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

PRINTED: 02/15/2013 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345156	B. WIN	G	-	02/07/2013		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	'	312	T ADDRESS, CITY, STATE, ZIP CODE WARREN AVENUE STON, NC 28502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	The facility was for the Medicare/Medic regulations, 42 CFI	und to be in compliance with caid Long Term Care R part 483, subpart B during survey of 02/07/2013.	FO	000				
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

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

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	ACNIT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391
CENTERS	S FOR MEDICARE	& MEDICAID OF VAIOR	Tives L	ים די ה	e construction	(X3) DAYE SU	IRVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		01 - MAIN BUILDING 01		
		345156	B. WIN			02/20/2013	
NAME OF PR	OVIDER OR SUPPLIER	AND REHABILITATION CENTER	<u>,</u>	312	ET ADDRESS, CITY, STATE, ZIP CODE 2 WARREN AVENUE NSTON, NC 28502		1 (76)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION DATE
K 000	INITIAL COMMEN	ITS	κ	000			4444
K 012 SS=D	conducted as per at 42 CFR 483,70 Health Care section publications. This construction utilization automatic sprinkle CFR#: 42 CFR 4 NFPA 101 LIFE S			⟨012	Unsealed penetraticeiling was sealed fire caulk. Maint Supervisor will coto monitor to ensucampliance.	enance ntinue	2/28/1.3
	Based on the object on 2/19/2013 the observed as nor include: There was reflected ceiling who removed.	D is not met as evidenced by: servations and staff interviews following Life Safety item was accompliant, specific findings were unsealed penetrations in the ere a detection device was 483.70 (a)	The same of the sa	•	Existing door har	dware	2/22/1
K 01	NFPA 101 LIFE	SAFETY CODE STANDARD		K 018	was removed & rep with hospital gre	de	

required to resist the passage of smoke. There is LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIES REPRESENTATIVE'S SIGNATURE

Doors protecting corridor openings in other than

those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only

required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as

> TITLE ADMINISTRATOR

hardware. Maintenance

to monitor.

Supervisor will continue

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sefeguards 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.

(X6) DATE

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SERABT	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	938-0391
CENTER	S FOR MEDICARE	& WEDICAID SEKVIOLO	lares sa	U MOI D	CONSTRUCTION	MAY DATE SU	RVEY
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUIL		01 - MAIN BUILDING 01		
		345156	B. WIN	-	T ADDRESS, CITY, STATE, ZIP CODE		/2013
NAME OF PI	ROVIDER OR SUPPLIER BY HALL NURSING A	ND REHABILITATION GENTER		312	WARREN AVENUE ISTON, NC 28502		IVE)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	MUULU DE	COMPLETION DATE
K 018	are provided with the door closed. I are permitted.	the closing of the doors. Doors a means suitable for keeping Dutch doors meeting 19.3.6.3.8 9.3.6.3	K	018	;		
K 02: SS=1	Based on the ob on 2/19/2013 the observed as non-include: The documit EAST did no on it. CFR#: 42 CFR 4 NFPA 101 LIFE 10 Smoke barriers a least a one half the accordance with terminate at an aprotected by fire panels and steel separate compafloor. Dampers apenetrations of sheating, ventilating ventilating.	is not met as evidenced by: servations and staff interviews following Life Safety item was compliant, specific findings or at the end of the special care t have rated hardware installed 183.70 (a) SAFETY CODE STANDARD are constructed to provide at nour fire resistance rating in 8.3. Smoke barriers may atrium wall. Windows are rated glazing or by wired glass frames. A minimum of two rtments are provided on each are not required in duct smoke barriers in fully ducted ing, and air conditioning systems 5, 19.1.6.3, 19.1.6.4		₹ 025	Unsealed penetrat were sealed with rated sheetrock & caulk. Maintenar Supervisor will m to ensure complis	rire fire ce conitor	2/26/13

