PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345383	B. WING_		09/	12/2012
NAME OF PE	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP COI	DE	
CENTURY	CARE OF LAURINBURG	3		8900 HASTY ROAD LAURINBURG, NC 28352		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 166 SS≃D	RESOLVE GRIEVAN A resident has the rig facility to resolve griev	O PROMPT EFFORTS TO CES ht to prompt efforts by the vances the resident may with respect to the behavior	F 166	acknowledges receipt of of Deficiency and propos correction to the extent summary of findings is fand in order to maintain with applicable rules and of quality care to resider	the Statement es the plan of that the actually correct compliance the provision tts.	
	by: Based on facility recorresident interviews, the a grievance regarding sampled residents (re	·		The below response to to Deficiency and plan of not denote agreement to by (facility name). The the right to submit do refute the stated definiformal appeals productive other administrative proceedings.	correction does with the citation facility reserves cumentation to ciency through	
	read; 1) The administresponsibility of investomplaints to appropriate departments appropriate departments appropriate departments appropriate departments and the appropriate departments and	ts" was reviewed on retation and Implementation rator has assigned the tigating grievances and rate department head. 2) vance and complaint report, thent head will begin an allegations. 3) The Complaint Investigation		ALLEGATION OF CO The plan of correction as written allegation of F166 1. a) 1:1 thorough resident (#88) a Social Worker 9/12/12.	is submitted f compliance. interview with nd facility took place on	a 12 12
	within seven (7) working the resident, or person resident, will be informinvestigation, as well a recommended, within the filling of the grieva Resident #88 was addruze/11/29/11. The quarter	mitted to the facility ly minimum data set		additional follo 1) inquires into placement per r in which the fac Worker is assis	on 9/1 1/12 with w-up needed: alternate esident request cility Social ting resident vicing staff was acility DON on	
		26/12 revealed resident #88		residents with o		(X6) DATE

Any deficienty 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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	PLE CONSTRUC	TION	(X3) DATE SU COMPLET	
		345383	B. WING_			09/1	2/2012
	COVIDER OR SUPPLIER	3		REET ADDRESS, 8900 HASTY RC LAURINBURG		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 166	at 8:56 AM the reside concern with nursing Resident #88 could not could not recall who the Resident #88 stated in the concern. The grievance log was March 2012 through \$488 filed a grievance grievance revealed reconcerns with nursing Admissions Coordinatinformation on the base revealed the Director the form on 9/11/12. The investigation did in resident #88 or that filt resident. On 9/11/12 at 5:25 Phindicated she received when the Admissions stated she had not intrinvestigated the grieval The Admissions Coorg/11/12 at 5:30 PM arcame to her office on grievance. She said si	ith resident #88 on 9/11/12 int stated there was a care several weeks ago. of recall a specific date and the concern was report to. to one had followed up on serviewed on 9/11/12 from September 2012. Resident on 8/23/12. Review of the sident #88 reported to care on 8/23/12 to the tor. The investigation ock of the grievance form of Nursing signed and dated The information provided on ot include an interview with addings were reported to the If the Director of Nursing of the grievance on 8/23/12 Coordinator filed it. She the erviewed resident #88 or ance prior to 9/11/12. Idinator was interviewed of indicated resident #88 8/23/12 and filed the the wrote the grievance on in the Director of Nursing's 3/12.	F 160	2.	behaviors, resident righow to treat resident's home (see attachment 3)24 hour report was find 1/12 and 5 working investigation faxed on of allegation of abuse to the State Agency. a) All grievances will to the facility Social Wor appropriate designed Admissions Coordinate Administrator) for logg Grievance Log (see att B). b) The facility Social Wor appropriate designed bring the grievance to stand-up for administrates taff review and discuss before being given to the appropriate Department Manager, or appropriate Department designee in absence of the Department Manager for follow-up c) The grievance review progress will be discussed addressed at each morn stand-up meeting for the working days or sooner follow-up has been control of the prievance status, including resident interviews and interviews related to grievance status, including the prievance status and the prievance status and the prievance status and t	in their A), and axed on g day 9/14/12 was sent be given Vorker, e (e.g. or, ging into achment Worker, e will morning ative ssion he at te n the nent v sed and ing e next 7 if npleted. clude ling staff ievance.	9/14/12 10/11/12 40ngaing
ORM CMS-256	7(02-99) Previous Versions Obse	plete Event ID: WU6S1	1 F	acility ID: 953087	This discussion will be	noted in sh	eet Page 2 of 8

