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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING ______ B. WING ______	**12/13/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	**PO BOX 1940** **SMITHFIELD, NC 27577**

(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 000	INITIAL COMMENTS The facility was found to be in compliance with the Medicare/Medicaid Long Term Care regulations, 42 CFR part 483, subpart B during the recertification survey of 12/12/2013.	F 000		

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.

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

PRINTED: 01/06/2014
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
	345175	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	PO BOX 1940 SMITHFIELD, NC 27577

(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 This Life safety Code(LSC) survey was conducted as per The Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building (0102) is type II construction, one story with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	JAN 17 2014	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/3/14 at approximately noon the following automatic sprinkler system component was non-compliant; specific findings include the emergency receptacle for heat in the sprinkler systems hot box had a normal colored cover plate on the receptacle, indicating normal power.	K 062	Emergency receptacle for heat in the sprinkler system hot box has been replaced with a red colored receptacle cover on January 3, 2014. Audit conducted on all facility receptacles requiring being red in color conducted by the Director of Environmental Services and/or his designee. Audit to be presented at the January 21, 2014, Quality Assurance Committee to the membership. Quarterly audit of appropriately colored/placed receptacles will be performed on a quarterly basis by the Director of Environmental Services and/or is designee and presented to the Administrator to ensure compliance. Audits will be included on the agenda of each quarterly Quality Assurance Committee meeting. Audits of facility receptacle compliance with appropriate color/placement designating emergency power will be reviewed, approved and maintained by the Quality Assurance Committee.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	Facility emergency generator will be inspected weekly and exercised under load for 30 minutes per month by the Director of Environmental Services and/or his designee. Inspected by Ezzell Electric Company on January 6, 2014 to ensure compliance and on January 10, 2014, routine maintenance, as per contract, was provided. Audit/log completed weekly to validate emergency generator functions when tested by Director of Environmental Services and/or his designee. Audits forwarded to Administrator for approval and to ensure compliance with regulation. Weekly audits/logs will be presented at the Quarterly Quality Assurance Committee meetings on January 21, 2014, and then quarterly for review and approval of its membership.	January 21, 2014

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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	345175	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	PO BOX 1940 SMITHFIELD, NC 27577

(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 144	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/3/14 at approximately noon the following emergency generator was non-compliant; specific findings include generator #1 did not transfer power when tested. The emergency generator cranked using manual means only.	K 144		

Nathan C. Arms

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	345175	A. BUILDING 02 - BUILDING 02 B. WING ______	01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	PO BOX 1940 SMITHFIELD, NC 27577

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K 000	INITIAL COMMENTS This Life safety Code(LSC) survey was conducted as per The Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building (0202) is type III construction, one story with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

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