STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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, staff interviews, and record reviews the facility failed to identify and/or repair items necessary for resident use in 1 of 2 common use shower rooms (C hall common use shower room) and in 2 of 66 resident rooms (A-17; C-3). The findings include: On 07/08/2013 an initial tour of the facility was conducted. During the tour the following observations were made: In resident room A-17 the air conditioning unit ' s wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw - the socket wires were easily seen due to the hanging socket. A wheel to the bed (A bed) next to the room's door was observed lying on the unoccupied bed (B bed) next to window. In the bathroom of resident room C-3 the resident's toilet was observed to be continuously running. In the resident common use bath/shower room on the C hall the center shower stall was not operational. An interview was conducted with the aid in the bath/shower room. The aid indicated the shower stall had not worked in a long time	F 253	DISCLAIMER RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Max H Reynolds — TITLE: Administrator — (X6) DATE: 7/25/2013

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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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, staff interviews, and record reviews the facility failed to identify and/or repair items necessary for resident use in 1 of 2 common use shower rooms (C hall common use shower room) and in 2 of 66 resident rooms (A-17; C-3). The findings include: On 07/08/2013 an initial tour of the facility was conducted. During the tour the following observations were made: In resident room A-17 the air conditioning unit ' s wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw - the socket wires were easily seen due to the hanging socket. A wheel to the bed (A bed) next to the room's door was observed lying on the unoccupied bed (B bed) next to window. In the bathroom of resident room C-3 the resident's toilet was observed to be continuously running. In the resident common use bath/shower room on the C hall the center shower stall was not operational. An interview was conducted with the aid in the bath/shower room. The aid indicated the shower stall had not worked in a long time	F 253	**F253** Presbyterian Home of Hawfields will continue to strive to ensure the facility's wall sockets are in working order, the Residents' toilet are not continuously running, the shower stalls all are operational and beds with all wheels attached. All in-house Residents will continue to have their housekeeping and maintenance services met to include wall sockets are securely attached to the wall, all wheels attached to the beds, toilets not continuously running and all issues have been repaired except shower stall. Shower stall part has been ordered. Air conditioners, wall sockets will also be checked monthly during routine maintenance checks. Since all in-house residents have the potential to be included in this issue, the RNC's, DON, Maintenance Department, Housekeeping Department and/or designee will conduct a visual review of all concerns and a retraining session for maintenance	07/25/2013 Except for shower stall will be completed by 08/08/13

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

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F 253	Continued From page 1 (months) as there was an issue with either cracked or broken pipes in the wall. There was no signage indicating the center shower stall was out of order. Multiple observations were made during 07/08/2013 and aids were observed bringing residents into and out of the bath/shower room conducting resident daily baths/shower care. On 07/09/2013 at 11:15 a.m. the following areas were re-observed: In resident room A-17 the air conditioning unit's wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw - the socket wires were still easily seen due to the hanging socket. The wheel to the bed (A bed) next to the room's door was observed to be still lying on the unoccupied bed (B bed) next to window. In the bathroom of resident room C-3 the resident's toilet was observed to still be continuously running. In the resident common use bath/shower room on the C hall the center shower stall was still not operational and there was no signage to indicate the shower stall was out of order. On 07/10/2013 at 4:20 p.m. the following areas were re-observed: In resident room A-17 the air conditioning unit's wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw - the socket wires were still easily seen due to the hanging socket. The wheel to the bed (A bed) next to the room's door was observed to be still lying on the unoccupied bed (B bed) next to window. In the bathroom of resident room C-3 the	F 253	request slip. A QA Audit Tool will be used for all concerns, three (3) times a week for one month and reviewed at least weekly by the DON, RNC and/or Administrator. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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F 253	Continued From page 2 resident's toilet was observed to still be continuously running. In the resident common use bath/shower room on the C hall the center shower stall was still not operational and there was no signage to indicate the shower stall was out of order. On 07/11/2013 at 7:15 a.m. the following areas were re-observed: In resident room A-17 the air conditioning unit's wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw - the socket wires were still easily seen due to the hanging socket. The wheel to the bed (A bed) next to the room's door was observed to be still lying on the unoccupied bed (B bed) next to window. In the bathroom of resident room C-3 the resident's toilet was observed to still be continuously running. In the resident common use bath/shower room on the C hall the center shower stall was still not operational and there was no signage to indicate the shower stall was out of order. On 07/11/2013 at 8:35 a.m. the following areas were observed with the facility's maintenance manager. In resident room A-17 the air conditioning unit's wall socket under the A/C unit and window was observed to be loose and hanging from the electrical box by 1 screw. The wheel to the bed (A bed) next to the room's door was observed lying on the unoccupied bed (B bed) next to window. The maintenance manager confirmed the wheel was off of the bed next to the room's door. In the bathroom of resident room C-3 the resident's toilet was observed to still be	F 253		

