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

MAY 07 2013 accepted in plan

PRINTED: 04/26/2013
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
	345365	A. BUILDING _____ B. WING _____	C 04/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON REHAB AND HEALTHCARE CTR	907 CUNNINGHAM RD KINSTON, NC 28501

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F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to pull a privacy curtain around a resident's bed during a bed bath for 1 of 1 resident (Resident #5).	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Staff Development Coordinator and/or designee has provided in-service training to specific CNA's assigned to resident #5 on providing privacy during care and draping resident during car to prevent exposure. The DNS or designee will provide counseling to CNA #1 to ensure compliance. 2. Corrective action for all residents possibly affected, is as follows: All CNA's have been in-serviced on providing privacy during care of all residents, by the SDC or designee. DNS and/or designees have observed through routine observation proper techniques for providing residents dignity/privacy. DNS and/or designee will continue to make regular scheduled rounds to ensure compliance with resident dignity/privacy of all residents. 3. Staff Development Coordinator and/or designee will provide in-service training during orientation and a needed to ensure proper compliance with resident dignity/privacy during ADL care. DNS and/or designee will monitor for compliance during regular rounds. Staff found to be non-	5/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE

Administrator — May 3, 2013

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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F 164	Continued From page 1 Findings included: Review of the clinical record indicated resident #5 was admitted to the facility on 9/26/2003. Review of a Minimum Data Set (MDS) dated 3/8/2013 revealed resident #5 had moderate impairment for making daily decisions and required physical assistance from one person for bathing. During an observation on 4/17/2013 at 6:00 AM, Nursing Assistant #1 (NA) was providing care to resident #5. The resident was observed in the bed adjacent to the hallway. The NA closed the door to the hallway prior to the care but failed to pull the privacy curtain around the resident's bed prior to and during care. The resident was completely unclothed during care. Midway through the bath, a staff member knocked on the door and opened it and exposed the unclothed resident to the hallway. When asked how this made her feel, the resident smiled and nodded and made no response. In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to pull the privacy curtain around the resident's bed prior to providing care. The NA gave no reason why this was not done. In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated privacy curtains were to be pulled completely around a resident's bed during care.	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* compliant will undergo further counseling and/or in-servicing. 4. The DNS and/or designee will monitor resident/dignity and privacy through observation and resident interview on a daily basis. The data will be reviewed and analyzed with a subsequent plan of action. The Performance Improvement Committee will review the log monthly x 3 months to validate overall compliance.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	Area was cleaned and treated on April 18, 2013. Also a complete building inspection was done.	

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F 253	Continued From page 2 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean mold from the ceiling in 1 of 1 resident's room (resident #72). Findings included: Record review indicated resident #72 was admitted to the facility on 10/21/2012 with cumulative diagnoses which included Alzheimer's dementia. In an observation on 4/15/2013 at 2:00 PM, 2 large areas were noted on the resident's ceiling black with a fuzzy appearance. One area was also surrounded by light brown and bulging. The resident was unable to voice how long the areas had been there. An observation on 4/16/2013 at 10:00 AM revealed no changes in the 2 areas. An observation on 4/17/2013 at 10:00 AM revealed no changes in the 2 areas. An observation on 4/18/2013 at 3:00 PM revealed no changes in the 2 areas. An interview was conducted on 4/18/2013 at 3:55 PM with the Housekeeping Manager (HM). The HM reported every resident's room is checked every day for any areas that need cleaning. The	F 253	All areas in resident's rooms are checked daily by housekeeping manager. Any and all areas found to be not clean or in good repair and corrected immediately. If items requiring replacement or repair are needed, a maintenance request id filled out to follow up with the repair. On a monthly basis, the House Keeping Manager will do complete building inspections of all resident rooms and common areas, and report all areas to maintenance department for repair and document on monthly CQI audit sheet that is presented at the monthly CQI meeting. 5/17/13 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 253	Continued From page 3 HM further indicated the expectation was any issues that could not be addressed by housekeepers should be brought to his attention. The HM was not aware of any issues in the room of resident #72. The interview was continued in the room of resident #72 on 4/18/2013 at 4:00 PM. When the HM observed the 2 areas on the ceiling with a darkened substance, he reported this should have been brought to his attention. The Administrator reported on 4/18/2013 at 4:15 PM, it was the expectation areas with mold should be addressed as soon as possible.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to properly clean the perineal area of a resident for 1 of 1 resident (Resident #5). Findings included: Review of the clinical record indicated resident #5 was admitted to the facility on 9/26/2003. Review of a Minimum Data Set (MDS) dated 3/8/2013 revealed resident #5 had moderate impairment for making daily decisions and	F 312	1.The SDC or designee will in-service CNA assigned to resident #5 on proper peri-care procedures. The CNA identified as having provided the care has been counseled regarding facility procedure for providing peri- care and respecting resident's privacy. The CNA will successfully perform a demonstration of incontinent care according to facility policy. 2. The DNS or designee will assess each resident's personal hygiene with special attention to incontinent care. Staff members identified as not providing appropriate personal hygiene to residents identified through this assessment process, will receive individual in-service by the DNS and/or designee and will be counseled by the DNS. 3. The SDC or designee will in-service the current nursing staff regarding providing proper peri-care. The DNS, SDC and their designees will observe	5/17/13

