 3:30 p.m. an initial tour of the facility was conducted. During the tour an observation was made of the resident community bath/shower room between resident rooms 16 and 18. During the observation it was noted there were several broken ceramic tiles located on the corners of the knee-wall separating the bathtub area and the shower area. A closer observation revealed the broken tiles had jagged and sharp edges that were at elbow height when seated in a shower chair and/or head and body height when lying on a shower bed. On the wall the shower was installed was a broken plastic showerhead holder bracket. The shower head was observed hanging from the tubing attached to the wall. Also observed next to the commode, the toilet paper holder was observed to be broken and loosely hanging from the wall (only having 2 of the 4 required screws attaching it to the wall). On the wall at the foot of the bath tub a towel bar was observed to be hanging by 2 screws. The shower	F 253	Housekeeping services are provided daily to all resident. The ceramic tile in shower room 1 and shower room 2 have been repaired. The tile along the shower wall(elbow high) has been fixed in both shower rooms. The shower head bracket has been replaced. The toilet paper holder and towel bar has been repaired. The grout has been cleaned and behind the shower doors have been cleaned. The wire shelf in shower room 2 has also been repaired. Cob webs have been cleaned from the exit doors The tv plastic outlet was replaced in RM 9. The black marks in RM 2, 9, and 20 have been cleaned and RM 2, 9 and 20 have been put on the schedule to be waxed/stripped. In room 14 the phone jack was replaced. The sheet rock in the laundry room as been repaired. Once a week, for 60 days, the shower rooms will be check by administrator to ensure the floor is clean, items are securely mounted to the wall, and the tile is in good repair. Once a month,, for 90 days, exit doors will be checked for cobwebs by the housekeeping supervisor.	3-21-13

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy Davis — TITLE: Administrator — (X6) DATE: 3-21-13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 1 stall was observed to have a black substance on the grout around the drain and in the corners where the walls meet the floor. Behind the door there was a buildup of black and dark brown dirt and debris against the wall. Additional observations were made on 02/18/2013 at 8:00 a.m., 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the subsequent observations it was revealed there had been no repairs/cleaning of any of the items noted during the initial tour. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor and housekeeping supervisor. The administrator also indicated he directed the facility's maintenance worker and the housekeeping staff. The administrator was asked to explain the housekeeping/maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder. A review of the facility's maintenance work orders was conducted with the administrator and	F 253	Once a week, for 90 days, 2 resident rooms will be checked by administrator to see if the rooms need housekeeping or maintenance to address any issue. Once a quarter, for 9 months, the administrator will check the dryer trap door to ensure the handle is in working condition and that the sheet rock in the laundry room is in good condition. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	3-21-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 2 maintenance worker. The administrator and maintenance worker indicated they had no work orders for any items needing repair in the resident common use bath/shower rooms and were unaware of any broken items. 2) On 02/17/2013 at 3:30 p.m. an initial tour of the facility was conducted. During the tour an observation was made of the resident community bath/shower room next to resident room 31. During the observation it was noted there were several broken ceramic tiles located on the corners of the knee-wall separating the bathtub area and the shower area. A closer observation revealed the broken tiles had jagged and sharp edges that were at elbow height when seated in a shower chair and/or head and body height when lying on a shower bed. The shower stall was observed to have a black substance on the grout around the drain and in the corners where the walls meet the floor. On the wall at the foot end of the bath tub a wire shelf unit was observed to be pulled out of the wall and hanging by 1 screw inserted only halfway in the sheetrock. Behind the door there was a buildup of black and dark brown dirt and debris against the wall. Additional observations were made on 02/18/2013 at 8:00 a.m., 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the subsequent observations it was revealed there had been no repairs and/or cleaning to any of the items noted during the initial tour. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor and housekeeping supervisor. The administrator also	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 3	F 253		

indicated he directed the facility's maintenance worker and the housekeeping staff. The administrator was asked to explain the housekeeping/maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder.

A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work orders for any items needing repair in the resident common use bath/shower rooms and were unaware of any broken items.

