STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

(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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff and resident interviews, the facility failed to investigate a grievance regarding nursing care for 1 of 2 sampled residents (resident #88). Findings included: A policy titled; "Investigating Grievances/Complaints" was reviewed on 9/11/12. Policy Interpretation and Implementation read; 1) The administrator has assigned the responsibility of investigating grievances and complaints to appropriate department head. 2) Upon receiving a grievance and complaint report, the appropriate department head will begin an investigation into the allegations. 3) The "Resident Grievance/Complaint Investigation Report Form" must be filed with the administrator within seven (7) working days of the incident. 4) The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten (10) working days of the filing of the grievance or complaint. Resident #88 was admitted to the facility 11/29/11. The quarterly minimum data set assessment dated 7/26/12 revealed resident #88	F 166	DISCLAIMER Century Care of Laurinburg acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by (facility name). The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. ALLEGATION OF COMPLIANCE The plan of correction is submitted as written allegation of compliance. F166 1. a) 1:1 thorough interview with resident (#88) and facility Social Worker took place on 9/12/12. b) Resident (#88) grievance was completed on 9/11/12 with additional follow-up needed: 1) inquires into alternate placement per resident request in which the facility Social Worker is assisting resident with, 2)re-inservicing staff was conducted by facility DON on 9/13/12 regarding caring for residents with difficult	9/12/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Dickerson, NHA — TITLE: Administrator — (X6) DATE: 10/3/12

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
	345383	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

(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 166	Continued From page 1 did not have any cognitively impairment or behaviors coded. During an interview with resident #88 on 9/11/12 at 8:56 AM the resident stated there was a concern with nursing care several weeks ago. Resident #88 could not recall a specific date and could not recall who the concern was report to. Resident #88 stated no one had followed up on the concern. The grievance log was reviewed on 9/11/12 from March 2012 through September 2012. Resident #88 filed a grievance on 8/23/12. Review of the grievance revealed resident #88 reported concerns with nursing care on 8/23/12 to the Admissions Coordinator. The investigation information on the back of the grievance form revealed the Director of Nursing signed and dated the form on 9/11/12. The information provided on the investigation did not include an interview with resident #88 or that findings were reported to the resident. On 9/11/12 at 5:25 PM the Director of Nursing indicated she received the grievance on 8/23/12 when the Admissions Coordinator filed it. She stated she had not interviewed resident #88 or investigated the grievance prior to 9/11/12. The Admissions Coordinator was interviewed 9/11/12 at 5:30 PM and indicated resident #88 came to her office on 8/23/12 and filed the grievance. She said she wrote the grievance on the form and placed it in the Director of Nursing's facility mailbox on 8/23/12. On 9/11/12 at 5:35 PM the Administrator	F 166	behaviors, resident rights, and how to treat resident's in their home (see attachment A), and 3)24 hour report was faxed on 9/11/12 and 5 working day investigation faxed on 9/14/12 of allegation of abuse was sent to the State Agency. 2. a) All grievances will be given to the facility Social Worker, or appropriate designee (e.g. Admissions Coordinator, Administrator) for logging into Grievance Log (see attachment B). b) The facility Social Worker, or appropriate designee will bring the grievance to morning stand-up for administrative staff review and discussion before being given to the appropriate Department Manager, or appropriate Department designee in the absence of the Department Manager for follow-up. c) The grievance review progress will be discussed and addressed at each morning stand-up meeting for the next 7 working days or sooner if follow-up has been completed. This discussion will include grievance status, including resident interviews and staff interviews related to grievance. This discussion will be noted in	9/14/12 10/11/12 ongoing 10/11/12 ongoing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