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUC	CTION	(X3) DATE SU COMPLE	
		345383	B. WING				1212040
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	[U9/	12/2012
CENTURY	CARE OF LAURINBURG	3		8900 HASTY RO	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC' ACH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 166	said she expected the as part of the grievand		F1	66	the minutes from the m stand-up meeting (see attachment C). d) The results of the gr investigation and resolvable according to the resolvable	ievance	10/11/12 4 orngoing
F 225 SS=D	ten business days. 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPO ALLEGATIONS/INDIV)(2) - (4) RT	F 2	25	will be given to the res and resident representa within 10 working day, the day of the alleged grievance.	tive	10/11/12 4 ongoing
	been found guilty of a mistreating residents I had a finding entered registry concerning ab of residents or misapp and report any knowle court of law against ar indicate unfitness for sother facility staff to thor licensing authorities. The facility must ensurinvolving mistreatment including injuries of unitarity and the mistreatment including injuries of an instruction.	by a court of law; or have into the State nurse aide cuse, neglect, mistreatment ropriation of their property; dge it has of actions by a memployee, which would service as a nurse aide or e State nurse aide registry is.		3.	a) All grievances will be to the facility Social Wappropriate designee(e Admissions Coordinate Administrator) for logg Grievance Log (see att B). b) The facility Social Wor appropriate designed bring the grievance to a stand-up for administrate staff review and discuss before being given to the proportions.	Vorker, or e.g. or, ging into achment Worker, e. will morning ative sion he	10/11/12 \$ ongoing
	immediately to the adr to other officials in acc through established pr State survey and certii The facility must have violations are thorough prevent further potenti investigation is in prog	ninistrator of the facility and ordance with State law ocedures (including to the fication agency). evidence that all alleged ally investigated, and must all abuse while the ress.			appropriate Department Manager, or appropriate Department designee in absence of the Department Manager for follow-up c) The Department Mawill up-date the admin team during morning ron the follow-up progress will be discuss	n the nent nager istrative neeting ress.	10/11/12 4 ongoing 10/11/12 4 ongoing
ORM CMS-2567	(02-99) Previous Versions Obso	lete Event ID: WU6S1	1 .	Facility ID: 953087	addressed at each morn	ning hal	eel Page 3 of 8

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		DISTRUCTION	(X3) DATE SU COMPLET	
		345383	B. WIN	3		09/1	2/2012
	ROVIDER OR SUPPLIER CARE OF LAURINBURG	9		8900 H	ADDRESS, CITY, STATE, ZIP CODE IASTY ROAD INBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICLENCY)	D BE PRIATE	(X5) COMPLETION DATE
F 225	with State law (includicertification agency) vincident, and if the alleappropriate corrective. This REQUIREMENT by: Based on record revifacility failed to report within 24 hours to the Registry for 2 of 2 sar #15, Resident #27). Findings included: 1. Resident #15 was a 5/28/11. The quarterly	other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified action must be taken. is not met as evidenced ew and staff interviews, the an allegation of abuse Health Care Personnel inpled residents (Resident edmitted into the facility on minimum data set	F	225	stand-up meeting for the working days or soone follow-up has been controlled the grievance status, inclures ident interviews and interviews related to the grievance. This discuss will be noted in the mifrom the morning standering (see attachmes) and results of the grievance will be given to the result and resident representation within 10 working day the day of the alleged grievance. f) The final discussion held in the morning states.	or if mpleted. clude ding d staff ne ession nutes d-up nt C). rievance lution sident ative s from	10/11/12 \$ ongoing 10/11/12 \$ ongoing
	was cognitively intact. A review of a written is Nurse #4 dated 8/17/7 Nursing (DON) was not Resident #15 reported Assistant) was rough #15 indicated to NA #1 NA #3 replied, "No, i'n A review of the 24 hot completed abuse alleg "Resident #15 claims when care was render	statement completed by 12 revealed the Director of 13 revealed the Director of 14 that NA #3 (Nursing 15 with her and when Resident 16 that she was hurting her, 17 not hurting you." 17 initial report revealed a 17 gation which read in part 18 NA #3 handled her rough 18 red on 8/16/12." The 24 19 nented as faxed to the			meeting the next work following the delivery resolution. Discussion to ascertain if the resolution was acceptable to the pinitiating the grievance resolution was not acceptable to the resident or resident or resident representative, other interventions/resolution be discussed and these communicated to the ror resident representate the Department Managappropriate designee. g) Inservice was conducted.	day of the of the of will be lution person e. If the eptable ent or will changes esident ive by ger or	10/11/12 d sugaing