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F 253	Continued From page 3 continuously running. The maintenance manager indicated the tank's flapper valve may be leaking causing the water to continuously run. In the resident's common use bath/shower room on the C hall the center shower stall was observed to be non-operational. The maintenance manager indicated he had known about the shower not working for almost a year. The maintenance manager indicated the wall would have to be taken down to repair the pipes in the wall and he was told because it was too costly to repair the shower would not be repaired. The maintenance manager could not explain why there was no signage to indicate the shower stall was closed and/or out of order. On 07/11/2013 at 8:45 a.m., an interview was conducted with the facility's maintenance manager. The maintenance manager was asked to explain the maintenance process when something was observed or found by staff needing repair. The maintenance manager indicated the facility had blank work orders at each nursing station (A/B hall and C/D hall). The facility's staff would fill out a work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility's staff member would place the filled out work order request form in the maintenance box at the nursing station. The maintenance manager indicated he would check the boxes several times a day and retrieve the work orders and conduct the repairs. The maintenance manager indicated if the repair needed parts to complete the work he would notify the administrator and defer the repair so the items needed could be ordered and received. When the items came in the work would be	F 253		

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F 253	Continued From page 4 completed and the work order request would also be completed. An attempt to review all work orders that were not yet repaired was conducted with the facility's maintenance manager. The maintenance manager indicated he had no outstanding work orders to be completed (all work requested verbally or by work order request were completed). The maintenance manager was asked if he had known about the items observed needing repair. The maintenance manager indicated he did not know about any of the things needing repair except the C hall's common use bath/shower room shower that was broken but still unrepaired. The maintenance manager indicated he did not have any work orders for any of the observed items including shower stall in the common use bathroom. The maintenance manager indicated that since he was told it would cost too much to repair the shower he never filled out a work order for it's repair. On 07/11/2013 at 6:35 p.m. an interview was conducted with the facility's administrator concerning the information of the shower in the C hall being too costly to repair. The administrator indicated the shower in the C hall common use bathroom was needed by the staff to conduct their job (give residents showers) and was going to be repaired.	F 253	**F441** Presbyterian Home of Hawfields will continue to strive to ensure the residents are provided a safe, sanitary and comfortable environment and to help prevent the development and transmission	08/08/2013
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	F 441		

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F 441	Continued From page 5 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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 observations, staff interviews, and record reviews the facility failed to follow Contact Isolation precautions for 1 of 4 residents (resident	F 441	of disease and infection. Since all Residents have the potential to be include in this issue; RNC's, MDS Coordinator, and/or DON will conduct a retraining session on all employees and a visual review of employees entering an isolation room by Presbyterian Home of Hawfields staff and visitor to ensure Isolation Precautions are being followed. A QA Audit Tool will be used three (3) times per week for one month and reviewed at least weekly by the DON, Administrator, and/or designee. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance. Nurse #1 was reeducated and counseled.	

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F 441	Continued From page 6 # 5) on Contact Isolation. The findings include: The Presbyterian Home of Hawfields - Isolation - Initiating Transmission Based Precautions policy and procedure revised August 2007 read in part on page 35: Transmission Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions. 1. If a resident is suspected of or identified as having a communicable infectious disease, the Charge Nurse or Nursing Supervisor shall notify the Infection Control Coordinator and the resident's Attending Physician for appropriate Transition Based Precautions. 4. Transmission Based Precautions will remain in effect until the Attending Physician or Infection Control Coordinator discontinues them which should occur after pertinent criteria for discontinuation are met. 5. When Transmission Based Precautions are implemented, the Infection Control Coordinator (or designee) shall: b. Post the appropriate notice on the room entrance door, and on the front of the resident's chart so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. Resident #5's chart indicated a lab report dated 05/13/2013 documented sampled resident #5 to be positive for E-Coli of the urine. Nurse's notes dated 05/13/2013 at 6:00 a.m. document the Attending Physician was notified of the positive	F 441		