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F 166	Continued From page 2 indicated it was the responsibility of each department head to investigate grievances. She said she expected the resident to be interviewed as part of the grievance investigation and she expected the investigation to be completed within ten business days.	F 166	the minutes from the morning stand-up meeting (see attachment C). d) The results of the grievance investigation and resolution will be given to the resident and resident representative within 10 working days from the day of the alleged grievance.	10/11/12 & ongoing
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	3. a) All grievances will be given to the facility Social Worker, or appropriate designee(e.g. Admissions Coordinator, Administrator) for logging into Grievance Log (see attachment B). b) The facility Social Worker, or appropriate designee will bring the grievance to morning stand-up for administrative staff review and discussion before being given to the appropriate Department Manager, or appropriate Department designee in the absence of the Department Manager for follow-up. c) The Department Manager will up-date the administrative team during morning meeting on the follow-up progress. d) The grievance review progress will be discussed and addressed at each morning	10/11/12 & ongoing 10/11/12 & ongoing 10/11/12 & ongoing 10/11/12 & ongoing

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F 225	Continued From page 3 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of abuse within 24 hours to the Health Care Personnel Registry for 2 of 2 sampled residents (Resident #15, Resident #27). Findings included: 1. Resident #15 was admitted into the facility on 5/28/11. The quarterly minimum data set completed on 6/25/12 indicated Resident #15 was cognitively intact. A review of a written statement completed by Nurse #4 dated 8/17/12 revealed the Director of Nursing (DON) was notified by Nurse #4 that Resident #15 reported that NA #3 (Nursing Assistant) was rough with her and when Resident #15 indicated to NA #3 that she was hurting her, NA #3 replied, "No, I'm not hurting you." A review of the 24 hour initial report revealed a completed abuse allegation which read in part "Resident #15 claims NA #3 handled her rough when care was rendered on 8/16/12." The 24 hour report was documented as faxed to the health care personnel registry (HCPR) on 8/20/12.	F 225	stand-up meeting for the next 7 working days or sooner if follow-up has been completed. This discussion will include grievance status, including resident interviews and staff interviews related to the grievance. This discussion will be noted in the minutes from the morning stand-up meeting (see attachment C). e) The results of the grievance investigation and resolution will be given to the resident and resident representative within 10 working days from the day of the alleged grievance. f) The final discussion will be held in the morning stand-up meeting the next workday following the delivery of the resolution. Discussion will be to ascertain if the resolution was acceptable to the person initiating the grievance. If the resolution was not acceptable to the resident or resident representative, other interventions/resolutions will be discussed and these changes communicated to the resident or resident representative by the Department Manager or appropriate designee. g) Inservice was conducted on 9/12/12 by facility	10/11/12 & ongoing 10/11/12 & ongoing 10/11/12 & ongoing

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F 225	Continued From page 4 In an interview on 9/11/12 at 3:45 pm, the DON indicated she became aware of Resident #15 allegation against NA #3 on 8/17/12. The DON added, she thought since it was nearing the weekend, she could wait until Monday 8/20/12, to report the allegation to the state agency. In an interview on 9/11/12 at 4:02 pm, the Administrator stated she expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation. 2. Resident #27 was admitted into the facility on 2/27/12. The quarterly minimum data set completed on 8/1/12 indicated Resident #27 was cognitively intact. A review of a written statement completed by Nurse #4 dated 8/17/12 revealed the Director of Nursing (DON) was notified by Nurse #4 that Resident #27 reported that NA #3 (Nursing Assistant) was rough when she repositioned her which caused her leg to hit the side of the bed table. A review of the 24 hour initial report revealed a completed abuse allegation which read in part "Resident #27 claims NA #3 was rough in rendering care to her on 8/16/12. She hurt me." The 24 hour report was documented as faxed to the HCPR on 8/20/12. In an interview on 9/11/12 at 3:45 pm, the DON indicated she became aware of Resident #27's allegation against NA #3 on 8/17/12. The DON added, she thought since it was nearing the	F 225	Administrator with all Departmental Managers discussing new grievance procedure and ensuring completion of grievance form is done appropriately including resident and staff interviews and follow-up. See attachment D. 4. a) Step One: In morning stand-up meeting compliance with plan will be reviewed 5 times weekly for 4 weeks, Step Two: followed by weekly times 4 weeks, Step Three: followed by monthly times 4 months during facility QA meetings, Step Four: followed by quarterly times 2 quarters during facility quarterly QA and as needed. b) Non-compliance with the plan of action during any of these reviews will be discussed by the QA Committee with root cause analysis performed, modifications to the plan as needed, followed by re-inservicing of staff as appropriate. c) Any modifications to the plan will result in the monitoring of compliance to begin at Step 1 again. d) All discussions and revisions will be included in	9/12/12 10/11/12 & ongoing 10/11/12 & ongoing 10/11/12 & ongoing