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCT	TION	(X3) DATE SU	
			A. BUILD	NG	1000004-1		
		345383	B, WING			09/1	12/2012
	ROVIDER OR SUPPLIER CARE OF LAURINBURG	3	s	TREET ADDRESS, 8900 HASTY ROA LAURINBURG,			
(X4) ID PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTI EH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 225	In an interview on 9/1 indicated she became allegation against NA added, she thought si weekend, she could wreport the allegation to the interview on 9/1 Administrator stated sto have been reported 24 hrs when the facilitialleged allegation. 2. Resident #27 was a 2/27/12. The quarterly completed on 8/1/12 i cognitively intact. A review of a written so Nurse #4 dated 8/17/10 Nursing (DON) was not Resident #27 reported Assistant) was rought.	1/12 at 3:45 pm, the DON aware of Resident #15 #3 on 8/17/12. The DON nce it was nearing the vait until Monday 8/20/12, to be the state agency. 1/12 at 4:02 pm, the he expected the allegation I to the state agency within by became aware of the admitted into the facility on minimum data set ndicated Resident #27 was statement completed by 12 revealed the Director of biffied by Nurse #4 that	F 22		Administrator with all Departmental Manage discussing new grieva procedure and ensurin completion of grievan is done appropriately resident and staff inter and follow-up. See att D. a) Step One: In mornistand-up meeting com with plan will be reviet times weekly for 4 we Two: followed by weetimes 4 weeks, Step T followed by monthly months during facility meetings, Step Four: I by quarterly times 2 q during facility quarter and as needed. b) Non-compliance w plan of action during at these reviews will be	rs nce g ce form including views achment ing pliance ewed 5 eks, Step ekly hree: times 4 QA followed uarters ly QA ith the any of discussed	9/12/12 10/11/12 4 ongoing
	table. A review of the 24 hou completed abuse alleg "Resident #27 claims rendering care to her of the 24 hour report was the HCPR on 8/20/12. In an interview on 9/12 indicated she became	ur initial report revealed a pation which read in part NA #3 was rough in on 8/16/12. She hurt me." is documented as faxed to 1/12 at 3:45 pm, the DON aware of Resident #27's #3 on 8/17/12. The DON			by the QA Committee root cause analysis per modifications to the proceeded, followed by rinservicing of staff as appropriate. c) Any modifications plan will result in the monitoring of complibegin at Step 1 again. d) All discussions and revisions will be inches.	rformed, lan as e- to the	10/11/12 4 ongoing 10/11/12 4 ongoing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ΄ ΄		LE CONSTRUCTION		(X3) DATE SU COMPLET	
			A. BUI	.DING	· · · · · · · · · · · · · · · · · · ·			.25
		345383	B. WIN	G			09/1	2/2012
	COVIDER OR SUPPLIER	3		89	EET ADDRESS, CITY, STATE, 2 00 HASTY ROAD AURINBURG, NC 28352	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIV CROSS-REFERENCEI DEFI	D TO THE APPRO CIENCY)	LD BE PRIATE	(X5) COMPLETION DATE
F 225	weekend, she could vereport the allegation to an interview on 9/1 Administrator stated sto have been reported 24 hrs when the facility	vait until Monday 8/20/12, to o the state agency.	F	225	minutes. F225 1. a) Report Agency of reported b) Full in appropria	ty QA meeting twas faxed to the state of the	o State neident 1/17/12. and s initiated	8/20/12
	policies and procedure	TC POLICIES lop and implement written es that prohibit , and abuse of residents	F	226	Appropri regarding complete faxed to S	g report of inc ate action was g incident and d 5 day repor State Agency ed timeframe	as taken d rt was within	8 24 12
	by: Based on record revieus facility failed to implement submitting report of ar	n allegation of abuse to the el Registry within 24 hours	Advisor of the control of the contro		licensed including departme regarding allegation within rewithin 24 of the allegation within 5 complete within 5 complete	service with a nursing staff, the DON, and the reporting the reporting to State Aguired time-factors of known and a dinvestigative days of known tion. See att	nd rs g of gency frame: owledge t ve report	10 11 12_
	dated June 2005 read suspected violation or mistreatment, neglect administrator, or his/hi- notify: The state licens responsible for survey Verbal/written notices	's policy for reporting abuse in part, "Should a substantiated incident of or abuse be reported, the er designee, will promptly sing/certification agency ing/licensing the facility. to agencies will be made occurrence of such incident		May distribute the second seco	3. a) Facility key to hat fax mach fax long of Agency at b) All otherstaff who	y DON was a ve access to a lines that are distance to Star acceded. The acceptance administration of the second acceptance acceptance as with the face of the second acceptance	the two able to tate ative access to	a/12/12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRU	CTION	(X3) DATE SU COMPLET	
		345383	B, WING			09/1	2/2012
	ROVIDER OR SUPPLIER Y CARE OF LAURINBURG	3		STREET ADDRESS 8900 HASTY R LAURINBURG			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 226	and such notices may carrier, fax, e-mail, or 1. Resident #15 was a 5/28/11. The quarterly completed on 6/25/12 cognitively intact. A review of the 24 hor completed abuse alleg "Resident #15 claims when care was rende hour report was document health care personnel 8/20/12. In an interview on 9/1 indicated she became allegation against NA added, she thought si weekend, she could weekend to have been reported 24 hrs when the facility alleged allegation. 2. Resident #27 was a 2/27/12. The quarterly completed on 8/1/12 in cognitively intact. A review of the 24 hor completed abuse alleg "Resident #27 claims"	be submitted via special by telephone." admitted into the facility on a minimum data set indicated Resident #1 was a pation which read in part NA #3 handled her rough red on 8/16/12." The 24 mented as faxed to the registry (HCPR) on 1/12 at 3:45 pm, the DON aware of Resident #15 #3 on 8/17/12. The DON note it was nearing the vait until Monday 8/20/12, to be the state agency. 1/12 at 4:02 pm, the he expected the allegation to the state agency within y became aware of the admitted into the facility on minimum data set agation which read in part	F 2		machine will notify one following administrativ of the need to fax a report the State Agency: Administrator, Social W. Admissions Coordinato Payroll Manager, Busin Office, DON and Maint Director have access to offices. a) Each allegation of abwill be reviewed by Administrator, Social W. or appropriate designee absence, will be reviewe timely reporting. b) Results of reviews w. included in minutes of a QA meetings times 3 m. quarterly times 3 and as needed. Any non-comp. with plan will be assess through root cause analy and subsequent modific of plan made with approstaff re-inserviced. a) Report was faxed to Agency on 8/20/12, increported to DON on 8/1 b) Full investigation and appropriate action was following report of inci-Appropriate action was regarding incident and completed 5 day report	e staff ort to Vorker, or, eess tenance these Vorker, in their ed for ill be monthly onths, oliance ed ysis eations opriate State ident 7/12. d initiated dent. taken	10/11/12 to ongoing 10/11/12 to ongoing 10/11/12 to ongoing 8/20/12

