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

PRINTED: 11/30/2012 FORM APPROVED OMB NO. 0938-0391

		WAY DOON TO DESCRIBE THE PARTY OF THE	(X3) MULTIPLE	CONSTRUCTION OCCUPA	(X3) DATE SUR	VEY			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION TO TO THE TOTAL TO THE TOTAL TOTAL TO THE TOTAL TO THE TOTAL TOTA	COMPLETED				
		345278	B. WNG		11/14	/2012			
	ROVIDER OR SUPPLIER		830	STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET MOUNT AIRY, NC 27030					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE			
F 164 SS=B	The resident has the confidentiality of his or records. Personal privacy included medical treatment, we communications, per meetings of family and does not require the room for each residential except as provided in the confidential except as th	right to personal privacy and or her personal and clinical udes accommodations, ritten and telephone sonal care, visits, and nd resident groups, but this facility to provide a private	F 164	Plan of correction for def 483.10(e) Personal Privacy/Confide Records Corrective action for the found to have been affect deficient practice: The nurse caring residents # 2, 3,4 and 30 was infor immediately of the	entiality of se residents ted by the for ,5,25,26, med he deficient				
	release of personal a individual outside the Individual outside the The resident's right the and clinical records of resident is transferre institution; or record. The facility must kee contained in the residual the form or storage of release is required behalthcare institution contract; or the residual thickness of the residual	and clinical records to any a facility. or refuse release of personal does not apply when the dease is required by law. p confidential all information dent's records, regardless of methods, except when y transfer to another to another to another the dent. This not met as evidenced ons, record review, facility views, the facility failed to medication administration ecured for 7 of 13 residents		practice. Remededucation and comprovided to the magnetic records, including of the medication administration readministering particular medications. Corrective action for the having potential to be affected the same deficient practice. Education provides the follomolicies; Confidence Confidentiality of Records	unseling y of patient g securing tecord while tient se residents fected by ce: ded for all wing entiality and	12/6/12			
LABORATORY	 DIRECTOR'S OR PROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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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Facility ID: 953376

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	A. BUILDING					
		345278	B. WING_	, 		11/14	/2012		
NAME OF PROVIDER OR SUPPLIER NORTHERN SURRY SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 830 ROCKFORD STREET						
		ATTENDED OF DESIGNATION	1 15	THOOM!	AIRY, NC 27030	ON	OVE)		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
F 164	Continued From page	3 1	F 16	34	Measures put into place to that the deficient practice		12/6/12		
	Findings included:				occur: Education and rev	view of the			
	, , , , , , , , , , , , , , , , , , ,	- Day			process to secure	i			
		y Policy entitled "Patient hardcopy of the medical			records during me				
		c medical records) Storage			administration by				
	and Security section:				records and locking				
		dical record shall be housed			medication cart.				
	in a physically secure loss, defacement, tan	area and protected against			Confidentiality of	Medical			
		y an unauthorized person(s).			Records included mandatory annual				
	on 11/14/12 from 9:40	of medication administration O AM to 2:07 PM the nurse			education.				
		on cart, unlocked the cart		į	Monitoring of performance	e to make	Ongoing		
	The state of the s	cations for the residents. cart and entered each			sure the solutions are sust				
		ving the unattended cart with			Monitoring of the	POC will			
		open and unsecured for			be accomplished l	у			
	privacy.				observation of two	0			
	Residents:				medication passes				
	1	# 5 9:40AM and 1:51PM			for one month by				
	Room 329 Resident	# 26 9:58AM			coordinator. The				
	Room 327 Resident				coordinator will re				
	Room 324 Resident Room 344 Resident				findings to the Di				
	Room 321 Resident				in turn will report				
	Room 332 Resident				committee during				
		Nurse on 11/14/12 at 5:00			quarterly meeting	•			
		dent's medical record or ation Record (MAR) should					٠		
	be kept closed when	• •							
		hould be kept away from							
	anyone who is not sta	aff. She further stated that							
	she forgot to close th	e book during the							
	medication passes.				And the second second				
	1				A STATE OF THE STA				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345278		B. WING			11/14/2012		
	OVIDER OR SUPPLIER			8	REET ADDRESS, CITY, STATE, ZIP CODE 130 ROCKFORD STREET MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 164	PM stated it was here should be closed who	DON on 11/14/12 at 5:10 expectation that the MAR en it is not being used or a room giving medications or	F	164			