3) On 02/17/2013 at 3:30 p.m. an initial tour of the facility was conducted. During the tour an observation was made of the facility's common use halls. During the observation it was noted that at the end of the hall on the glass wall/window between rooms 1 and 2 there were several cob webs attached to the glass wall's curtain rod and extending down and attached to a paper sign 18" below the curtain rod. Additional observations were made on 02/18/2013 at 8:00 a.m. and 02/19/2013 at 10:30 a.m. During the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 4 subsequent observations it was revealed the cob webs had not been cleaned and/or removed since the initial tour observation. On 02/18/2013 at 9:15 a.m. an observation was made of a housekeeping staff member cleaning the hall's handrails between resident room's 1 and 2. The housekeeper made no attempt to clean and/or remove the cob web. The housekeeper was asked how often she cleaned the area. The housekeeper indicated she cleaned the area daily. On 02/19/2013 at 2:30 p.m. an observation was made of the facility administrator checking the exit door on the glass wall/window between resident rooms 1 and 2. The administrator checked the wiring from the door's alarm sensors located just above and to the left of the cob webs observed during the facility tour. The administrator made no attempt to clean and/or remove the cob webs or notify housekeeping of the condition. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor and housekeeping supervisor. The administrator also indicated he directed the facility's maintenance worker and the housekeeping staff. The administrator was asked to explain the housekeeping/maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 5 On 02/20/2013 at 10:45 a.m. an observation was made with the facility's administrator and the facility's maintenance worker of the cob webs hanging from the curtain rod to the paper sign on the glass wall/window between resident rooms 1 and 2. The administrator indicated he had not realized the cob webs were there when he checked the exit door alarm on 02/19/2013. 4) On 02/18/2013 at 9:16 a.m. an observation was made of resident room #9 where facility residents # 2 and #20 resided. Both residents were bed ridden and were unable to communicate. The room's floor was observed to have long and wide black marks where the resident's bed wheels had blackened the floors at the foot of each bed. The room's floor was observed to be dirty and had a build up of brown and black debris along the wall's floor line and behind the head of each resident's beds. The room's wall cable TV receptacle plastic outlet cover was observed to be broken and the cable wire was observed to be hanging 2 ft. from wall onto the floor. Additional room observations were made on 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the subsequent observations it was revealed there had been no repairs and/or corrective cleaning to any of the items noted during the initial observations. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor and housekeeping supervisor. The administrator also indicated he directed the facility's maintenance worker and the housekeeping staff. The administrator was asked to explain the	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 6 housekeeping/maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder. A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work orders for any items needing repair in resident room # 9. On 02/20/2013 at 10:45 a.m. an observation was made with the facility's administrator and the facility's maintenance worker of the resident's room (room #9), the dark marks on the floor, the broken cable TV receptacle, and the dirty floor and debris against the walls. The administrator could not explain why the black marks on the floor and dirty areas in the room were not cleaned by the housekeeping staff. The maintenance worker indicated he was not aware of the broken cable TV receptacle and the wire hanging out on the floor. 5) 02/18/2013 at 11:22 a.m. an observation was made of resident room #14 where resident #10	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 7 resided. During the observation a phone electrical plastic outlet was observed lying on the gray foot extender pad of the B bed. An observation was made of the room's phone attaching point on the wall by the B bed. It appeared the phone electrical outlet had been pulled off of the walls attaching/wiring point. Additional observations were made on 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the subsequent observations it was revealed there had been no repairs to the phone jack connection on the wall and the plastic outlet was still lying on the foot end of the B bed on 02/19/2013 and on the residents TV stand on 02/20/2013. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor. The administrator also indicated he directed the facility's maintenance worker. The administrator was asked to explain the housekeeping and/or maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 8 A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work orders for any items needing repair in resident room # 14. On 02/20/2013 at 10:45 a.m. an observation was made with the facility's administrator and the facility's maintenance worker of the resident's room (room #14). The phone jack plastic electrical outlet was observed to still lying on the B bed's TV stand. The administrator and maintenance worker could not explain why the room's phone jack plastic electrical outlet was pulled off of the wall and lying on the B bed's TV stand and/or why they had not received a work order or verbal notification of the phone jack being broken. 6) 02/18/2013 at 11:56 a.m. an observation was made of resident room #1 where resident # 58 resided. The floor tile was observed to have 2 large yellow stains on floor to the right of the entry door by the resident's folding chairs. An interview was conducted with resident #58 who could see the yellow stains on the floor but could not state how long the yellow stains had been there or what may have caused the stains. Additional observations were made on 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the subsequent observations it was revealed there had been no attempt to clean and/or remove the yellow stains from the resident's floor as they were the same as noted during the initial observations. On 02/20/13 at 10:30 a.m. interviews were made	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 9	F 253		

with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor and housekeeping supervisor. The administrator also indicated he directed the facility's maintenance worker and the housekeeping staff. The administrator was asked to explain the housekeeping/maintenance process for cleaning and/or repairing items in the facility. The administrator indicated the house keeping staff cleaned the facility daily and as things came up that required immediate attention.