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F 312	Continued From page 4 required physical assistance from one person for bathing. During an observation on 4/17/2013 at 6:00 AM, Nursing Assistant #1 (NA) provided care to resident #5. The NA washed the resident's perineal area with a clean soapy washcloth. The NA cleaned at the front vaginal area and cleaned from front to back and cleaned the rectal area. The NA then used the soiled washcloth and again washed the front vaginal area with with the soiled washcloth. In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to clean from front to back and should not have used the soiled washcloth to repeat cleaning of the vaginal area. The NA gave no reason why this done. In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated resident's perineal area should be cleaned front to back, and a soiled washcloth should not be used again in the vaginal area.	F 312	the nursing staff performing peri-care. As necessary each employee will be rein-serviced and/or counseled to assure compliance with facility policy. The SDC and/or designee will include peri-care in the orientation of new staff to the nursing department , to include observation of the employee providing peri-care. 4. The DNS or designees will monitor peri-care through direct observation of nursing staff the performing of peri-care and monitor through a Quality Assurance tool to assure compliance with facility policy. The DNS will also review concerns/grievances reports of this nature. This will be done weekly for 1 month, then monthly for the next three months, then quarterly. The Performance Improvement Committee will review QI tool monthly times 3 months to validate overall compliance. *This Plan of Correction is the center's credible allegation of compliance.*	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary condition of one of one fans in the dish room as evidenced by a black, greasy build up on the blades and covering of the fan. Findings included: Observation was made on 4/17/13 at 11:40 AM of the large, round wall fan approximately 6 feet off the ground in the dish room located on the wall above the clean side of the dish machine with a black, greasy build up. An interview was conducted on 4/17/13 at 11:44 AM with the Certified Dietary Manager (CDM) who indicated that the fan had not been cleaned since November 2012 when she reviewed the calendar. An interview with the Director of Maintenance on 4/18/13 at 12:00 PM indicated that the fan should be cleaned when other vents in the kitchen are cleaned. That would be on a 30 day basis.	F 371	1. Individual residents not identified on the HCFA-25667. The Dietary Manager has developed and implemented a cleaning schedule for wall fan located in the dish room. 2. The nature of the deficiency does not directly affect residents. The remaining equipment was inspected by the Dietary Manager and the ED and a cleaning schedule was developed. 3. The Dietary Manager will in-service staff on the cleaning of the fan. Cleaning of kitchen equipment will be included in the orientation of new dietary staff. 4. The Dietary Manager and/or designee will monitor cleanliness of the fan through direct observation of the fan for cleanliness. This will be monitored through a Quality Assurance tool to assure compliance with facility policy. This will be done daily times 1 month, then weekly times 3 months then on a monthly ongoing basis by dietary, and monthly by Maintenance Director. The Performance Improvement Committee will review QA tool monthly x 3 months to validate overall compliance.	5/17/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 441	Continued From page 6 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to properly dispose of a soiled washcloth following perineal care for 1 of 1 resident (resident #5). Findings included: Review of a facility policy dated 4/28/2010 entitled	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. SDC and/or designee has provided in-service training to specific CNA's assigned to resident #5 on proper handling of soiled linen. The DNS or designee will provide counseling to CNA #1 to ensure compliance. 2. CNA's currently employed have been in-serviced on proper handling of soiled linen while caring for residents, by SDC and/or designee. DNS and/or designee have observed through routine observation proper techniques for proper handling of soiled linen. DNS and/or designee will continue to make regular scheduled rounds to ensure compliance with infection control pertaining to proper handling of linen. 3. SDC and/or designee will provide in-service training during orientation to ensure proper compliance with linen handling. DNS and/or designee will monitor for compliance during regular rounds. Staff found to be non-compliant will undergo further counseling and in-servicing. 4. The DNS and/or designee will monitor proper handling of soiled	5/17/13