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1 /5		AND HUMAN SERVICES			OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NOTICE.	A. BUILDING			
		345278	B. WING		12/04	/2012
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
NORTHE	RN SURRY SNF		1 -	IOUNT AIRY, NC 27030		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	īS .	К 000			
.	conducted as per T at 42CFR 483.70(a Care section of the publications. This b	ode(LSC) survey was the Code of Federal Register); using the Existing Health LSC and its referenced oullding is Type I fire resistent ry, with a complete automatic				
K 029 SS=D	are as follows: NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protec	construction (with % hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 029	Plan of Correction for K A 45 minute rated door w installed to replace the 20 rated door located at the e room near the elevator. A door closer will be insta the 45 minute rated door the electrical room near th elevators. All fire doors on electrica were assessed by manage maintenance for 45 minute	rill be minute blectrical alled on located at he	1/17/13
	Based on observa approximately 9:30 noted: 1) The electrical ro did not have sprink comply with to mee	is not met as evidenced by: tion on Tuesday 12/4/12 at AM onward the following was com located near the elevators fer coverage or constructed to the one hour fire resistance ements with a 45 minute self		or sprinkler coverage. All fire doors have been a the preventative maintena program list. All fire doors will be asse annually by maintenance	ance essed	Ongoing Ongoing

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an acterisk (*) 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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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING B. WING 12/04/2012 345278 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 830 ROCKFORD STREET NORTHERN SURRY SNF MOUNT AIRY, NC 27030 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY) K 029 | Continued From page 1 K 029 42 CFR 483.70(a) K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 Plan of Correction for K038 SS=E Installation of concrete sidewalk 1/17/13 Exit access is arranged so that exits are readily accessible at all times in accordance with section and retaining wall leading from stairwell #5 exit stairs to the public 19.2.1 7.1. parking area. All exit pathways monitored daily Ongoing by security staff to assure means of This STANDARD is not met as evidenced by: egress. Based on observation on Tuesday 12/4/12 at approximately 9:30 AM onward the following was noted: 1) The exit access were observed as noncompliant: specific findings include exit access was not a solid path (easily maintained in inclement weather) to a public way (exit from stairwell #5 exit stairs) 42 CFR 483.70(a) Plan of Correction for K067 K 067 NFPA 101 LIFE SAFETY CODE STANDARD K 067 Access door installed in room 352 12/18/12 SS=D to provide access to the smoke duct Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed detector in the exhaust system. in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A. 12/18/12 Access to all smoke detectors on 19.5.2.2 and surrounding the unit has been assessed by the maintenance manager. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/4/12 at approximately 9:30 AM onward the following was noted:

FORM CMS-2567(02-99) Previous Versions Obsolete The first of the second of the

Event ID: SM7H21

Facility ID: 953376 If continuation sheet Page 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BUI B. Wil	LDING	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
NAME OF E	PROVIDER OR SUPPLIER	345278	1	,	EET ADDRESS, CITY, STATE, ZIP CODE		4/2012
	RN SURRY SNF			83	OUNT AIRY, NC 27030		
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			HOULD BE	(X6) COMPLETION DATE
K 067	An access door smoke duct detector	was not provided for the or located in the HVAC unit attent room 352 in order to	K)67			
K 072 SS=E	Means of egress ar of all obstructions o use in the case of fi furnishings, decorat	FETY CODE STANDARD e continuously maintained free r impediments to full instant re or other emergency. No ions, or other objects obstruct ress from, or visibility of exits.	K)72	Plan of Correction for Replaced the closer on the charting table located at Wall charting tables are on a semi-annual prevent maintenance program.	the wall room 324.	12/18/12 Ongoing
S SECTION AND ASSESSMENT OF THE SECTION ASSE	Based on observat approximately 9:30 noted:	s not met as evidenced by: lon on Tuesday 12/4/12 at AM onward the following was			Nursing staff educated to maintenance of any dela faulty closers of wall chables. Installed door closer on	ayed or arting janitor	Ongoing
mpanerosamenta de acesar que procede acesar acesar que procede acesar acesar acesar acesar acesar acesar acesar	room 324 did not retract and when left down would block the corridor greater than 7.5 inches. 2) The janitor closet located on the corridor opened into the corridor less than 180 degrees as there were handralls installed. With this condition the doors must have a device installed to bring the door back to the closed and latched position after being opened.			closet door located on the Maintenance manager a unit doors for proper clomeans of egress hallway	ssessed all	12/18/12	
	CFR#: 42 CFR 483	.70 (a)					
					in Name (Name) an ann an An Anna (Name)		

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