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F 225	Continued From page 5 weekend, she could wait until Monday 8/20/12, to report the allegation to the state agency. In an interview on 9/11/12 at 4:02 pm, the Administrator stated she expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation.	F 225	the facility QA meeting minutes. F225 1. a) Report was faxed to State Agency on 8/20/12, incident reported to DON on 8/17/12. b) Full investigation and appropriate action was initiated following report of incident. Appropriate action was taken regarding incident and completed 5 day report was faxed to State Agency within the allotted timeframe (8/24/12).	8/20/12 8/24/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their policy for submitting report of an allegation of abuse to the Health Care Personnel Registry within 24 hours for 2 of 2 sampled residents (Resident #15, Resident #27). Findings included: A review of the facility's policy for reporting abuse dated June 2005 read in part, "Should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the administrator, or his/her designee, will promptly notify: The state licensing/certification agency responsible for surveying/licensing the facility. Verbal/written notices to agencies will be made within 24 hours of the occurrence of such incident	F 226	2. a) Re-inservice with all licensed nursing staff, including the DON, and departmental managers regarding the reporting of allegations to State Agency within required time-frame: within 24 hours of knowledge of the allegation and a completed investigative report within 5 days of knowledge of the allegation. See attachment E. 3. a) Facility DON was given a key to have access to the two fax machines that are able to fax long distance to State Agency as needed. b) All other administrative staff who do not have access to the offices with the fax	10/11/12 9/12/12

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F 226	Continued From page 6 and such notices may be submitted via special carrier, fax, e-mail, or by telephone." 1. Resident #15 was admitted into the facility on 5/28/11. The quarterly minimum data set completed on 6/25/12 indicated Resident #1 was cognitively intact. A review of the 24 hour initial report revealed a completed abuse allegation which read in part "Resident #15 claims NA #3 handled her rough when care was rendered on 8/16/12." The 24 hour report was documented as faxed to the health care personnel registry (HCPR) on 8/20/12. In an interview on 9/11/12 at 3:45 pm, the DON indicated she became aware of Resident #15 allegation against NA #3 on 8/17/12. The DON added, she thought since it was nearing the weekend, she could wait until Monday 8/20/12, to report the allegation to the state agency. In an interview on 9/11/12 at 4:02 pm, the Administrator stated she expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation. 2. Resident #27 was admitted into the facility on 2/27/12. The quarterly minimum data set completed on 8/1/12 indicated Resident #27 was cognitively intact. A review of the 24 hour initial report revealed a completed abuse allegation which read in part "Resident #27 claims NA #3 was rough in rendering care to her on 8/16/12. She hurt me."	F 226	machine will notify one of the following administrative staff of the need to fax a report to the State Agency: Administrator, Social Worker, Admissions Coordinator, Payroll Manager, Business Office, DON and Maintenance Director have access to these offices. 4. a) Each allegation of abuse will be reviewed by Administrator, Social Worker, or appropriate designee in their absence, will be reviewed for timely reporting. b) Results of reviews will be included in minutes of monthly QA meetings times 3 months, quarterly times 3 and as needed. Any non-compliance with plan will be assessed through root cause analysis and subsequent modifications of plan made with appropriate staff re-inserviced. F226 1. a) Report was faxed to State Agency on 8/20/12, incident reported to DON on 8/17/12. b) Full investigation and appropriate action was initiated following report of incident. Appropriate action was taken regarding incident and completed 5 day report was	10/11/12 & ongoing 10/11/12 & ongoing 10/11/12 & ongoing 8/20/12