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		LE CONSTRUCTIO	N	(X3) DATE SURVEY COMPLETED	
		345383	B. WIN	G			0014	12/2012
	ROVIDER OR SUPPLIER	}	•	89	EET ADDRESS, CI 100 HASTY ROAD AURINBURG, N		09/1	1212012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPERTIES OF THE APPROPE	D BE PRIATE	(X5) COMPLETION DATE
F 226	In an interview on 9/12 indicated she became allegation against NA added, she thought six weekend, she could wreport the allegation to In an interview on 9/12 Administrator stated sto have been reported.	1/12 at 3:45 pm, the DON aware of Resident #27's #3 on 8/17/12. The DON noce it was nearing the rait until Monday 8/20/12; to the state agency.	L.	226	2. 3.	faxed to State Agency the allotted timefram (8/24/12). a) Re-inservice with licensed nursing staff including the DON, a departmental manage regarding the reporting allegations to State A within required timewithin 24 hours of known that allegation and completed investigation within 5 days of known the allegation. See at E. a) Facility DON was key to have access to fax machines that are fax long distance to SA Agency as needed. b) All other administration of the need to fax a rethe State Agency: Administrator, Social Admissions Coordina Payroll Manager, Bus Office, DON and Ma Director have access offices. a) Each allegation of will be reviewed by	all f, and ers ing of agency frame: nowledge a ive report wledge of ttachment given a the two able to State rative e access to ax one of the tive staff eport to I Worker, ator, siness intenance to these	8 24 12 9 12 12 4 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 noncompliance 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 # onging