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

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F 441	Continued From page 7 lab report. Sampled resident # 5 was placed on Contact Isolation precautions and signage was placed on the resident's door indicating sampled resident #5 was on Contact Isolation Precautions and staff will wash hands and glove prior to entering the room and if there is the possibility of making contact with the resident or the bed, and resident's items, a gown will be worn. 07/10/2013 at 8:35 a.m. an observation of a medication pass was conducted on the facility's B hall with nurse # 1. While nurse #1 prepared resident # 5's medication it was also observed resident #5 was on contact precautions per the signage on the resident's door (Contact Isolation, staff will wash hands and glove prior to entering the room and if there is the possibility of making contact with the resident or the bed, and resident's items, a gown will be worn). The nurse was observed to enter the resident's room after washing her hands and gloving. The nurse was observed to make made contact with the resident's bed with her legs and arms while - changing the resident's head of bed (HOB) elevation via the bed's electronic controller laying on the opposite side of the bed, making contact with the bed and sheets/blanket with her legs as she leaned over the bed to pick up the electronic control unit and operate it. The nurse was also observed to contact the resident's bedside table with her arms as she moved the table back towards the wall to provide more room and placing the medications and cup of water on the table. While administering the resident's medications the nurse was observed to administer eye drops to the resident by leaning over and touching the bed and the resident's left shoulder area with her scrubs (clothing) and right	F 441		

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F 441	Continued From page 8	F 441		

arm. The nurse was then observed to exit the room and indicated she had forgotten to administer the resident her liquid medication. The nurse then re-entered the resident's room with the liquid medication only after washing her hands and gloving. Nurse #1 leaned over the bed a 2nd time contacting the resident's bed with her legs while she re-adjusted the elevation of the resident's bed via the electronic control unit. The nurse then leaned over the resident's bed contacting the bed so the resident could drink from the cup with the liquid medication.

An interview was conducted with nurse #1 on 07/10/2013 at 8:55 a.m. concerning resident #5's Contact Isolation precaution signage on the door and the observations of her during the medication pass to resident #5. Nurse #1 acknowledged and indicated she was supposed to be wearing a gown when in the room as she was making contact with the resident, the resident's bed, and bedside table. The nurse indicated she had broken the facility's Contact Isolation precaution protocols with resident #5 and may have contaminated her clothing. The nurse could not explain why she did not follow the contact precautions.

On 07/10/2013 at 10:31 a.m. phone contact was made with resident #5's Attending Physician concerning the resident's Contact Isolation. The physician indicated the resident had a positive lab result on 05/13/2013. The physician indicated she contacted the facility's A/B hall unit coordinator on 07/05/2013 and gave orders to have resident # 5's urine re-collected and sent for testing to see if the resident could be taken off of isolation precautions. The physician indicated

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F 441	Continued From page 9 she had not received any results as of the interview and the resident was to remain on Contact Isolation precautions until the urine was collected, tested, and results were received. An interview was conducted with the Director of Nursing (DON) on 07/10/2013 at 10:55 a.m. concerning his expectations of facility staff to follow the facility's posted Contact Isolation Precautions signage placed on resident's room entrance doors. The DON indicated he was the facility's Infection Control Coordinator and his expectations were that all staff be instructed on infection control, the facility's policies and procedures, and the Contact Isolation signage on the resident's room doors and were to follow the information to reduce the spread of infection among the facility's residents. The DON indicated nurse #1 should have put on a gown prior to entering resident #5's room if she was making contact with her clothing against the resident, resident's bed and/or bedside table which may have been contaminated.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to identify and/or repair call light systems necessary for resident use in 1 of 2 common use shower rooms (C hall	F 463	**F-463** Presbyterian Home of Hawfields will continue to strive to ensure the call light system works properly. Since all Residents have the potential to be included in this issue; the RNC's, Housekeeping Department, Maintenance Department, and/or designee will conduct an inspection of the call bells in order to assure they work properly. The call light system in the shower room (C-Hall common use shower room) and Residents' room (A-12) have been repaired.	07/25/2013

