STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING _____ B. WING _____	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

(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 There were no deficiencies cited as a result of the Recertification survey of 01/12/12.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

(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 029 SS=E	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 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) The storage room across from room 113 and clean linen room corridor door located near the nurse station did not have positive latching. 42 CFR 483.70(a)	K 029	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K-029 (Bldg 1)** • **On 2/7/2012 the storage room across from #113 and the clean linen room door on 100-hall were repaired by adjusting the strike plates to ensure positive latching and smoke tight requirements are met.** • **The Maintenance Director and Assistant were in-serviced on smoke tight door requirements on 2/13/2012 by the Administrator.** • **An audit for positive, smoke tight latching will be completed monthly by the Maintenance Director or his designee.** • **The Executive QI Committee will review the Audit Tools monthly for continued compliance.**	3/16/12

RECEIVED
FEB 17 2012
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Raymond J. Tadlock	Administrator	2/16/2012

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING 02 - BUILDING 02 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

(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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) The corridor door to room 503 did not close, latch and seal. 2) The corridor door to shower room on 500 hall did not close smoke tight. 42 CFR 483.70(a)	K 018	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K-018** • **On 1/31/2012 the door latch to room #503 was replaced to ensure positive latching and seal.** • **On 2/8/2012 the shower room door frame on 400-hall was repaired to ensure positive latching and smoke tight requirements will be met NLT 3/2/2012. Fire rated stripping to be used to finish smoke tight requirements was special ordered on 2/10/12 and will be installed not later than 3/16/2012.** • **The Maintenance Director and Assistant were in-serviced on smoke tight door requirements on 2/15/2012 by the Administrator.** • **An audit for positive, smoke tight latching will be completed monthly by the Maintenance Director or his designee.** • **The Executive QI Committee will review the Audit Tools monthly for continued compliance.**	3/16/12
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald J. Faulkner | TITLE: Administrator | (X6) DATE: 2/16/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING 02 - BUILDING 02 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

(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 021	Continued From page 1 hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1)The stairwell door on 400 hall did not positive positive latching when the mag locks were disconnected. 42 CFR 483.70(a)	K 021	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3/16/12 **K-021** • **On 2/1/2012 the door latch to for the 400-hall stairwell was replaced to ensure positive latching and seal.** • **The Maintenance Director and Assistant were inservcied on positive latching and smoke tight door requirements on 2/15/12 by the Administrator.** • **An audit for positive, smoke tight latching will be completed monthly by the Maintenance Director or his designee.** • **The Executive QI Committee will review rthe Audit Tools monthly for continued compliance.**	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K-025** • **On 2/1/2012 the four doors in the smoke walls for the attic area were completely repaired to ensure smoke tight:**	

RJFadden

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING 02 - BUILDING 02 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

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K 025	Continued From page 2 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) The smoke walls in the attic area has door the separate compartment that did not close smoke tight and the sprinkler pipe that penetrated the smoke wall were not sealed in order to maintain the required rating of the wall. 2) The smoke wall located in the Cherry Hill Dinning and Rec room has holes and or penetrations that were not sealed in order to maintain the required rating of the wall. 42 CFR 483.70(a)	K 025	**o Each door latch was replaced with a new door handle.** **o Door frames, closure devises and hinges adjusted.** **o Doors and floors repaired to ensure no rubbing.** **o All door checked to ensure smoke tight achieved.** **• All attic area and Cherry Hill Dining and Rec Room smoke wall penetrations were sealed with Fire Barrier Sealant CP25WB in order to maintain the required rating of the wall.** **• The Maintenance Director and Assistant were in-servcied on positive latching, smoke tight door requirements and smoke wall penetrations on 2/15/12 by the Administrator.** **• An audit for positive, smoke tight latching will be completed monthly by the Maintenance Director or his designee.** **• The Executive QI Committee will review the Audit Tools monthly for continued compliance.**	3/16/12
K 029 SS=E	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 029	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K-029** **• On 2/1/2012, the self closing device for room #901 door (temporary storage) was installed and tested to ensure it self-closed to include positive latching.**	

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	345334	A. BUILDING 02 - BUILDING 02 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) The resident room used for temporary storage on 900 hall across form the nurse station was not equipped with a self closing device. 2) The soiled linen door located next to the exit to loading bay did not close smoke tight. 42 CFR 483.70(a)	K 029	• **The housekeeping closet door frame at the exit to the loading bay was adjusted and repaired on 2/7/2012 ensuring it now meets the requirements for a smoke tight seal when self-closing.** • **The Maintenance Director and Assistant were in-serviced on positive latching, smoke tight door and self-closing requirements on 2/15/2012 by the Administrator.** • **An audit for positive, smoke tight latching will be completed monthly by the Maintenance Director or his designee.** • **The Executive QI Committee will review the Audit Tools monthly for continued compliance.**	
K 038 SS=E	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 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) At the exit to the rear laundry service entrance there was not a sidewalk and/or hard surface continuing to the public way. 42 CFR 483.70(a)	K 038	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K-038** **On 2/9/2012, a new sidewalk addition was completed that connected the rear laundry service entrance with the "public way" that meets the "sidewalk and/or hard surface" requirement.**	3/16/12
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345334	A. BUILDING 02 - BUILDING 02 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF CHAPEL HILL	1716 LEGION ROAD CHAPEL HILL, NC 27517

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K 076	Continued From page 4 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted: 1) Two oxygen cylinders were found stored unsecured in the resident bathroom at on 400 hall near the nurse station. 42 CFR 483.70(a)	K 076	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3/16/12 **K-076** • **On 1/31/2012, the unsecured oxygen cylinders found on the 400-hall were immediately and properly secured in the storage racks for empties. A sweep audit of the building confirmed that there were no unsecured cylinders.** • **Staff was in-servcied on proper requirements for full and empty oxygen cylinders by February 17, 2012 by the Administrator and Director of Nursing.** • **An audit for proper oxygen storage will be completed weekly by the Maintenance Director or his designee.** • **The Executive QI Committee will review the Audit Tools monthly for continued compliance.**	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on January 31, 2012 between 9:30 and 3:30 PM the following was noted:	K 144		

R J Fiddler