On 02/20/2013 at 10:45 a.m. an observation was made with the facility's administrator and the facility's maintenance worker of the resident's room (room #1). The administrator could not explain why the yellow stains had not been cleaned off the resident's floor.

7) On 02/20/13 at 10:05 a.m. the facility's laundry services was observed with the facility's administrator (housekeeping supervisor) and the day shift laundry worker. The wall in the laundry area (clean side) in front of the dryers was observed to have sheetrock broken off of the wall at both corners exposing the metal beading nailed to the studs. A large laundry hamper was observed resting against the broken sheetrock. Sheetrock debris was observed on the floor beneath the hamper. The day shift laundry worker could not state how long the sheetrock had been broken off of the wall except that it had been quite a while.

On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 10	F 253		

he was the facility's maintenance supervisor. The administrator also indicated he directed the facility's maintenance worker. The administrator was asked to explain the maintenance process for repairing items in the facility. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder.

A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work order for the broken sheetrock on the wall across from the dryers in the laundry room.

8) On 02/20/13 at 10:05 a.m. the facility's laundry services was observed with the facility's administrator (housekeeping supervisor) and the day shift laundry worker. The laundry's dryers (3) were observed. The middle dryer's lint trap door handle was observed to be broken and had a pair of vice-grip pliers holding the closing latch and handle onto the door. The administrator could not state how long the lint door's handle and latch mechanism had been broken. The laundry worker could not state how long the middle dryer door handle had been broken but indicated it had been at least several weeks.

On 02/20/13 at 10:30 a.m. interviews were made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 253	Continued From page 11 with the facility's administrator and the facility's maintenance worker. The administrator indicated he was the facility's maintenance supervisor. The administrator also indicated he directed the facility's maintenance worker. The administrator was asked to explain the maintenance process for repairing items in the facility. The maintenance worker indicated the facility's repair process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder. A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work order for the broken handle on the middle laundry room dryer lint trap door.	F 253		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 323	Continued From page 12 Based on observations, staff interviews, and record reviews the facility failed to ensure facility residents were free of potential hazards by not securing potentially dangerous cleaning chemicals and not repairing broken ceramic tiles in 2 of 2 common use bath/shower rooms. The findings include: 1) On 02/17/2013 at 3:30 p.m. observations were made of resident community bath/shower room between resident rooms 16 and 18. During the observation it was noted there was an unsecured cabinet containing Clorox bleach spray and Clorox bleach wipes that was accessible to any resident who may come in to use the bath/shower room. Also during the observation it was noted that there were several broken ceramic tiles located on the corners of the knee-wall separating the bathtub and the shower areas. A closer observation revealed the broken tiles had jagged and sharp edges that were at elbow height when seated in a shower chair and/or head and body height when lying on a shower bed. Additional observations were made on 02/18/2013 at 8:05 a.m., 02/19/2013 at 10:35 a.m., and 02/20/2013 at 10:48 a.m. During the additional observations facility staff members were observed to take residents into the common use bath/shower rooms, leave the residents alone for a few minutes then return to provide resident care. During these subsequent observations it was also revealed the cleaning chemicals were still in the unsecured cabinets which the residents in the bath/shower rooms had access to. Also during the subsequent observations it was revealed there had been no repairs to the broken, jagged and sharp ceramic tiles on the corners of	F 323	The shower room between 16 and 18 has a lock on the cabinet and is being locked. The tile in the shower room has been repaired. The shower room next to room 31 has a lock on the cabinet and is being locked. The tile in the shower room has been repaired. All the cabinets in all the shower rooms have locks and tile in all of the shower rooms have been repaired. Once a week, for 60 days the cabinets in the shower rooms will be check by the administrator to ensure they are being locked. Also weekly for 60 days, the administrator will check the tile in the shower rooms to ensure they are in good repair.. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	3-21-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 323	Continued From page 13 the knee-wall in the bath/shower room. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator was asked to explain the housekeeping/maintenance process for limiting access to hazardous chemicals by facility residents. The administrator indicated all hazardous chemicals were supposed to be stored in a way to be inaccessible to facility residents. The administrator indicated this process meant the chemicals were to be secured via a locking mechanism. The administrator and maintenance worker were then asked to explain the maintenance process when a hazard was identified that needed maintenance repair. The maintenance worker indicated the facility's process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder. A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work orders for the broken/jagged tiles located in the facility's 2 common use bath/shower rooms and did not know how long the tiles had been broken as there were no verbal reports or work orders from staff to indicate a hazardous condition in the common use bath/shower rooms existed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 323	Continued From page 14 On 02/20/13 at 10:45 a.m. observations of the facility's 2 common use bath/shower rooms were made with the facility's administrator and the facility's maintenance worker. Both shower rooms were observed to have the broken tiles on the knee-walls between the bath tub and the shower areas. The administrator and maintenance worker indicated the broken tiles should have been reported verbally or by a work order. The cabinets containing the Clorox spray bleach and Clorox bleach wipes were also observed to be unsecured. The administrator indicated the cabinets should have been locked. 2) On 02/17/2013 at 3:40 p.m. observations were made of resident community bath/shower room next to resident room 31. During the observation it was noted there was an unsecured cabinet containing Clorox bleach spray and Clorox bleach wipes that was accessible to any resident who may come in to use the bath/shower room. Also during the observation it was noted that there were several broken ceramic tiles located on the corners of the knee-wall separating the bathtub and the shower areas. A closer observation revealed the broken tiles had jagged and sharp edges that were at elbow height when seated in a shower chair and/or head and body height when lying on a shower bed. Additional observations were made on 02/18/2013 at 8:00 a.m., 02/19/2013 at 10:30 a.m., and 02/20/2013 at 10:45 a.m. During the additional observations facility staff members were observed to take residents into the common use bath/shower rooms, leave the residents alone for a few minutes then return to provide resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 323	Continued From page 15	F 323		