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F 441	Continued From page 7 " Infection Control Work Practices " indicated " all procedures involving blood or potentially infectious materials are performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets of these substances. " During an observation on 4/17/2013 at 6:00 AM, Nursing Assistant #1 (NA) provided perineal care to resident #5. Prior to cleaning the perineal area, areas of feces were observed in the resident ' s perineal area. The NA cleaned the resident ' s perineal area with a wet washcloth. The NA then laid the soiled washcloth on top of the resident ' s bedspread which was on top of the bed. The NA took a shirt and a pair of pants out of the resident ' s closet and laid both items on top of the soiled washcloth. The NA dressed the resident in the pants and shirt. In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to dispose of the soiled washcloth in a bag after she used it. The NA gave no reason why this was not done. In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated staff should place a soiled washcloth in a plastic bag and dispose in the proper waste bin.	F 441	linen through observation. The data will be reviewed and analyzed with a subsequent plan of action is needed. The performance Improvement Committee will review the log monthly x 3 months to validate overall compliance. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469		

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F 469	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to maintain an effective pest control program so that the facility was free of roaches. Findings included: Review of facility forms entitled "Integrated Pest Management Pest Sighting Log" revealed the following sightings of roaches: 1/11/2013 Roaches in Payroll and Rooms 304, 305,306. 1/15/2013 Roaches on 100 and 200 Hall 2/1/2013 Roaches Room 203 2/5/2013 Roaches Rooms 103, 102 and 104 2/7/2013 Desk and Bulletin Board and Room 206 2/8/2013 Roaches Watercooler and Front Lounge 2/11/2013 Roaches Rooms 4 Resident Rooms on the 300-400 Hall and 300 Hall Bathroom 2/15/2013 Roaches Room 104 2/27/2013 Roaches Resident Rooms on 200 Hall 300 Hall Bathroom and Room 508 2/28/2013 Roaches Rooms on 100, 300 and 400 Halls 3/1/2013 Roaches Hall 200 Breakroom and Resident rooms on 300 and 500 Hall Roach sightings were also documented every day in March 2013 except 3/20, 3/22/3/23 and 3/24. Sightings were in numerous areas of the facility. Sightings were also documented on 4/1/2013, 4/3/2013, 4/4/2013, 4/5/2013, 4/15/2013 and 4/16/2013. Review of resident council minutes indicated	F 469	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 469 The Pest control company was called and arrived for treatment of pest control on building on April 19, 2013. The Pest control company was also scheduled to repeat visits daily the following week. After that week, will continue weekly visits for the next three months at which point they will start a bi-monthly visit schedule. Employees will be reeducated at next mandatory all staff meeting on May 9, 2013 on measures taken concerning Pest Control for the building. During monthly facility rounds conducted by the housekeeping manager; all areas with sightings will be recorded, corrected, and noted on monthly CQI sheet and taken to monthly CQI meeting.	5/17/13

