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

PRINTED: 01/31/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345500	B. WING			01/3	31/2014
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE				STREET ADDRESS, CITY, STATE, 21 1221 BROAD STREET FUQUAY VARINA, NC 27526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result of a recertification survey conducted 01/27/2014 through 1/31/2014. The facility is in substantial compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).		TAG				

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SE RVICES (X1) PROVIDER/SUPI LIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDII 01 B. WING 34550) 02/26/2014 Y, STATE, ZIP CODE STREET ADDRESS, C NAME OF PROVIDER OR SUPPLIER 1221 BROAD STRE WINDSOR POINT CONTINUING CARE FUQUAY VARINA IC 27526 SUMMARY STATEMENT OF DEFICIEN CIES PROVIDI S PLAN OF CURRECTION (X5) COMPLETION ŧĎ (X4) ID (EACH COF **ECTIVE ACTION SHOULD BE** FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX BATE CROSS-REFE INCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFO (MATION) TAG TAG DEFICIENCY Windsor Poir acknowledges receipt of K 000 Statement of eficiencies and proposes K 000 INITIAL COMMENTS this Plan of C rection to the extent that the sum ary of findings is This Life Safety Code(LSC) survey vas factually core It and in order to conducted as per The Code of Fede al Register at 42 CFR 483.70(a), using the 2000 Existing maintain con liance with the Health Care section of the LSC and its referenced applicable re ase provisions for our publications. This building is type III I rotected residents. e Plan of Correction is construction, one story with a complete written allegation of submitted as automatic sprinkler system. Windsor Point's compliance. response to f a Statement of The Deficiencies determined during he survey Deficiencies : d Plan of Correction area as follows: e agreement with the does not den NFPA 101 LIFE SAFETY CODE ST/ NDARD K 038 K 038 1/12/14 reficiencies, nor does it Statement of SS=D constitute ar dmission that any Exit access is arranged so that exits are readily accessible at all times in accordance with section deficiency is curate. Further, LETTER Windsor Poil reserves the right to 7.1. 19.2.1 submit docur antation to refute any of the stated du giencies on the Statement of Peficiencies through informal dist te resolution, formal appeal proce , and/or, any other This STANDARD is not met as evid inced by: administratis or legal proceeding. 42 CFR 483.70(a) K 038 By observation on 2/26/14 at approx mately noon the exit egress was non-compliant, specific Windsor Point ntinuing Care will ensure findings include; the locking system at the end of s is arranged so that exits that all exit acc the service hall did not function per 4CSBC or Ible in accordance with LSC. The door appeared to be designed to meet are readily accr section 7.1, 19. NCSBC but did not release on the master release switch located at the nurses station. An audit on all it access was completed on K 062 NFPA 101 LIFE SAFETY CODE ST/ NDARD K 062 4/12/14 2/26/2014. The ocking system released SS≃D properly on all her doors on the master Required automatic sprinkler system s are :ated at the nurses' station release switch continuously maintained in reliable c serating except the sen ₂ hall. condition and are inspected and tested 19,7.6, 4.6.12, NFPA 13, NFPA 25, periodically. icking system will be wired The service hal 9.7.5 ase on the master release so that it will re switch located the nurses' station. (X8) DAYE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIEN REPRESENTATIVE'S SIGNATURE .8 Tor

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findings stated above are disclosable 90 days

