A 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. In the exit conference all deficiencies noted were discussed with administration. Facility is using special locking.

Stories: one
Construction Type V
Constructed: 1990
Fully Sprinkled - Yes
At time of survey the:
Certified Beds: Medicare/Medicaid - 120
Census - 104

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:

**K 027**

**SS=D**

NFPA 101 LIFE SAFETY CODE STANDARD

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.

Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by:

42 CFR 483.70 (a)
Based on observations, on 03/19/2015 at Fire Doors on 200 Hall near room 241 that would not fully close were identified

Electronically Signed

04/07/2015

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.
<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 027</td>
<td>Continued From page 1</td>
<td>approximately 8:30 AM onward, the following deficiencies were noted: smoke doors in smoke barrier on 200 hall by rooms 241 and 242 did not close an latch for smoke tight seal.</td>
<td>K 027</td>
<td>and John Combs and David Letchworth were notified on 3-20-2015 to come out and correct. Fire doors were repaired 4-2-2015 by John and David. All other Fire Doors throughout the facility were audited to assure proper closure and latch for smoke tight seal on 3-20-15 by Maintenance Assistant. Any door identified as not presenting as a smoke tight fire door was repaired by John Combs and David Letchworth on 4-2-2014. The facility maintenance director will audit the facility doors for appropriate closure mechanisms weekly for four weeks then monthly for 3 months to assure all doors close properly. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on assuring the Fire Doors are in good repair and close appropriately. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.</td>
<td>K 027</td>
<td>3/20/15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K 029</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>One hour fire rated construction (with ¾ hour</td>
<td>K 029</td>
<td>3/20/15</td>
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</table>
K 029 Continued From page 2

19.3.2.1

This STANDARD is not met as evidenced by:

42 CFR 483.70 (a)
Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: soild linen door on 200 hall was not positive latching at time of survey.

NFPA 101, 19.3.5.4
NFPA 101, 8.4.1

This deficiency affected one of six smoke compartments
Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.

The Door to 200 Hall Soiled Linen room was repaired to be self-close on 3/20/2015 by the Maintenance Assistant.

All other doors throughout the facility were audited to assure had appropriate closure mechanisms on 3-20-15 by Maintenance Assistant. Any door identified was repaired on 3-20-2015.

The facility maintenance director will audit the facility doors for appropriate closure mechanisms weekly for four weeks then monthly for 3 months to assure all doors are in good repair and close properly.

The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on assuring the doors are in good repair and close appropriately.

The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any
<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 029</td>
<td></td>
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<td>Continued From page 3  identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as necessary.</td>
</tr>
<tr>
<td>K 052</td>
<td>SS=E</td>
<td></td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</td>
</tr>
<tr>
<td></td>
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<td>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: 1. facility could not provide proper documentation that the fire alarm system had a yearly inspection. 2. facility could not provide proper documentation that a sensitivity test on smoke detectors had been performed in 2 years.</td>
</tr>
<tr>
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<td>Upon being made aware of lack of documentation pertaining to 1. Fire alarm system annually inspected. 2. Sensitivity tests on smoke detectors performed every 2 years, the Maintenance Assistant notified BFPE to schedule tests. Tests for alarm system and sensitivity were completed by Tim Brian with BFPE on 3-30-2015.</td>
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<td></td>
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<td>This documentation is essential for the safety of all residents. Maintenance Assistant audited documentation of these NFPA 101, 19.3.4, NFPA 101. 9.6, NFPA 72</td>
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</table>

**K 029 3/30/15**

42 CFR 483.70 (a)

Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted:

1. facility could not provide proper documentation that the fire alarm system had a yearly inspection.
2. facility could not provide proper documentation that a sensitivity test on smoke detectors had been performed in 2 years.

NFPA 101, 19.3.4
NFPA 101. 9.6
NFPA 72
### Statement of Deficiencies and Plan of Correction

**A. Building 01 - Main Building 01**

**State of North Carolina**

**Date Survey Completed**: 03/19/2015

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2461 LEGION ROAD
FAYETTEVILLE, NC 28306

**NAME OF PROVIDER OR SUPPLIER**

CUMBERLAND NURSING AND REHABILITATION CENTER

**ID, PREFIX, TAG**

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<tr>
<td>K 052</td>
<td>Continued From page 4</td>
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</table>

**Summary Statement of Deficiencies**

- **K 052**
  - This deficiency affected entire facility.
  - Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.

- **K 062**
  - **NFPA 101 LIFE SAFETY CODE STANDARD**
  - Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.
  - This STANDARD is not met as evidenced by:
    - 42 CFR 483.70 (a)
    - Based on observations, on 03/19/2015 at
  - Sprinkler head in kitchen that did not have escutcheon was corrected on 3/20/2015.