care. During these subsequent observations it was also revealed the cleaning chemicals were still in the unsecured cabinets which the residents in the bath/shower rooms had access to. Also during the subsequent observations it was revealed there had been no repairs to the broken, jagged and sharp ceramic tiles on the corners of the knee-wall in the bath/shower room.

On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator was asked to explain the housekeeping/maintenance process for limiting access to hazardous chemicals by facility residents. The administrator indicated all hazardous chemicals were supposed to be stored in a way to be inaccessible to facility residents. The administrator indicated this process meant the chemicals were to be secured via a locking mechanism. The administrator and maintenance worker were then asked to explain the maintenance process when a hazard was identified that needed maintenance repair. The maintenance worker indicated the facility's process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder.

A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 323	Continued From page 16 orders for the broken/jagged tiles located in the facility's 2 common use bath/shower rooms and did not know how long the tiles had been broken as there were no verbal reports or work orders from staff to indicate a hazardous condition in the common use bath/shower rooms existed. On 02/20/13 at 10:45 a.m. observations of the facility's 2 common use bath/shower rooms were made with the facility's administrator and the facility's maintenance worker. Both shower rooms were observed to have the broken tiles on the knee-walls between the bath tub and the shower areas. The administrator and maintenance worker indicated the broken tiles should have been reported verbally or by a work order. The cabinets containing the Clorox spray bleach and Clorox bleach wipes were also observed to be unsecured. The administrator indicated the cabinets should have been locked. During the observations 02/20/13 at 10:45 a.m. the shower room next to resident room 31 was observed with the administrator and the maintenance worker to have a staff member providing care to a facility resident next to the broken tiles and unsecured cabinet.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened food items were sealed, dated and labeled in 4 of 5 refrigeration units; by not ensuring food items were stored at appropriate temperatures in 1 of 3 reach-in freezers; and, by not ensuring dishes and utensils were cleaned and stored under sanitary conditions. Findings included: 1. During the initial tour of the kitchen on 2/17/13 at 3:30pm, observations of the refrigeration units revealed food items that were not sealed, dated or labeled. Reach-in freezer #2 contained 1-opened bag of French fries; and 1-resealed bag of chicken patties and 1-resealed bag of potato wedges that were not dated or labeled. Reach-in refrigerator #1 consisted of 3-cooked breaded meat patties, partially wrapped in a piece of foil, 1-resealed bag of shredded cheese, and 1-unknown food wrapped in foil in a plastic bag that were not dated or labeled. Also, there was an employee's lunch bag (identified as belonging to the Cook who stated that the bag also contained her insulin). Reach-in refrigerator #2 consisted of 3-labeled beverages which were identified as belonging to the staff. Reaching freezer #3 contained 1-resealed bag of uncooked breaded patties that were not dated or labeled, and 1-torn bag of potato puffs.	F 371	All food items in the freezers have been labeled, dated and sealed. Employee items have been removed from the freezer. Freezers have also been serviced as well as the dishwasher. The dishwasher also uses a sanitizer as well as high heat. Dietary employees are logging the freezer temps daily. Once a week, for 60 days, the dietary manager will check the freezer to ensure food is sealed, labeled and dated, and that the freezer and dishwasher are operating at the proper temperature. The dietary manager will also check weekly, for 60 days, that no employee items are in the freezers and that the freezer temps are being logged. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	3-21-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 371	Continued From page 18 During a kitchen observation on 2/20/13 at 2:40pm, Reach-in freezer #2 contained 1-opened box of beef patties. 2. During the initial tour of the kitchen on 2/17/13 at 3:30pm, the internal temperature of Reach-in Freezer #1 was +20 degrees Fahrenheit and +8 degrees Fahrenheit in Reach-in Freezer#2. Review of the Refrigerator/Freezer Temperature Log revealed no documentation of temperatures recorded in afternoon or evening on this date. During a kitchen observation on 2/20/13 at 2:40pm, the internal temperature of Reach-in freezer #2 was +22 degrees Fahrenheit. This freezer contained 1-opened box of beef patties which had a temperature of 38 degrees Fahrenheit and the patties were soft, bendable, easy to tear. The freezer also contained 1-bag of resealed chicken patties which had a temperature of +26 degrees Fahrenheit. The DM (Dietary Manager) stated the box of beef patties and the bag of chicken patties would be immediately discarded and someone would check the freezer ' s temperature. During an interview on 2/21/13 at 9:40am, the DM stated that the Refrigerator repairman checked Reach-in freezers' #1 and #2 at 6:45pm on 2/20/13 and concluded that the drain on freezer #2 was clogged, causing the evaporator to freeze up. The repairman corrected the problem and Freezer #2 was currently working. The DM stated that her expectation of freezers' temperatures are 0 degrees Fahrenheit or below. The DM revealed that the refrigerator units were to be checked and recorded by dietary staff at 5:30am and again at	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 371	Continued From page 19 night (approximately 8:25pm) before dietary staff closed the kitchen. The DM indicated that on Tuesday, 2/19/13 she noticed that the temperatures in the freezer was slowly rising (+20 degrees Fahrenheit) and called the Refrigeration Repairman who did not come until the evening of 2/20/13. She also informed the Administrator about the problem with the freezer on 2/20/13. 