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F 226	Continued From page 7 The 24 hour report was documented as faxed to the HCPR on 8/20/12. In an interview on 9/11/12 at 3:45 pm, the DON indicated she became aware of Resident #27's allegation against NA #3 on 8/17/12. The DON added, she thought since it was nearing the weekend, she could wait until Monday 8/20/12; to report the allegation to the state agency. In an interview on 9/11/12 at 4:02 pm, the Administrator stated she expected the allegation to have been reported to the state agency within 24 hrs when the facility became aware of the alleged allegation.	F 226	faxed to State Agency within the allotted timeframe (8/24/12). 2. a) Re-inservice with all licensed nursing staff, including the DON, and departmental managers regarding the reporting of allegations to State Agency within required time-frame: within 24 hours of knowledge of the allegation and a completed investigative report within 5 days of knowledge of the allegation. See attachment E. 3. a) Facility DON was given a key to have access to the two fax machines that are able to fax long distance to State Agency as needed. b) All other administrative staff who do not have access to the offices with the fax machine will notify one of the following administrative staff of the need to fax a report to the State Agency: Administrator, Social Worker, Admissions Coordinator, Payroll Manager, Business Office, DON and Maintenance Director have access to these offices. 4. a) Each allegation of abuse will be reviewed by	8/24/12 10/11/12 9/12/12 10/11/12 & ongoing

Administrator, Social Worker, or appropriate designee in their absence, will be reviewed for timely reporting. b) Results of reviews will be included in minutes of monthly QA meetings times 3 months, quarterly times 3 and as needed. Any non-compliance with plan will be assessed through root cause analysis and subsequent modifications of plan made with appropriate staff re-inserviced.	10/11/12 & ongoing 10/11/12 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V unprotected construction, is utilizing North Carolina Special locking arrangements and is partially equipped with an automatic sprinkler system and is full detected with smoke and/or heat detection throughout the facility. CFR#: 42 CFR 483.70 (a)	K 000	1. a) The master door release door device was lowered to ensure it is below 48 inches above the finished floor. This was corrected at the front nurses' station (rose hall) and the back nurses' station (peach hall). This was completed by electrical contractor on 10/30/12. See attachment A and attachment B. b) The service (therapy) hall required exit egress to the public way with a non slick solid surface other than grass or soil was corrected on 10/31/12. Crush and run gravel was placed in this area to ensure exit egress was available to the parking lot. See attachment c.	10/30/12 10/31/12
K 038 SS=D	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 the observations and staff interviews on 10/17/2012 the following Life Safety Item was observed as noncompliant, specific findings include: A. The master door release device at each regularly manned station were above 48 inches above the finished floor. B. The therapy hallway required exit egress was not complete to the public way with a non slick solid surface other than grass or soil. CFR#: 42 CFR 483.70 (a)	K 038	2. a) Facility maintenance director accessed other areas for possible deficient master door release manned stations above 48 inches above finished floor. No other areas of deficiencies were identified. b) Facility maintenance director accessed other areas for possible deficient exit egress to the public way. No other areas of deficiencies were identified. 3. Facility maintenance director or designee will monitor areas for necessary maintenance as needed, i.e. grass and/or weeds in crush and run gravel, to ensure surface remains solid. 4. The Safety Committee will review any possibility for deficiency. The Safety Committee Chairperson, or designee, will present their findings at the QA Committee meeting for additional information as needed. This will be documented in the QA meeting minutes.	10/30/12 10/31/12 11/24/12 and ongoing 11/24/12 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret A. Dickerson | TITLE: Administrator | (X6) DATE: 11/2/12

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

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	345383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2012

