STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345419	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the residents status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to accurately assess 1 of 26 residents (Resident #118) reviewed for assessments.

Findings included:

Resident #118 was admitted on 3/08/13. The resident's documented diagnoses included dysphagia, reflux, and chronic obstructive pulmonary disease.

A review of the resident's medication orders started on 3/8/13 revealed Oxygen 2 liters per minute continuous oxygen therapy and 3 medications that were given by mixing oxygen with a liquid and the resident inhaling the vapor.

The admission Minimum Data Set (MDS) with an Assessment Reference Date of 3/15/13 indicated no swallowing disorders, and no respiratory treatments including oxygen therapy.

The resident's nutritional diagnosis indicated poor eating related to dysphagia.

Interviewed the MDS Coordinator at 1:25 pm on 4/18/13 regarding the resident's inaccurate care plan. He did not give an indication as to why the assessment was inaccurate

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 disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey of 4/18/13. Event ID# 41SS11.	F 000		

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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
	345419	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/15/2013

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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 special locking system per North Carolina State Building Code. The deficiencies determined during the survey are as follows:	K 000		
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 8:30 am onward, the following items were noncompliant, specific findings include; rated door in smoke wall(attic access is in maintenance shop) did not close and latch, to maintain the rating of wall to be smoke resistance. 42 CFR 483.70(a)	K 012	K 012 Door Closure has been adjusted on May 16, 2013. It now closes and latches properly. Maintenance staff will monitor as part of the monthly inspection process to ensure that door is latching appropriately.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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

Administrator 5/31/13

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.

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K 029	Continued From page 1 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1. soiled linen door did not close and latch. 2. Infection control door was not self closing. 42 CFR 483.70(a)	K 029	K 029 1. Door latch in soiled linen room was repaired on May 16,2013. Staff will be re-educated concerning necessity to provide work orders for repairs in a timely manner prior to June 29,2013. Maintenance staff monitors status of doors on a monthly basis as part of the monthly inspections. 2. Self closure device installed to the infection control door on May 17,2013. The door is now closing and latching as required. Maintenance staff will monitor on a monthly basis as part of the monthly inspection.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings	K 038		

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K 038	Continued From page 2 include: employee locker room door in kitchen and office beside fire panel room requires two motion of hand to open to exit egress. 42 CFR 483.70(a)	K 038	K 038 Door handles and locks on employee locker room and kitchen office were replaced on May 16, 2013 with one motion of hand locks as required.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: valve connected to accelerator was not electrical supervised at time of survey. 42 CFR 483.70(a)	K 056	K 056 The valve on the sprinkler system connected to accelerator is scheduled for repair and will be completed prior to June 29,2913.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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K 062	Continued From page 3 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include; facility could not provide proper documentation at time of survey, that a 3 year full flow test and 5 year obstruction investigation has been performed on sprinkler system. 42 CFR 483.70(a)	K 062	K 062 Proper Documentation of the 3 year full flow test performed on April 30, 2013 is now on file. The 5 year obstruction investigation has been scheduled and will be performed prior to June 29,2013.	