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STATEMENT AND PLAN C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED					
,		SEATH SOMING HOMBER	A, BU	ILDIN	IG 01 - MAIN BUILDING 01	COMPL	.e.reu		
		345383	B. Wil	NG_	,	10/-	18/2012		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE				
CENTUR	Y CARE OF LAURINE	BURG		8900 HASTY ROAD					
				L	AURINBURG, NC 28352				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	PROVIDER'S PLAN OF CORRECT PREFIX TAG (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE		
K 038 SS=D	conducted as per T at 42 CFR 483.70(a Health Care section publications. This faconstruction, is utilizated to the publication of the construction	de (LSC) survey was he Code of Federal Register); using the 2000 Existing of the LSC and its referenced cility is Type V unprotected ting North Carolina Special ts and is partially equipped orinkler system and is full e and/or heat detection by. 70 (a) FETY CODE STANDARD ged so that exits are readily es in accordance with section not met as evidenced by: vations and staff interviews of silowing Life Safety item was appliant, specific findings release device at each ation were above 48 inches por. //ay required exit egress was public way with a non slick tan grass or soil.	KO	38	1. a) The master door door device was lowered to ensure below 48 inches above the finished. This was corrected at the front nur station (rose hall) and the back nur station (peach hall). This was come electrical contractor on 10/30/12. attachment A and attachment B. b) The service (ther required exit egress to the public won slick solid surface other than gooil was corrected on 10/31/12. Crun gravel was placed in this area the exit egress was available to the par See attachment c. 2. a) Facility maintent director accessed other areas for pedeficient master door release mann stations above 48 inches above finifloor. No other areas of deficiencic identified. b) Facility maintent director accessed other areas for pedeficient exit egress to the public wother areas of deficiencies were ided. 3. Facility maintenance direct designee will monitor areas for necessing maintenance as needed, i.e. grass at weeds in crush and run gravel, to ensurface remains solid. 4. The Safety Committee will any possibility for deficiency. The Committee Chairperson, or designed present their findings at the QA Commeting for additional information and needed. This will be documented in the surface remains solid.	it is al floor. ses' ses' spleted by See sapy) hall ray with a grass or sush and o ensure king lot. shed shed ses were sapeled shed shed ses were sapeled shed shed shed shed shed shed shed sh	10/30/12 10/31/12 10/31/12 11/24/12 and ongoiver		
	CFR#: 42 CFR 483.	```			meeting minutes.	411	and		
/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	B //	R/SUPPLIER REPRESENTATIVE'S SIGN/	TURE		TITLE		(X6) DATE		
	wigorut X.	Dicters of School which			Administrator		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.