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K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD Is not met as evidenced by: Based on the observations and staff interviews on 10/17/2012 the following Life Safety item was observed as noncompliant, specific findings include: The Fire Alarm Control Panel was in an unresolved trouble condition during the survey. CFR#: 42 CFR 483.70 (a)	K 052	**Tag K 052** 1. Fire alarm control panel (FACP) has been inspected and the trouble condition has been resolved. This was completed by BFPE on 10/31/12. See attachment d. 2. Both panels (rose hall and peach hall) Fire Alarm Control Panels (FACP) inspected by BFPE on 10/31/12 and both panels working properly with trouble cleared. 3. During all routine fire drills, facility maintenance director or designee will monitor fire alarm control panel to ensure there is no trouble on the panel. Documentation will be maintained by the maintenance director, or designee, regarding these audits. See attachment e. 4. The Safety Committee will review these audits on a monthly basis for 3 months, then quarterly for three quarters, then annually and as needed. The Safety Committee Chairperson, or designee, will present their findings at the QA Committee meeting.	10/31/12 10/31/12 11/24/12 and ongoing 11/24/12 and ongoing
K 144 SS=E	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.	K 144	**Tag K 144** 1. Facility maintenance director inspected and repaired facility generator on 10/24/12. It required a new temperature sensor which was replaced on 10/24/12 which resulted in generator functioning properly. 2.Facility maintenance director or designee will complete "Weekly Generator Check" to ensures generator cranks and transfers	10/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

(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 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 10/17/2012 the following Life Safety generator item was observed as noncompliant, specific findings include: The emergency power system did not transfer power back to the life safety circuit within the required 10 seconds. CFR#: 42 CFR 483.70 (a)	K 144	within 10 seconds or less of test (see attachment f). 3. The maintenance director, or designee, will audit generator to ensure it cranks and transfers within 10 seconds of test on a weekly basis x 3 weeks, monthly x 3 months, quarterly x 3 quarters, and as needed thereafter. Documentation will be maintained by the maintenance director, or designee, regarding these audits. 4.The Safety Committee will review these audits on a monthly basis for 3 months, then quarterly for three quarters, then annually and as needed. The Safety Committee Chairperson, or designee, will present their findings at the QA Committee meeting	11/24/12 and ongoing 11/24/12 and ongoing 11/24/12 and ongoing

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

PRINTED: 10/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING 02 - BUILDING 02 NOV 06 2012 B. WING	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY CARE OF LAURINBURG	8900 HASTY ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V unprotected construction, is utilizing North Carolina Special locking arrangements and is partially equipped with an automatic sprinkler system and is full detected with smoke and/or heat detection throughout the facility. CFR#: 42 CFR 483.70 (a)	K 000	**This plan of correction is submitted by the facility as written credible allegation of compliance.** **Tag K 046** 1. On 10/26/12, the small dining room on the renovated hallway was repaired and currently has a unitary light on the emergency circuit so that the area is light in darkness in a power outage.	10/26/12
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 10/17/2012 the following Life Safety illumination item was observed as noncompliant, specific findings include: The small dining room on the renovated hallway did not have a unitary light on the emergency circuit and as a result would leave that area in darkness in a power outage. CFR#: 42 CFR 483.70 (a)	K 046	2. Facility maintenance director accessed other areas for possible deficient unitary lighting. Other areas that were identified as needing to be corrected included the therapy gym. This lighting was also corrected to ensure the area is light in darkness in a power outage. 3. Facility maintenance director accessed other areas for possible deficient unitary lighting. Other areas that were identified as needing to be corrected included the therapy gym. This lighting was also corrected to ensure the area is light in darkness in a power outage 4. The Safety Committee will continue to review any possibility for deficiency. The Safety Committee Chairperson, or designee, will present their findings at the QA Committee meeting for additional information as needed. This will be documented in the QA meeting minutes. **Tag K 038**	10/26/12 10/26/12 11/24/12 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret K. Dickerson | TITLE: Administrator | (X6) DATE: 11/2/12

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.