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

Event ID: X2XZ21

Facility |D; 923024

If continuation sheet Page 2 of 4



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	OF HEALTH	AND HUMAN SERVICES				OMB NO.	938-0391
DEPARTA	MENT OF HEALTH	& MEDICAID SERVICES			CONSTRUCTION	TIVEL DATE SUF	EVEY
CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
			B, WIN	G		02/20/2013	
		345156	۲	CTRES	T ADDRESS, CITY, STATE, ZIP CODE		1
NAME OF PR	OVIDER OR SUPPLIER			312	WARREN AVENUE		
навмой	Y HALL NURSING A	ND REHABILITATION CENTER		KIN	ISTON, NC 28502	CTION	(X5) COMPLETION
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY		
K 025	Continued From p	age 2	K	025		,	
					ł,		
K 056 SS=C	Based on the observed as noncinclude: The milair handler. This penetrations in the CFR#: 42 CFR ANFPA 101 LIFE: If there is an autinstalled in according the Installation provide complete building. The synaccordance with Inspection, Test Water-Based Fi supervised. This supply for the angle of the supply for the synaccordance with Inspection, Test was a supply for the synapsy for	omatic sprinkler system, it is redance with NFPA 13, Standard on of Sprinkler Systems, to be coverage for all portions of the stem is properly maintained in NFPA 25, Standard for the sing, and Maintenance of the re Protection Systems. It is fully be a reliable, adequate water system. Required sprinkler unipped with water flow and tamper are electrically connected to the		(056	Dietary Supervisor inserviced staff non-blocking of heads in the walk freezer. Dietary will continue to	sprinkle: in Suprvi	
	on 2/19/2013 to	RD is not met as evidenced by: observations and staff interviews ne following Life Safety item was oncompliant, specific findings facility had its sprinkler head in the r blocked by items being stored o	e n				
		Gian ID Y2	1		Facility ID: 923024	If continuation	sheet Page 3 0

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

Event ID: X2XZ21

Facility ID: 923024



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	and the barrers	AND HIMAN SERVICES				OMB NO. (938-0391
DEPARTI		AND HUMAN SERVICES			- AGNICTRICTION	(X3) DATE SUI	RVEY
CENTERS FOR MEDICARE & MEDICAL CENTERS FOR MEDICARE & MEDICAL STATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	E CONSTRUCTION 01 - MAIN BUILDING 01		
AND L DAVE OF		345156	B. WI		ET ADDRESS, CITY, STATE, ZIP CODE	02/20	/2013
NAME OF PI	ROVIDER OR SUPPLIER	TO THE PROPERTY OF THE PROPERT		312	WARREN AVENUE NSTON, NC 28502		
HARMONY HALL NURSING AND REHABILITATION CENTER			1 ID		PROVIDER'S PLAN OF CORRE	CTION HOULD BE	COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	PREI	FIX G	(EACH CORRECTIVE ACTION OF CROSS-REFERENCED YO THE AP DEFICIENCY)	PROPRIATE	
K 056	Continued From p	age 3	K	056			
	the shelving.				-		
	CFR#: 42 CFR 4	83.70 (a)			jn ,		
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FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: X2XZ21

Facility ID: 923024

If continuation sheet Page 4 of 4



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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			MAR 0 7 2013		02/25/ZU13 APPROVED 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		CONSTRUCTION 02 - BUILDING 02	(X3) DATE SI COMPLE	URVEY ETED
	•	345156	B, WIN	G		02/2	0/2013
	ROVIDER OR SUPPLIER	IND REHABILITATION CENTER		312 V	r address, city, state, zip code Warren avenue Ston, NC 28502		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ついしひ はた	COMPLETION DATE
K 000	INITIAL COMMEN	TS	К	000			
	conducted as per at 42 CFR 483.70(Health Care section publications. This construction utilized locking arrangement automatic sprinkle CFR#: 42 CFR 48 NOTE: There were				į,		
					k;	•	
I A P O C A T C I	DIDECTORIS OF POTA	AMERISLIPPI IER REPRESENTATIVES SIC	I BNATURE		TITLE		(XO) 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.