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F 469	Continued From page 9 residents complained about roaches in the facility in the March 2013 and April 2013 meetings. An observation in resident room 203 on 4/16/2013 at 6:00 AM revealed a roach crawling on the floor beside the resident ' s bed, a 2nd roach observed crawling under the resident's bed, a 3rd roach observed in a box of gloves on the resident ' s night table and a 4th roach crawling under the resident's night stand where food and drink were noted on the floor. Nursing Assistant (NA) #1 was interviewed on 4/16/2013 at 6:00 AM, and stated "They are everywhere." When asked if she had seen the food on the floor, the NA stated, "It was here when I came on last night.'" She reported it was her job to clean up food off the floor. The NA further reported second shift should have cleaned it up, and " it got busy last night. " The NA stated she reported seeing roaches to the nurse many times. Staff Nurse #1 was interviewed on 4/16/2013 at 6:15 AM. She reported there were roaches in the facility, and she indicated she turned in reports to maintenance when she saw roaches. She reported she saw the food on the floor in the resident's room on the 200 hall when she came on duty last night, and she revealed she was too busy to clean it up and stated it was the duty of staff to clean food up if they saw it. In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated the expectation was staff should clean up spilled food and drink off the floor when they see it in an effort to control roaches.	F 469	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 469	Continued From page 10 In an interview with the Administrator on 4/17/2013 at 10:50 AM, the Administrator reported the facility had a roach issue for several months. She reported extensive efforts had been implemented in efforts to get rid of the roaches that included staff inservices, changing exterminating companies, exterminator coming at least weekly, fumigating rooms, but the problem was ongoing.	F 469	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

DA CENTERS FOR MEDICARE & MEDICAID SERVICES

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
	345365	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON REHAB AND HEALTHCARE CTR	907 CUNNINGHAM RD KINSTON, NC 28501

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. Facility is using NC special locking system. The deficiencies determined during the survey are as follows: No LSC deficiencies noted at time of survey. 42 CFR 483.70(a)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5-28-13

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.

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

PRINTED: 05/10/2013
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
	345365	A. BUILDING 02 - BUILDING 02 B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON REHAB AND HEALTHCARE CTR	907 CUNNINGHAM RD KINSTON, NC 28501

(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 Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. Facility is using NC special locking system. The deficiencies determined during the survey are as follows:	K 000	K – 012 Door assembly in smoke wall in attic was repaired within 24 hours. Also, ceiling access door to be replaced with new door. All smoke doors and ceiling access doors were checked throughout the facility for proper operation and compliance.	6-13-13
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: door assembly in smoke wall in attic on 500 hall did not close for smoke tight seal. Also, rated access door in rated ceiling on 500 hall did not close and latch(no springs on door). 42 CFR 483.70(a)	K 012	All smoke doors and ceiling access doors to be checked monthly during preventative maintenance rounds and logged. All preventative rounds records to be brought to quarterly CQI meeting for their approval. All access doors as well as smoke doors to be repaired or replaced no later than June 13, 2013.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067	K- 067 All units inspected and found not to have access doors for inspection and or cleaning.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 6-28-13

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.

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

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345365	A. BUILDING 02 - BUILDING 02 B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON REHAB AND HEALTHCARE CTR	907 CUNNINGHAM RD KINSTON, NC 28501

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K 067	Continued From page 1 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: at time of survey, no access doors were in duct to view duct detector tubes for cleanness(in attic, facility wide). 42 CFR 483.70(a)	K 067	All HVAC units to have doors installed for cleaning and inspection purposes. All units sensor within HVAC units to be checked during monthly preventative maintenance rounds and logged. All preventative rounds records to be brought to quarterly CQI meeting for their approval. All access doors to be installed and operational by June 13, 2013.	6-13-13