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F 463	Continued From page 10 common use shower room) and in 1 of 66 resident rooms (A-17). The findings include: On 07/08/2013 an initial tour of the facility was conducted. During the tour the following observations were made: In resident room A-17 room's call light button/cord was observed coiled up on the night stand by the B bed. The call light button cord had exposed wires on one end and the cord's plug piece was observed still in wall socket and had a hole where the cord's wires should be attached. In the resident common use bath/shower room on the C hall it was observed that the call light button for the center shower stall was not operational. An interview was conducted with the aid in the bath/shower room. The aid indicated the call light switch for the center shower stall had not worked for a long time. There was no signage indicating the center shower stall was out of order or that the call light button/switch was not working. Multiple observations were made during 07/08/2013 of aids bringing residents into and out of the bath/shower room conducting daily baths and shower care. On 07/09/2013 at 11:15 a.m. the following areas were re-observed: Resident room A-17 room's call light button/cord was observed to still be coiled up on the night stand by the B bed. The call light button cord still had exposed wires on one end and the cord's plug piece was observed still in wall socket and had a hole where the cord's wires should be attached. In the resident common use bath/shower room on the C hall it was observed	F 463	A QA Audit Tool will be used for all areas three (3) times per week for one (1) month and reviewed at least weekly by the DON, RNC's and/or Administrator. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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(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
F 463	Continued From page 11 that the call light button for the center shower stall was still not operational. There was no signage indicating the center shower stall was out of order or that the call light button/switch was still not working. On 07/10/2013 at 4:20 p.m. the following areas were re-observed: Resident room A-17 room's call light button/cord was observed to still be coiled up on the night stand by the B bed. The call light button cord still had exposed wires on one end and the cord's plug piece was observed still in wall socket and had a hole where the cord's wires should be attached. In the resident common use bath/shower room on the C hall it was observed that the call light button for the center shower stall was still not operational. There was no signage indicating the center shower stall was out of order or that the call light button/switch was still not working. On 07/11/2013 at 8:35 a.m. the following areas were observed with the facility's maintenance manager: Resident room A-17 room's call light button/cord was observed to still be coiled up on the night stand by the B bed. The call light button cord still had exposed wires on one end and the cord's plug piece was observed still in wall socket and had a hole where the cord's wires should be attached. In the resident common use bath/shower room on the C hall it was observed that the call light button for the center shower stall was still not operational. There was no signage indicating the center shower stall was out of order or that the call light button/switch was still not working.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	07/11/2013

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THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

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F 463	Continued From page 12 On 07/11/2013 at 8:45 a.m., an interview was conducted with the facility's maintenance manager. The maintenance manager was asked to explain the maintenance process when something was observed or found by staff needing repair. The maintenance manager indicated the facility had blank work orders at each nursing station (A/B hall and C/D hall). The facility's staff would fill out a work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility's staff member would place the filled out work order request form in the maintenance box at the nursing stations. The maintenance manager indicated he would check the boxes several times a day and retrieve the work orders and conduct the repairs. The maintenance manager indicated if the repair needed parts to complete the work he would notify the administrator and defer the repair so the items needed could be ordered and received. When the items came in the work would be completed and the work order request would also be completed. An attempt to review all work orders that were not yet repaired was conducted with the facility's maintenance manager. The maintenance manager indicated he had no outstanding work orders to be completed (all work requested verbally or by work order request were completed). The maintenance manager was asked if he had known about the call light buttons in room C-17 and the C hall common use bath/shower room needing repair. The maintenance manager indicated he did know the center shower stall was not working because of	F 463		

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	345363	A. BUILDING _____ B. WING _____	07/11/2013

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F 463	Continued From page 13 broken pipes in the wall but was unaware of either of the call light buttons not working and no one had filled out a work order or verbally told him they needed to be repaired.	F 463		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to ensure hand rails were securely attached/mounted to the wall on 1 of 5 facility's halls. The findings include: On 07/08/2013 an initial tour of the facility was conducted. During the tour the following observation was made: The hand rail on the right side of the C hallway next to resident common shower room was found to be loose on wall (board on the wall was loose revealing wood screws between the board and the wall) and the hand rail was loose on the metal brackets attaching it to the board mounted to the wall. On 07/09/2013 at 11:15 a.m. the following areas were re-observed: The hand rail on the right side of the C hallway next to resident common shower room was found to be loose on wall (board on the wall was loose revealing wood screws between the board and the wall) and the hand rail was loose on the metal brackets attaching it to the board mounted to the	F 468	**F-468** Presbyterian Home of Hawfields will continue to strive to ensure that all hand rails are securely attached/mounted to the wall. Since all Residents have the potential to be included in this issue; Housekeeping Department and/or Maintenance Department will conduct a visual assessment. All hand rails have been checked and fixed. New longer screws will be used to fix loose hand rails. Also a retraining memo was utilized regarding filling out Maintenance Slip Request. A QA Audit Tool will be used for all areas three (3) times a week for one (1) month and reviewed at least weekly by the DON, MDS Coordinator, Administrator and/or designee. QA Committee will review the QA Action Plan one (1) month for	07/25/2013

