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

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER (X2) MAINTHLE CONSTRUCTION A BUILDING (X2) MAINTHLE CONSTRUCTION (A BUILDING A BUILDING A BUILDING (X3) MAINTHLE CONSTRUCTION (A BUILDING A BUILDING A BUILDING A BUILDING (X3) MAINTHLE CONSTRUCTION (A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING ABOVE THE APPROPRIATE (X4) DEPOSIT OF THE APPROPRIATE (X4)	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				CIVIL IVO.	
NAME OF PROVIDER OR SUPPLIER GRANTSBROOK NURSING AND REHABILITATION CENTER (A) ID SUMMARY STATEMENT OF DEPTOFFIQUES (EACH OPERCITY MAYS BE PRICEDED BY THAT TAG FROM INSTITUL (EACH OPERCITY MAYS BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUL (EACH OPERCITY MAY BE PRICEDED BY THAT TAG FOR INSTITUTE MAY BE PRICEDED BY THAT THE PROPRIATE MAY BE PROPERTIED. FOR INSTITUTE M	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1.			COMPLE	TED
RANTSBROOK NURSING AND REHABILITATION CENTER REGULATORY OR USE IDENTIFYING INFORMATION (MICHAEL) FOR CHARLES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TARK) TAKE FOOD INITIAL COMMENTS The facility was found to be in compliance with the Medicard/Medicaid Long Term Care regulations, 42 CFF part 493, subpart B during the recertification survey of (DATE of exit) The recentification survey of (DATE of exit)			345292	B. WI	√G		09/19	9/2012
SUMMARY STATEMENT OF DEFICIENCIES PROPERTY REPROPERTY REPROPER			ND REHABII ITATION CENTER		29	90 KEEL RD		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS The facility was found to be in compliance with the Medicare/Medicald Long Term Care regulations, 42 CFR part 483, subpart 8 during the recertification survey of (DATE of exit) F 000 INITIAL COMMENTS The facility was found to be in compliance with the Medicare/Medicald Long Term Care regulations, 42 CFR part 483, subpart 8 during the recertification survey of (DATE of exit)	GRANIS	BROOK NOROING A		T	l G		TION.	(VE)
The facility was found to be in compliance with the Medicare/Medicaid Long Term Care regulations, 42 CFR part 483, subpart B during the recertification survey of (DATE of exit)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
the Medicare/Medicaid Long Term Care regulations, 42 CFR part 493, subpart B during the recertification survey of (DATE of exit)	F 000	INITIAL COMMEN	TS	F	000			
AND THE COURSE OF BROWNEDISHDELIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		the Medicare/Med	icaid Long Term Care R part 483, subpart B during					
TITLE (X6) DATE								
TITLE (X6) DATE								
TITLE (X6) DATE								
LEGALTERS OF PROVIDER/SHIPPHER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
ARGENTON'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
LEGALICADY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
LIBERATORIS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
LIBORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
		DV DIDECTORIO OR PRO	MINEDISLIPPI JER REPRESENTATIVE'S SI	IGNATUR	Ē.	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.

PENTER	S FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		DIE CONSTRUCTION GET WE CAN DATE S	. 0938-039	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	COMPL	ETED		
		345292	B. WING	10/0	9/2012	
ME OF P	ROVIDER OR SUPPLIER	.	STR	EET ADDRESS GNEST OF TRONSPECTION		
RANTS	BROOK NURSING A	ND REHABILITATION CENTER		RANTSBORO, NC 28529		
(X4) ID PREFIX TAG	ALVOIT DECICIENT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC DATE	
	Surveyor: 27871 This Life Safety Coconducted as per at 42 CFR 483.70 Care section of the publications. This one story, with a cosystem. Facility is system. The deficiencies of are as follows: NFPA 101 LIFE Solor openings in 20-minute fire pro 1%-inch thick soliprotective plates from the bottom of thorizontal sliding	Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V-construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC-specical locking system. The deficiencies determined during the survey		Grantsbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the Summary of Findings is factually correct in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as a written allegation of compliance. Grantsbrook Nursing and Rehabilitation Center's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any stated deficiencies is accurate. Grantsbrook Nursing and Rehabilitation Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings.		
	accordance with "	ving with egress and positive	K027	Cross corridor door (left side) at 400 hall has been repaired to open properly. Other cross corridor doors have been inspected and repairs made as necessary to ensure proper opening. Maintenance will monitor weekly x3 months to insure continued compliance.	11-12-12	
	Surveyor: 27871 Based on observ approximately 11 items were nonc-	is not met as evidenced by: rations and staff interview at rat			(X6) DAT	
	not required to sy latching is not red 19.3.7.7 This STANDARD Surveyor: 27871 Based on observ approximately 11 items were noncinclude: cross co of 400 hall would	ving with egress and positive quired. 19.3.7.5, 19.3.7.6, is not met as evidenced by: rations and staff interview at 1:30 am onward, the following ompliant, specific findings urridor door (left side) coming out	K027	has been repaired to open properly. Other cross corridor doors have been inspected and repairs made as necessary to ensure proper opening. Maintenance will monitor weekly x3 months to insure continued		