3. During four observations of the operating dishwashing machine in the kitchen on 2/20/13 from 2:28pm to 2:32pm, the water temperatures during the rinse cycle ranged from 155 degrees Fahrenheit to 175 degrees Fahrenheit. Afterwards, dietary staff were observed removing the rinsed dishware from the dishwashing machine and stacking the items on the tray-line service, in the plate warmer, and on the storage shelves, ready for use. During an interview on 2/20/13 at 2:38pm, dietary staff revealed there was a problem with the dishwashing machine's heater, and a repairman had been notified. Dietary staff also indicated that the staff had been directed to continuously reset the button on the booster until the dishwasher was repaired. During an interview on 2/20/13 at 3:10pm, the DM revealed the reset button on the booster which heats the water in the dishwasher, began continuously cutting off the previous day. The repairman was notified, and until he arrived the staff were instructed to monitor rinse temperature. The DM stated that the water temperature of the dishwashing machine should not fall below 180 degrees Fahrenheit, but if it	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 371	Continued From page 20 happened the dishes must be rewashed.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	In the med room and supply room, the expired boost, 8 ounce oral fluid supplement and sterile water has been discarded. The expired staple remover, feeding tubes, catheters, and Y connectors have been discard. All expired items have been removed from the med room and supply room. The treatment cart is being locked when not attended. The treatment nurse has a key to make sure the treatment cart stays locked when unattended. Once a week, for 90 days, the director of Nursing will check the Med room and Supply Room to ensure expired items have been removed. Also once a week, for 90 days, the Director of Nursing will check to make sure the Treatment cart is being locked. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	3-21-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure expired drugs and medical items were not available for use in 2 of 6 medical storage areas and failed to ensure 1 of 6 medical storage areas was secured when not in use or out of the users view/control. 1) 02/18/2013 at 10:15 a.m. an observation was made of the facility's skilled nursing unit's medication storage room with staff member #1 Patricia Graves LPN. The following items were found to be expired: In the refrigerator on the top shelf there were 13 individual boxes of Boost, an 8 ounce oral liquid supplement (lot # 131957211C), that were observed to have expired on 02/13/2013. Staff member #1 acknowledged the Boost supplement was expired and should have been removed from the refrigerator on 02/13/2013. On the counter there was a 1000 ml bottle of Sterile water (Lot# JOA203) with an expiration date of 01/2013 next to an unopened bottle of sterile water which was not expired. The bottle appeared to have been open and approximately 1/8th of the solution removed. Staff member #1 indicated the sterile water was used for wound irrigation and other things, was expired and should have been poured out at the end of January 2013. An interview was conducted with the DON on 02/18/2013 at 11:00 a.m. concerning the expired medications and her expectation of not having expired medications readily available for nursing	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 22 use. The DON indicated the licensed staff members were supposed to check all medications and medical consumables daily and before use for expiration dates then remove the item from use if found expired. The DON indicated and the Boost and sterile water should have been removed the medication room. 2) On 02/18/2013 at 10:45 a.m. the facility's Medical Supply Closet was observed with staff member #1 LPN Patricia Graves. The following medical items were found to be expired: On the second wire shelf from the top on the right hand wall were 5 Cypress Skin Staple Remover Kits (Lot# CZA04-01 expired 01/2013). On the third wire shelf from the top on the right hand wall were 3 Kimberly Clark 18 French Gastrostomy Feeding Tubes (Lot# AA8273D03 expired 09/2011). On the third wire shelf from the top on the right hand wall were 5 Rusch Tripple Port 14 French Gastrostomy Catheters (Lot# 126322-1 with an expiration date of 07/2012). On the second wire shelf from the top on the left hand wall were 4 V.A.C. Y connectors in an open box (Lot# 12753 which expired on11/2010). An interview was conducted with staff member #1 concerning the expired items. Staff member #1 indicated all of the items were expired and should not have been in the Medical supply closet with the other medical items that were not expired.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 23	F 431		