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F 468	Continued From page 14 wall. On 07/10/2013 at 4:20 p.m. the following areas were re-observed: The hand rail on the right side of the C hallway next to resident common shower room was found to be loose on wall (board on the wall was loose revealing wood screws between the board and the wall) and the hand rail was loose on the metal brackets attaching it to the board mounted to the wall. On 07/11/2013 at 7:15 a.m. the following areas were re-observed: The hand rail on the right side of the C hallway next to resident common shower room was found to be loose on wall (board on the wall was loose revealing wood screws between the board and the wall) and the hand rail was loose on the metal brackets attaching it to the board mounted to the wall. On 07/11/2013 at 8:35 a.m. the following area was observed with the facility's maintenance manager: The hand rail on the right side of the C hallway next to resident common shower room was found to be loose on wall (board on the wall was loose revealing wood screws between the board and the wall) and the hand rail was loose on the metal brackets attaching it to the board mounted to the wall. On 07/11/2013 at 8:45 a.m., an interview was conducted with the facility's maintenance manager. The maintenance manager was asked to explain the maintenance process when something was observed or found by staff	F 468	three (3) months and revise the action plan to ensure continued compliance.	

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F 468	Continued From page 15 needing repair. The maintenance manager indicated the facility had work orders at each nursing station (A/B hall and C/D hall). The facility's staff would fill out a blank work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility's staff member would place the filled out work order request and place it in the maintenance box at the nursing stations. The maintenance manager indicated he would check the boxes several times a day and retrieve the work orders and conduct the repairs. The maintenance manager indicated if the repair needed parts to complete the work he would notify the administrator and defer the repair so the items needed could be ordered and received. When the items came in the work would be completed and the work order request would also be completed. An attempt to review all work orders that were not yet repaired was conducted with the facility's maintenance manager. The maintenance manager indicated he had no outstanding work orders to be completed (all work requested verbally or by work order request were completed). The maintenance manager was asked if he had known about the loose hand rail next to the C hall resident common use shower/bathroom. The maintenance manager indicated he did not know about the loose hand rail and had never received a work order or was told verbally the handrail was loose and needed to be repaired.	F 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/08/2013

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K 000	INITIAL COMMENTS 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 protected construction, and is utilizing North Carolina Special Locking arrangements . The facility is equipped with an automatic sprinkler system.	K 000	**DISCLAIMER** RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	
K 012 SS=D	CFR#: 42 CFR 483.70 (a) 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: Based on the observations and staff interviews on 8/8/2013 the following Life Safety item was observed as non-compliant, specific findings include: There were unsealed penetrations around the sprinkler head in the activities office near the light fixture in the office.	K 012		
K 018 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary H Reynolds — TITLE: Administrator — (X6) DATE: 8/19/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS 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 protected construction, and is utilizing North Carolina Special Locking arrangements . The facility is equipped with an automatic sprinkler system.	K 000		
K 012 SS=D	CFR#: 42 CFR 483.70 (a) 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: Based on the observations and staff interviews on 8/8/2013 the following Life Safety Item was observed as noncompliant, specific findings include: There were unsealed penetrations around the sprinkler head in the activities office near the light fixture in the office.	K 012	**K 012** Presbyterian Home of Hawfields will continue to strive to ensure the areas around the sprinkler head in the activity office near the light fixture in the office is sealed. Since all sprinkler heads have the potential to be included in this issue; the Maintenance Director or designee will conduct a visual inspection of all sprinkler heads to ensure they are sealed. A QA Audit Tool will be used one (1) time each week for one (1) month and reviewed at least weekly by the Administrator, Maintenance Director, and/or Designee. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	08/19/13
K 018 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 8/8/2013 the following Life Safety item was observed as noncompliant, specific findings include: The door to the A/B door to the shower room was dragging on the frame and would not close latch and seal properly when tested. CFR#: 42 CFR 483.70 (a)	K 018	**K 018** Presbyterian Home of Hawfields will continue to ensure the door to the A/B Shower Room will close without dragging on the frame and will latch and seal property. Since all doors have the potential to be included in this issue; the Maintenance Director or Designee will conduct a visual inspection of all doors to ensure they latch and seal properly. A QA Audit Tool will be use one (1) time each week for one (1) month and reviewed at least monthly by the Administrator, Maintenance Director, and/or Designee. QA Committee will Review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	08/19/2013