This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The facility utilizes Special Locking throughout. All deficiencies were discussed and acknowledged by facility management and staff.

Total number of beds: 100
Census at time of Survey: 81
The deficiencies determined during the survey are as follows:

K 027
NFPA 101 LIFE SAFETY CODE STANDARD

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8
This STANDARD is not met as evidenced by:
42 CFR 483.70
Based on observation and staff interview, 6/17/2015, at 1:00 am onward, the following item was non compliant; specific findings include: the Cross Corridors fire/smoke doors at/near Nsg Station #3 had kick-down hardware installed that would impede closing of the doors in a fire/emergency.

NFPA 101, 2000 Ed: Sect 18.3.7.3, Sect 18.3.7.6
Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Doors in Smoke barrier walls shall be self-closing or automatic closing.

The deficiency affected 2 of 5 smoke compartments.

1. Kick-down hardware was removed from the door by the maintenance director on 6/26/15.
2. All other doors in the facility were viewed by the maintenance director, and no others were found with the deficient practice. Completed on 6/26/15.
3. Maintenance director will be inserviced by the administrator about the need to assure all smoke barrier doors automatically close, without impediment in a fire/emergency. To be completed by 6/30/15.
4. All smoke barrier doors will be checked weekly times 4 weeks; then twice monthly thereafter by the maintenance director. Results will be submitted to the monthly QA committee for review.

This STANDARD is not met as evidenced by:
42 CFR 483.70
Based on observation and staff interview, 6/17/2015, at 1:00 am onward, the following item

1. Self-closing hardware was installed by the maintenance director on 6/26/15.
2. All other hazardous areas in the
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X4) ID</th>
<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>Continued From page 2 was non compliant; specific findings include: the required self-closing hardware for Hazardous Storage room corridor doors had been removed:</td>
</tr>
<tr>
<td></td>
<td>1. Medical Supply Room</td>
</tr>
<tr>
<td></td>
<td>2 Equipment Storage Room</td>
</tr>
<tr>
<td></td>
<td>Reference NFPA 101, 2000 Ed, Sect 19.3.2.1</td>
</tr>
<tr>
<td></td>
<td>The def(s) affected 1 of 5 smoke compartments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X5) COMPLETION DATE</th>
<th>K 029</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/8/15</td>
<td>building were checked by the maintenance director on 6/30/15 for self-closing devices and no other deficient practice was found.</td>
</tr>
<tr>
<td></td>
<td>3. Maintenance staff will be in-serviced by the administrator by 6/30/15 about the need for fire-rated doors to have devices that allow for automatic closing in the event of fire or emergency.</td>
</tr>
<tr>
<td></td>
<td>4. Doors will be checked by the maintenance director weekly time 4 weeks to assure that closing devices allow for automatic closing; then twice monthly thereafter. Results will be presented at the monthly QA meeting. Need for additional checks will be identified by the committee members.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 052</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
</tr>
<tr>
<td>SS=F</td>
<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X5) COMPLETION DATE</th>
<th>K 052</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/8/15</td>
<td>1. Quarterly inspection of fire system will be completed by Pye Barker on 7/1/15.</td>
</tr>
<tr>
<td></td>
<td>2. All other required fire inspections (such as ansl and fire extinguishers) were reviewed on 6/30/15. No other deficient practice was found.</td>
</tr>
<tr>
<td></td>
<td>3. Maintenance director will be inserviced.</td>
</tr>
<tr>
<td>(X4) ID</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K 052</td>
<td>Continued From page 3 Reference NFPA 101, 2000 Ed, Sect 9.6.1.7 The deficiency affected the entire facility, 5 of 5 smoke compartments.</td>
</tr>
<tr>
<td>K 062</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</td>
</tr>
<tr>
<td>K 076</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are</td>
</tr>
</tbody>
</table>
A. BUILDING
01 - MAIN  BLDG 01

 STATEMENT OF DEFICIENCIES 
 AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345561

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BLDG 01

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

06/17/2015

NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE/FUQUAY-VARINA

STREET ADDRESS, CITY, STATE, ZIP CODE

410 S JUDD PARKWAY SE
FUQUAY VARINA, NC  27526

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES 
(EACH DEFICIENCY MUST BE PRECEDED BY FULL 
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

K 076 Continued From page 4

This STANDARD is not met as evidenced by:
42 CFR 483.70(a)

By observation on 6/17/2015 at approximately noon, the oxygen storage was non-compliant, specific findings include;

(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.
(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4

The deficiency affected 1 of 5 smoke compartments.

K 076

1. The plastic storage rack was removed by the maintenance director on 6/26/15.
2. All other oxygen storage was checked by the maintenance director on 6/26/15, and no other deficient practice was discovered.
3. Maintenance and central supply staff will be in-serviced by the administrator by 6/30/15 concerning appropriate methods for storing oxygen tanks (chained, or metal stand or cart).
4. Maintenance director will check oxygen storage twice weekly times 4 weeks; then weekly times for 4 weeks; then monthly thereafter. Deficient practice will be immediately corrected by the maintenance staff. Results will be submitted by the maintenance director to the QA committee monthly. Need for additional checks or interventions will be determined by the committee.

K 144

NFPA 101 LIFE SAFETY CODE STANDARD

Generators are inspected weekly and exercised

K 144

7/8/15
### K 144 Continued From page 5

under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

This STANDARD is not met as evidenced by:

- 42 CFR 483.70
- Based on documentation and staff interview - 6/17/2015: The staff could not substantiate that the emergency generator was exercised under full load for a minimum of 30 minutes per month. They had only been conducting weekly run tests.
- Reference NFPA 99, 1999 Ed, Sect 3.4.4.1
- The deficiency affected the entire facility, 5 of 5 Smoke compartments.

1. The generator will be tested under full load by the maintenance director by 7/1/14.
2. No other requirements for full-load generator testing exist. Weekly testing has been completed as required.
3. Maintenance director will be in-serviced by the administrator by 6/30/15 concerning the requirements for generator testing, including the requirement for monthly testing under full load circumstancies.
4. Results of generator testing will be submitted monthly by the maintenance director to the QA committee. Need for additional testing or interventions will be determined by the committee.