An interview was conducted with the DON on 02/18/2013 at 11:00 a.m. concerning the expired medications and her expectation of not having expired medications readily available for nursing use. The DON indicated the licensed staff members were supposed to check all medications and medical consumables daily and before use for expiration dates then remove the item from use if found expired.

3) Between 02/18/2013 and 02/20/2013 multiple observations were made of the facility's wound care and treatment cart. During the observations the cart was observed to have eleven different resident's prescription drugs (creams, sauves, ointments, and medicated dressings) in it's drawers. Below are the listed dates and times the wound care and treatment cart was observed to be unlocked and unattended:

On 02/18/2013 between 11:05 a.m. and 11:20 a.m. a continuous observation of facility's medication and treatment cart was conducted. The cart was observed to be unlocked and unattended next to resident room #9. The cart's locking mechanism was in the out/unlocked position with the red dot indicating the cart was unlocked was showing. Three facility residents were observed to wheel themselves by the unattended treatment cart. A family member also walked by the unattended cart. The wound care/treatment nurse was in room #9 providing care for a resident out of sight of the cart (door shut). Upon leaving the resident's room the nurse went to the resident community bath/shower room next to room 16. The nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 24 did not lock the cart before during or after the care. From the bathroom the nurse went to the nurse's station out of sight of the cart then returned to the cart at 11:20 a.m. On 02/18/2013 at 1:15 p.m. an observation of the wound care and treatment cart was made next to resident room # 16. The cart's locking mechanism was in the out/unlocked position and the red dot indicating the cart was unlocked was showing. Three staff members and two residents were observed to walk by the unattended cart. The wound care nurse was observed to come out of room 16 at 1:40 p.m. and move the unlocked cart next to room 23 and went into room 23. Two family members walked by the cart while the treatment nurse was in room 23 with the door closed. At 1:59 p.m. the nurse exited room 23 and went into room 24 with another staff member. The treatment nurse did not lock the treatment cart before, during, or after going into room 24. The treatment nurse then returned to the cart, got treatment supplies and medications from the cart and went back into room 23 and closed the door 2:02 p.m. The treatment nurse did not lock the wound care/treatment cart as the locking mechanism was still observed in the out position and the red dot was still visible indicating it was unlocked. A facility volunteer was observed to walk by the unattended and unlocked treatment cart 4-5 times. During interview the volunteer indicated she was in the facility 4-5 days a week and just visit residents. The volunteer indicated she did not work for and was not employed by the facility. At 2:06 p.m. the volunteer and two family members were observed standing next to the unlocked and unattended cart. The treatment nurse was ten observed to exit room 23 and	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 25 walked down the hall leaving the treatment cart still unlocked and unattended from 2:10 p.m. - 2:55 p.m. AT 3:00 p.m. the treatment nurse moved the cart between rooms 6 & 8 where it remained in the hallway till 3:35 p.m. unattended and unlocked. The locking mechanism was still in the out position and the red dot was displayed. The treatment nurse returned to the cart then moved it next to room 11 and went into the room and shut the door out of sight/supervision of the cart. The cart remained unlocked. Several residents were observed to move past the unlocked cart. A family member and a resident were also observed standing and sitting next to the unlocked cart talking and socializing. At 4:05 p.m. the cart was observed to be in the same hall with locking mechanism out and red dot showing indicating it was unlocked. The treatment nurse was not on the hall. On 02/19/2013 at 7:45 to 8:00 a.m. an observation was made of the facility's wound care/treatment cart. The cart was located in the main entrance hall between two of the facility's medication administration carts next the facility's day/activities room. A closer observation of the treatment/wound care cart revealed the carts locking mechanism was in the out position and the red dot visible indicating the cart was unlocked. The carts drawers were easily opened and still contained the prescription medications as noted previously. There were no nurses at the nurse's station and/or close proximity to the cart to be observing or using the cart. There was a female house keeping cleaning staff member in the hall in close proximity to the cart. On 02/20/13 at 10:55 a.m. an observation was	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 26	F 431		

