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

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345507	B. Wil	 √G		06/1	3/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MYRTLE GROVE				57	EET ADDRESS, CITY, STATE, ZIP CODE 725 CAROLINA BEACH ROAD /ILMINGTON, NC 28408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	the Medicare/Medic Regulations 42 CFI	und to be in compliance with caid Long Term Care R Part 483, Sub part B during d compaint investigation	F				
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES		COPR	FORM APPROVE OMB NO. 0938-039	D	
CENTERS FOR MEDICARE & MEDICAID SERVICES			OCO MULTIPLE CONSTRUCTION		(X8) DATE SURVEY COMPLETED		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED	ĺ		
		345607	B. WING		06/26/2012	╝	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF WYRTLE	GROVE		5726 CAROLINA BEACH ROAD WILMINGTON, NC 28408			
(X4) ID PREFIX TAG	SUMMARY STA	(TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE	JULIA PE I OVER EGISON	ų	
1/40				Preparation and submission of t	his plan of	\neg	
K 000	INITIAL COMMEN	rs	₭ 00	correction does not constitute at admission or agreement by the	n facility of of the		
	conducted as per T at 42 CFR 483.70(a Health Care section	ode (LSC) survey was 'he Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced building is Type V construction,		correctness of the conclusion st statement of deficiencies. This correction is prepared and submit because of requirements under federal law. I am signing the document is	ated on the plan of nitted solely state and		
	Arrangements. The automatic sprinkler	e facility is equipped with an second		signify I have received this docu that the plan of correction being on this document is accurate. A signature does not indicate the	ment and submitted fy facility has		
K 062 SS≃E	1	AFETY CODE STANDARD		accepted the allegations contain 2567 or the deficiencies in whice alleged deficiencies were cited.	ned in this		
	continuously maint condition and are in periodically. 19.7	c sprinkler systems are ained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA					
	25, 9.7.5	•	K 06	Corrective Action to Correct De Practice: 1. The cited valve on the accele the dry pipe sprinkler system with the dry pipe sprinkler system.	erator for		
	Based on the obset during the tour on the required accelerate sprinkler system, that is essential to valve is not current.	is not met as evidenced by: ervations and staff interview 6/26/2012 the facility has a or installed on its dry pipe This accelerator has a valve the sprinkler system. This liy electrically supervised to against it being accidently		to be electrically supervised to paystem against it being acciden off. This will be corrected no lat 08/10/2012.	orotect the tly tumed		
	CFR#: 42 CFR 48	3.70 (a)	المراجع والمقطعة والمراجعة والمراجعة				
			1		(%) DATE		
	L.L.	DER/BORPLIER REPRESENTATIVE'S SIG		Adams to Arman to provide the provided from correcting pro	7 17 17	_	
Any deficiency statement ending with an extensic (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that any deficiency statement ending with an extensic (*) denotes a deficiency which the institution may be excused from correcting providing the determined above are disclosed as 0 days other entequards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosed and 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 disclosed any following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued							
brogram bar	ticipation.				notionation sheet Page 1	<u>~~~</u> 01.1	

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

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FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH	AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES
	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

345507

B. WING

06/26/2012

NAME OF PROVIDER OR SUPPLIER

AUTUMN CARE OF MYRTLE GROVE

STREET ADDRESS, CITY, STATE, ZIP CODE 6726 CAROLINA BEACH ROAD OBLOD OU MANDELINA MAN

02 - BUILDING 2

Adjoing out of wilking glood			WILMINGTON, NC 28408			
(XA) 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)	COMPLETION DATE		
K 000	INITIAL COMMENTS	K 000				
	This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483,70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V construction, and is utilizing North Carolina Special Locking Arrangements. The facility is equipped with an automatic sprinkler system.					
K 047 SS=D	CFR# 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	An exit directional sign leading from the rehab department to the egress corridor will be installed no later than 08/10/2012.			
	This STANDARD is not met as evidenced by: Based on the observations and staff Interview during the tour on 6/26/2012 the exit directional signage leading from the rehab department to the the egress corridor was incomplete as there was no directional sign leading to the egress corridor. CFR#: 42 CFR 483.70 (a)					

LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(X6) DATE

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