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.

Facility ID: 923031

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	RS FOR MEDICARE	& MEDICAID SERVICES					0830-038
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE LDING	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	URVEY ETED
		345292	B. WIN	IG		10/0	9/2012
	ROVIDER OR SUPPLIER BROOK NURSING A	ND REHABILITATION CENTER		290 F	r address, city, state, zip code Keel Rd NTSBORO, NC 28529	: 	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 027	42 CFR 483.70(a)	ge 1 FETY CODE STANDARD		027	-		
SS=E	Exit access is arrar	nged so that exits are readily less in accordance with section					
	Surveyor: 27871 Based on observat approximately 11:3 items were noncon include: doors to the	is not met as evidenced by: ions and staff interview at 0 am onward, the following appliant, specific findings e employee bathroom(service and one of the content of the co	K0:	(s rc ha th th	xit handles to employees service hallway) and door in doom (kitchen) have been replandles that do not require two rehand to open. Similar doors to building have been insperandles replaced as necessary. Marill monitor for continued compli	ry storage aced with motions of hroughout ected and aintenance	11-12-12
K 056	1	AFETY CODE STANDARD	K	056			refere de servicio es servicios e
SS≓E	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		KO	bj n ir	prinkler heads on 400 half cor y paint have been repaired or r ecessary. Other sprinkler heads ispected and repaired/repl ecessary. Maintenance will nonthly for continued complianc	eplaced as have been aced as monitor	11-12-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION O 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		345292	B. WING _		10/09	/2012
	ROVIDER OR SUPPLIER BROOK NURSING A	ND REHABILITATION CENTER	25	EET ADDRESS, CITY, STATE, ZIP CODE 90 KEEL RD RANTSBORO, NC 28529		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 056	Continued From pa	ige 2	K 056			
	Surveyor: 27871 Based on observat approximately 11:3 items were noncon	is not met as evidenced by: ions and staff interview at 0 am onward, the following appliant, specific findings for heads on 400 hall(near a paint on orifice.		·		
K 067 SS=E		AFETY CODE STANDARD	K 067	Construction and the grown 218 community	-cuisad	
	with the provisions in accordance with	, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K067	Smoke damper in room 218 comply excessive paint has been repareplaced. Other dampers through building have been repaired/replancessary. Maintenance will monthly for continued compliance.	nired or out the aced as	11-12-12
	Surveyor: 27871 Based on observal approximately 11:3 items were noncor	is not met as evidenced by: ions and staff interview at 80 am onward, the following npliant, specific findings e damper in room 218 has on damper.				
K 147	42 CFR 483.70(a) NFPA 101 LIFE SA	AFETY CODE STANDARD	K 147			
SS=E	Electrical wiring an with NFPA 70, Na	d equipment is in accordance tional Electrical Code. 9.1.2				
	This STANDARD	is not met as evidenced by:				et Page 3 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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				PLE CONSTRUCTION 16 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345292	B, WING_		10/09/2012	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 190 KEEL RD GRANTSBORO, NC 28529	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 147	Continued From page 3 Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: open junctions boxes in attic(access from men's bathroom front lobby). Also exposed wiring at HVAC unit(same area).		K 147 Copen junction boxes in attic closed to comply with cod wiring at HVAC unit (all bathroom front lobby) has be Other junction boxes and HVA have been inspected and necessary. Maintenance will monthly for continued compliant		Exposed ve mens covered. caccesses paired as monitor	11-12-12
	42 CFR 483.70(a)					
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		TO THE STOREST				
		The second secon				- describers - de - describers
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