made with the facility's administrator and maintenance worker of the facility's wound care/treatment cart located next to room 12. The wound care/treatment nurse was not near the cart. The wound care and treatment cart was observed to be unlocked and the locking mechanism was in the out position with the red dot displayed. The administrator indicated the treatment cart was supposed to be locked when not in use/attended. The administrator and the maintenance worker indicated they had no knowledge if the locking mechanism was possibly broken or why the cart was left unattended and not locked.

On 02/20/13 at 11:00 a.m. an interview was conducted with the wound care nurse concerning the observations of the wound care/treatment cart being left unattended/unlocked. The wound care nurse Stated, "I just never lock the cart." The nurse indicated she would move the cart in the hall, leave it unattended and unlocked (which included the 3 previous days observations). The wound care nurse indicated and demonstrated the cart would lock. The wound care nurse indicated she knew she was supposed to lock the cart when she left it unattended and/or left it in the hall at night after she left. The nurse also indicated there were prescription medications (ointments, creams, sauves, and dressings) for the facility residents that had wound care treatment orders given by the physician.

An interview was conducted with the DON on 02/20/13 at 11:05 p.m. about her expectations of the treatment cart being left unlocked/unattended. The DON indicated her expectation was that the wound care/treatment cart was supposed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 431	Continued From page 27 locked when left unattended the same as the medication administration carts.	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to maintain 1 of 1 dishwashing machine, 1 of 3 reach-in freezers, and 1 of 3 laundry dryers in safe and sanitary operating conditions. Findings included: 1. During the initial tour of the kitchen on 2/17/13 at 3:30pm, the internal temperature of Reach-in Freezer #1 was +20 degrees Fahrenheit and +8 degrees Fahrenheit in Reach-in Freezer#2. Review of the Refrigerator/Freezer Temperature Log revealed no documentation of temperatures recorded in afternoon or evening on this date. During a kitchen observation on 2/20/13 at 2:40pm, the internal temperature of Reach-in freezer #2 was +22 degrees Fahrenheit. This freezer contained 1-opened box of beef patties which had a temperature of 38 degrees Fahrenheit and the patties were soft, bendable, easy to tear. The freezer also contained 1-bag of resealed chicken patties which had a temperature of +26 degrees Fahrenheit. The DM (Dietary	F 456	Freezer 1 and Freezer 2 has been serviced. All freezers have been operating at the proper temperatures. The dishwasher has been serviced also and has been operating at proper levels. The laundry dryer trap door handle has been repaired and all the dryer handles are in good condition. Once a week for 60 days, the dietary manager will check the freezers and dishwasher to make sure it is at the proper temps. Once a quarter, for 9 months, the administrator will check the dryer trap door handles to make sure they are in good condition. Any negative findings from these checks/audits will be sent to the next quarterly QA meeting for reevaluation.	3-21-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 456	Continued From page 28 Manager) stated the box of beef patties and the bag of chicken patties would be immediately discarded and someone would check the freezer's temperature. During an interview on 2/21/13 at 9:40am, the DM stated that the Refrigerator repairman checked Reach-in freezers' #1 and #2 at 6:45pm on 2/20/13 and concluded that the drain on freezer #2 was clogged, causing the evaporator to freeze up. The repairman corrected the problem and Freezer #2 was currently working. The DM stated that her expectation of freezers' temperatures are 0 degrees Fahrenheit or below. The DM revealed that the refrigerator units were to be checked and recorded by dietary staff at 5:30am and again at night (approximately 8:25pm) before dietary staff closed the kitchen. The DM indicated that on Tuesday, 2/19/13 she noticed that the temperatures in the freezer was slowly rising (+20 degrees Fahrenheit) and called the Refrigeration Repairman who did not come until the evening of 2/20/13. She also informed the Administrator about the problem with the freezer on 2/20/13. 