

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

PRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2015
NAME OF PROVIDER OR SUPPLIER TWIN LAKES COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WADE COBLE DRIVE BURLINGTON, NC 27215		
(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 Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I (211) construction, two story, with a complete automatic sprinkler system. At time of survey the: Total Certified Bed Count =104 Census =91 The deficiencies determined during the survey are as follows:	K 000			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on January 2, 2015 at approximately 9:00 AM onward, the following deficiencies were noted:	K 025	The large hole in the smoke wall located above the Day room on Sandpiper Way was repaired on Thursday January 15th, 2015 by placing new sheet rock in the hole and screwing in place. Fire Caulk	1/15/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/16/2015

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: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2015
NAME OF PROVIDER OR SUPPLIER TWIN LAKES COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WADE COBLE DRIVE BURLINGTON, NC 27215		
(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 025	Continued From page 1 1) The smoke walls located at the Sandpiper Way Day Room has a large hole that was not sealed in order to maintain the fire resistance rating of the wall. NFPA 101, 19.3.7.3 NFPA 101, 8.3.6.1	K 025	<p>was used all around the seams to maintain the required fire resistance rating of the wall.</p> <p>The facility will identify other occurrences of the deficient practice having the potential to impact residents by ensuring no other smoke wall holes/penetrations have occurred. Upon finding any such hole/penetrations, they will be immediately repaired by the maintenance staff.</p> <p>Future work done will be reviewed by maintenance staff assigned by the Director of Plant Operations to ensure compliance with the fire resistance rating requirements.</p> <p>The facility will review the finished work after each project to ensure the barrier requirements have been fulfilled. The Director of Plant Operations will report to the Administrator who will in turn report to the next regular meeting of the Quality Assurance Committee.</p> <p>The correction of this deficient practice was completed on January 15, 2015.</p>		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire 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	K 029			1/13/15

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

PRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2015
NAME OF PROVIDER OR SUPPLIER TWIN LAKES COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WADE COBLE DRIVE BURLINGTON, NC 27215		
(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 029	Continued From page 2 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on January 2, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) The corridor door to the central supply room did not close and latch when checked.	K 029	The central supply room corridor door was repaired so that it will close, latch and seal in its frame. The facility will identify other occurrences of the deficient practice having the potential to impact residents by ensuring other doors also close, latch and seal in their frames. Compliance will be monitored by maintenance staff during its inspection tours of the building. The reports of these inspections will be provided to the Director of Plant Operations and the Administrator on a monthly basis. The correction of this deficient practice was completed on January 13, 2015.		
K 056 SS=D	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	K 056		1/23/15	

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

PRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2015
NAME OF PROVIDER OR SUPPLIER TWIN LAKES COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WADE COBLE DRIVE BURLINGTON, NC 27215		
(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 056	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on January 2, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) Mechanical room A, second floor was not protected with sprinkler coverage. 2) Additional sprinkler coverage will need to be added below the HVAC ducts in Mechanical room B. The existing sprinkler head in the room is blocked by the HVAC duct work located below the device.	K 056	The installation of sprinkler coverage in accordance with NFPA 13 are as follows: 1. Mechanical Room A, on second floor will have two (2) new sprinkler heads installed providing complete coverage of the room. 2. Mechanical Room B, on second floor will have a new sprinkler head installed dropping below the HVAC duct work to provide complete coverage of the room. The facility will identify other similar issues of deficient practices. The positions of sprinklers in the building will be reviewed quarterly and annually by United Sprinkler during their prearranged scheduled inspections. The correction of this deficient practice Is scheduled to be completed by January 23rd, 2015.		
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on January 2, 2015 at approximately 9:00 AM onward, the following	K 104	The inspection and repair of smoke dampers to provide necessary protection of smoke barrier penetration by ductwork in accordance with 8.3.6. began on	1/15/15	

PRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TEXTL21 Facility ID: 923513 If continuation sheet Page 5 of 6

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

PRINTED: 01/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345235	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/02/2015
NAME OF PROVIDER OR SUPPLIER TWIN LAKES COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WADE COBLE DRIVE BURLINGTON, NC 27215		
(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 5 Based on observations, on January 2, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) The emergency generator did not transfer load from normal to emergency connected load within 10 seconds. The time to transfer from normal to emergency connected load exceeded 15 seconds.	K 144	practice was corrected on January 8, 2015 transferring the load in under 10 seconds in accordance with NFPA 99, 3.4.4.1. On January 8th 2015, the contractor was on site making the proper adjustments to ensure power is transferred from the emergency generator is under the required 10 seconds. The adjustments were successful as verified by two (2) transfer tests of 9.77 seconds and 9.95 seconds respectively. Compliance will be monitored by inspecting the generators weekly and exercising under load for a minimum of 30 minutes monthly. The timing of the load transfer will be conducted during this monthly generator load testing. All repairs and adjustments were completed by January 8th , 2015.		