**Conclusion**

The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issue will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.
## Summary Statement of Deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>K 062</td>
<td>Continued From page 5</td>
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<tr>
<td>K 069</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<td>1. escutcheon cover was missing from sprinkler head in kitchen area.</td>
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<td>2. boxes stored within 18 inches of sprinkler head in cooler and freezer in kitchen.</td>
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<tr>
<td>3/20/2015 by Maintenance Assistant. The space located in the walk-in cooler and walk-in freezer has been corrected by Maintenance Assistant as of 3-20-2015 to ensure clearance for the sprinkler heads in the amount of 18 from sprinkler head.</td>
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<td>This deficiency affected only kitchen. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</td>
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<tr>
<td>3/20/15</td>
<td>NFPA 101, 19.7.6</td>
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<td>NFPA 25</td>
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<td>NFPA 13</td>
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### Corrective Plan of Correction

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

- Facility audit to ensure all sprinkler heads have escutcheon piece and audit to ensure 18 clearance for sprinkler heads was completed on 3-20-15 by Maintenance Assistant. Any areas identified were corrected by Assistant Director of Maintenance on 3-20-2015.
- The facility maintenance director will audit the facility sprinkler heads for escutcheon and also clearance of 18 weekly for four weeks then monthly for 3 months to assure all doors are in good repair and close properly.
- The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation and corrections as indicated.
K 069 Continued From page 6

Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96

This STANDARD is not met as evidenced by:
42 CFR 483.70 (a) Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: facility could not provide proper documentation on hood system being inspected in six months.

NFPA 101, 19.3.2.6 NFPA 96

This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.

Upon being made aware of lack of documentation for the Annual Kitchen Hood Inspection, Administrator was able to locate the inspection document on 3-20-2015. This inspection was complete November 2014.

This documentation is essential to ensure the safety of all residents. Maintenance Assistant audited documentation of these records and similar records to ensure they were on file on 3-20-2015. Any findings were corrected on 3-20-2015 by Maintenance Assistant. The facility maintenance director will audit the facility to ensure documentation is kept in a 3 ring binder for easy retrieval weekly for four weeks then monthly for 3 months.

The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on importance of keeping documentation on file in an organized 3 ring binder.

The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issue will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>K 069</td>
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<td>K 069</td>
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<td>recommendation or corrections as indicated.</td>
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<tr>
<td>K 072</td>
<td>SS=D</td>
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<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 072</td>
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<td></td>
<td>Electric Wheelchair, Hoyer Lift, along with Scale was removed from corridor exit near dining room on 3-20-15 by Maintenance Assistant to ensure means of egress are free from obstructions or impediments.</td>
<td>3/20/15</td>
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<td>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</td>
<td></td>
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<td>Facility audit to ensure facility means of egress are free from any obstructions or impediments was completed on 3-20-2015 by Maintenance Assistant. Any areas identified were corrected by Maintenance Assistant on 3-20-2015. The facility maintenance director will audit the facility to ensure facility means of egress are free from obstructions or impediments weekly for four weeks then monthly for 3 months.</td>
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<td>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: electric wheelchair, hoyer lift and scale was stored on corridor exit by Dining room. NFPA 101, 7.1.10</td>
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<td>The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on the importance of keeping hallways / means of egress free from any obstructions or</td>
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<td>This deficiency affected one of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</td>
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<td>sharing or impediments.</td>
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</table>
K 072  Continued From page 8

K 144  NFPA 101 LIFE SAFETY CODE STANDARD

This STANDARD is not met as evidenced by:
42 CFR 483.70 (a)
Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: facility could not provide proper documentation that generator is being run under load for 30 minutes monthly.

NFPA 99, 3.4.4.1
NFPA 110, 8.4.2

impediments.

The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.

Upon being made aware of annual documentation pertaining to generator tests being conducted monthly for 30 min on a full load, Administrator was able to confirm the documentation was on file at corporate main office 3-20-2015. Administrator also conducted load test as well on 3-20-15.

This documentation is essential to ensure the safety of all residents. Maintenance
**Summary Statement of Deficiencies**

This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.

<table>
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<tr>
<th>K 144</th>
<th>Continued From page 9</th>
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<tbody>
<tr>
<td></td>
<td>Assistant audited documentation of these records and similar records to ensure they were on file on 3-20-2015. Any findings were corrected on 3-20-2015 by Maintenance Assistant. The facility maintenance director will audit the facility to ensure documentation is kept in a 3 ring binder for easy retrieval weekly for four weeks then monthly for 3 months. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on importance of keeping documentation on file in an organized 3 ring binder. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.</td>
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