2. During four observations of the operating dishwashing machine in the kitchen on 2/20/13 from 2:28pm to 2:32pm, the water temperatures during the rinse cycle ranged from 155 degrees Fahrenheit to 175 degrees Fahrenheit. Afterwards, dietary staff were observed removing the rinsed dishware from the dishwashing machine and stacking the items on the tray-line service, in the plate warmer, and on the storage shelves, ready for use. During an interview on 2/20/13 at 2:38pm, dietary	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 456	Continued From page 29 staff revealed there was a problem with the dishwashing machine's heater, and a repairman had been notified. Dietary staff also indicated that the staff had been directed to continuously reset the button on the booster until the dishwasher was repaired. During an interview on 2/20/13 at 3:10pm, the DM revealed the reset button on the booster which heats the water in the dishwasher, began continuously cutting off the previous day. The repairman was notified, and until he arrived the staff were instructed to monitor rinse temperature. The DM stated that the water temperature of the dishwashing machine should not fall below 180 degree Fahrenheit, but if it happened the dishes must be rewashed. 3. On 02/20/13 at 10:05 a.m. the facility's laundry was observed with the facility's administrator and the day shift laundry worker. The facility's 3 commercial dryers were observed. The middle dryer's lint trap door handle was observed to be broken and had a pair of vice-grip pliers holding the closing latch and handle onto the door. The day shift laundry worker was interviewed on 02/20/2013 at 10:15 a.m. The laundry worker did not know how long the middle dryer door handle had been broken but said it was at least several weeks. The laundry worker was asked how often the lint traps were cleaned and she indicated it was supposed to be done after every load. The laundry worker demonstrated how she opened and closed the broken lint trap door. It took the laundry worker several attempts to open and close the lint trap door as the vice grip pliers would rub against the door and not fully open	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 456	Continued From page 30 and/or close the door's latching mechanism. An interview was conducted with the administrator on 02/20/2013 at 10:15 a.m. The administrator could not state how long the drier's lint trap door handle and latch mechanism had been broken. On 02/20/13 at 10:30 a.m. interviews were made with the facility's administrator and the facility's maintenance worker. The administrator and maintenance worker were asked to explain the maintenance process when a broken item was identified that needed maintenance repair. The maintenance worker indicated the facility's process required a staff member to fill out a work order (located at the nurse's station) and place the work order in the nurse's station maintenance in box or tell the maintenance worker of the item in need of repair. The maintenance worker indicated he kept the work orders that were not yet completed and the completed work orders were kept by an administrative staff member in a binder. A review of the facility's maintenance work orders was conducted with the administrator and maintenance worker. The administrator and maintenance worker indicated they had no work orders for the broken handle on the middle drier's lint trap door.	F 456		

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

PRINTED: 03/08/2013
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
	345316	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 The facility is a type 111 protected, fully sprinkled except for the closets and there are no locks on the exit doors. 42 CFR 483.70 (a)	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 03/08/2013 the dry sprinkler system did not have a high and low air pressure alarm on the dry side of the system. 42 CFR 483.70 (a)	K 056	Crawford Sprinkler has been contacted about the sprinkler system. They will connect a high and low air pressure alarm on the dry side of the system. Once a quarter, for 9 months, the administrator will check the high and low air pressure alarm on the sprinkler system. .Any negative findings from these checks will be sent to the next quarterly QA meeting for reevaluation.	4-2-13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nonty Davis | TITLE: Administrator | (X6) DATE: 3-22-13

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.

CD

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

PRINTED: 03/08/2013
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
	345316	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 03/08/2013 the tamper alarm on the wet system failed to alarm when the valve was closed. 42 CFR 483.70 (a)	K 062	Crawford Sprinkler has been contacted about the tamper alarm on the wet system. They will replace the tamper alarm so that when the valve is closed the alarm will sound. Once a month, for 9 months, the administrator will check the tamper switch to ensure the alarm sounds when the valve is closed. Any negative findings from these checks will be sent to the next quarterly QA meeting for reevaluation.	4-2-13