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

Event ID: WU6S21

Facility ID: 953087

If continuation sheet Page 1 of 3

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		345383	B. WIN			10/-	18/2012
	PROVIDER OR SUPPLIER RY CARE OF LAURINE	BURG	-	89	EET ADDRESS, CITY, STATE, ZIP CODE 900 HASTY ROAD AURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 052 SS=E	A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has	FETY CODE STANDARD required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance n complying with applicable PA 70 and 72. 9.6.1.4	Κo		1. Fire alarm control panel (Final Republic Control Panel (Final Republic Control Panel Control Panel Control Panel (Final Republic Control Panel Control Pa	condition leted by t d. peach ACP) d both	10/31/12
K 144 SS=E	Based on the obser on 10/17/2012 the for observed as noncon include: The Fire Al unresolved trouble of CFR#: 42 CFR 483 NFPA 101 LIFE SAF	ETY CODE STANDARD ected weekly and exercised nutes per month in	K 14	44	3. During all routine fire drill facility maintenance director or des will monitor fire alarm control pane ensure there is no trouble on the part Documentation will be maintained maintenance director, or designee, at these audits. See attachment e. 4. The Safety Committee will these audits on a monthly basis for months, then quarterly for three quatten annually and as needed. The Scommittee Chairperson, or designe present their findings at the QA Commetting. Tag K 144 1. Facility maintenance director in and repaired facility generator on 1st required a new temperature sensor was replaced on 10/24/12 which resignerator functioning properly. 2. Facility maintenance director or civil complete "Weekly Generator Censures generator cranks and transfer.	ignee el to nel. by the regarding Il review 3 arters, Safety se, will mmittee spected 0/24/12. or which sulted in lesignee Check" to	11/24/12 and ovigoing 11/24/12 and ovigoing

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

Event ID:WU6S21

Facility ID: 953087

If continuation sheet Page 2 of 3



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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE		
		345383	B. WII	NG		10/	18/2012	
	PROVIDER OR SUPPLIER RY CARE OF LAURINE	BURG		89	EET ADDRESS, CITY, STATE, ZIP CODE 00 HASTY ROAD AURINBURG, NC 28352			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
K 144	Based on the obse on 10/17/2012 the fi item was observed findings include; Th	s not met as evidenced by: rvations and staff interviews ollowing Life Safety generator as noncompliant, specific be emergency power system er back to the life safety uired 10 seconds.	Kı		within 10 seconds or less of test (attachment f). 3. The maintenance director, or owill audit generator to ensure it contains the condition of test weekly basis x 3 weeks, monthly months, quarterly x 3 quarters, an needed thereafter. Documentation maintained by the maintenance didesignee, regarding these audits. 4. The Safety Committee will reviaudits on a monthly basis for 3 m quarterly for three quarters, then a and as needed. The Safety Comm Chairperson, or designee, will prefindings at the QA Committee me	lesignee, ranks and t on a x 3 d as n will be rector, or ew these onths, then annually littee sent their	11/24/12 and ong vine 11/24/12 and ongoing 11/24/12 and ongoing	







DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 - BUILDING 02 NOV 0 6 20 2 A. BUILDING B. WING 345383 10/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8900 HASTY ROAD **CENTURY CARE OF LAURINBURG** LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX PREFIX. (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 This plan of correction is submitted by the facility as written credible allegation of compliance. 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 Tag K 046 Health Care section of the LSC and its referenced publications. This facility is Type V unprotected 1. On 10/26/12, the small dining room on the renovated hallway was repaired and construction, is utilizing North Carolina Special locking arrangements and is partially equipped currently has a unitary light on the with an automatic sprinkler system and is full emergency circuit so that the area is light in 10/24/12 detected with smoke and/or heat detection darkness in a power outage. throughout the facility. 2. Facility maintenance director accessed CFR#: 42 CFR 483.70 (a) other areas for possible deficient unitary K 046 NFPA 101 LIFE SAFETY CODE STANDARD K 046 lighting. Other areas that were identified as needing to be corrected included the therapy SS=D Emergency lighting of at least 1½ hour duration is gym. This lighting was also corrected to ensure the area is light in darkness in a provided in accordance with 7.9. 19.2.9.1. 10/20/12 power outage. 3. Facility maintenance director accessed This STANDARD is not met as evidenced by: other areas for possible deficient unitary Based on the observations and staff interviews lighting. Other areas that were identified as on 10/17/2012 the following Life Safety needing to be corrected included the therapy illumination item was observed as noncompliant, gym. This lighting was also corrected to specific findings include: The small dining room ensure the area is light in darkness in a 10/26/12 on the renovated hallway did not have a unitary power outage light on the emergency circuit and as a result would leave that area in darkness in a power 4. The Safety Committee will continue to outage. review any possibility for deficiency. The Safety Committee Chairperson, or designee, CFR#: 42 CFR 483.70 (a) will present their findings at the QA Committee meeting for additional information as needed. This will be documented in the QA meeting minutes. ongolng Tag K 038 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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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Event ID: WU6S21

Facility ID: 953087

If continuation sheet Page 1 of 1