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SU PLIER/CLIA		Constant Prince of the Constant of the Constan			- OMB NO. 0938-0391			
AND PLAN	OF CORRECTION	IDENTIFICATIO	PLIER/CLIA NUMBER:			E CONSTRUCTION 01 - MAIN BUILD		(X3) DA	TE SURVEY MPLETED	
		3451	00	B. WING						
	PROVIDER OR SUPPLIER OR POINT CONTINUIN	G CARE			1	TREET ADDRESS, 221 BROAD STR UQUAY VARIN	TY, STATE, ZIP CODE T NC 27526	02	/26/2014	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIE	VCIES	7	۲.					
PREFIX TAG	(EACH DEPICIENC)	MUST BE PRECEDE SC IDENTIFYING INF	3 9Y ELILI	PREFI TAG		PROVIC (EACH CC CROSS-REF	I'S PLAN OF CORRECTION IECTIVE ACTION SHOULD IENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
K 062	Continued From page 1 This STANDARD is not met as evic enced by: 42 CFR 483.70(a)			Ko	162	All exit doors ensure that t on the maste nurses' static	doors are properly released elease switch located at the			
	By documentation to inspection was 10/2 properly maintained Standard for the Ins	9/2013. The sy: in accordance to pection, Testing	tem shall be fith NFPA 25, and		-	Any issues re be reported t Assurance Co	ed to improper release the Quality Assessment nittee.	will and		
לפח א	Maintenance of water-based fire protection systems. Provide quarterly certification for the sprinkler system. NFPA 101 LIFE SAFETY CODE STy NDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturers specifications. 19.5.2.1, 9.2. NFP/ 90A,		К 0		K062					
K 067 SS≒D				67	Windsor Poin our automation continuously operating con	ontinuing Care ensures prinkler systems are lintained in reliable tion and tested.	that	4/12/14		
	19.5.2.2				CHARLES CHARLES	Advanced Fire Maintenance certification for be completed	esigns was contacted b ector so that the quart the sprinkler system co	erly		
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/26/14 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was no recompliant; specific findings include, there was not an					The Maintena by the Executi regarding the quarterly cert- system.	e Director will be in-ser Director by 4/12/2014 guired documentation a ation for the sprinkler	for		
K 076 S6=D	emergency shut dow observed station. (H Health care entrance NFPA 101 LIFE SAFI	VAC unit locater and the recepti ETY CODE STA	at the in area) VDARD	K 07	8	The Administr certification fo		terly		
	Medical gas storage : protected in accordar for Health Care Facili	nce with NFPA 9 tles.), Standards					THE RESERVE THE PROPERTY OF TH		
	(a) Oxygen storage ic		er than					[
NM CMS-258	7(02-99) Provious Versions Ob	\$olole	Event IO: U2V721		Encille	N ID: 950929	1-1-1-1			

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ENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OMB	ORMAPPRO NO. 0938-0
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPI LIER/CLIA IDENTIFICATION JUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDIN		OMPLETED
		34550)	B. WING			02/26/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, C	, STATE, ZIP CODE	OZIZOIZO I
VINDSO	R POINT CONTINUIN	G CARE		1221 BROAD STRE	C 27526	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN ITES MUST BE PRECEDED BY FULL SC IDENTIFYING INFOF MATION)	ID PREFIX TAG	PROVIDE	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	COMPLET COMPLET
K 076	Continued From pa	ge 2	K 07	K067		
	3,000 cu.ft. are end separation. (b) Locations for sur 3,000 cu.ft. are vent 4.3.1,1.2, 19.3.2,4		with the manufa	itinuing Care will establish entilating, and air ily with the provisions of a installed in accordance urer's specifications.	h	
				The Maintenanc services to Insta switch at a readi	Director will contract in emergency shutdown observed station.	
	42 CFR 483.70(a) By observation on 2: the oxygen storage of findings include; full were stored together enclosure, empty cyl	not met as evidericed by: /26/14 at approxin ately noon was non-complian; specific and empty oxyger cylinders r. If stored within he same linders shall be segregated o signage) from full cylinders.		Further inspectic periodically since cylinders are cur in secured racks full and empty.	on 2/16/2014 and as proved that all oxygen tily separated and stored th the proper signage for	
	Empty cylinders shall confusion and delay hurriedly, (NFPA 99	ll be marked to avoid if a full cylinder is needed 4-3.5.2,2b(2)] (ox) gen ith care entrance, ecception		An in-service will Medical Records segregate empty cylinders.	t conducted by the ark to address the need to aygen cylinders and full	D
		**		The Medical Rect oxygen storage a weekly for two w weeks and then a oxygen storage c	is Clerk will observe as and poll staff twice ks, once weekly for four lodically to ensure apliance.	
		~		The plan of corre on February 26, ; next regularly sch and Assurance Coeffectiveness,	on for the Life Safety visit t4 will be reviewed in the fuled Quality Assessment mittee meeting for it's	
				The corrective at	on will be completed by	