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

PRINTED: 08/07/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345407	B. WING		05/21/2015	
NAME OF PROVIDER OR SUPPLIER CROSS CREEK HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
K 000		.SC) survey was conducted ederal Register at 42CFR	K 00	00		
	483.70(a); using the 2 section of the LSC an publications. The fac locking systems. In t deficiencies noted we administration.	ility is utilizing speical he exit conference all				
	Stories: One Construction Type V F Constructed: 1991 Fully Sprinkled - Yes At time of survey the: Certified Beds: Media Census - 45					
K 012 SS=D	NOT MET as evidence NFPA 101 LIFE SAFE Building construction	2 CFR, Subpart 483.70(a) is e by: ETY CODE STANDARD type and height meets one .6.2, 19.1.6.3, 19.1.6.4,	K 0 ⁻	12	5/25/15	
	42 CFR 483.70 (a) Based on observation 5/21/2015 at approxin following deficiencies	neet the requirement for a		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this	al	
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE	(X6) DATE	

Electronically Signed 06/16/2015

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.

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K 012	The facility has unseated ceiling in the following 1. Mechanical room 2. Janitor's closet in the rear exit from the	aled penetrations in the rated g locations: in the dietary department the dietary department near kitchen al room in the dining room	K 0	plan of correction. The plan of corconstitutes the facility; sallegation compliance such that all alleged deficiencies cited have been or work corrected by the dates indicated. K 012 SS=D Corrective Action Unsealed penetrations in the rate in the following locations were set: 1) Mechanical Room Dietary Dep. 2) Janitor; s closet Dietary Dep. 3) Center Mechanical Room in Room Identification of related safety has potentially affecting Residents Inspections were conducted by the Environmental Services Director of 5/22/15. The rated ceilings are in mechanical rooms and janitor; so systemic Changes Monthly inspections will be conducted by the Environmental Services Director of 5/22/15. The rated ceilings are in mechanical rooms and Janitor C Any unsealed penetrations in the ceilings will be corrected immediated. Quality Assurance The monitoring is included in the System Preventative Maintenance Schedule as part of the monthly F Check List. This will be done more ongoing. Reports will be given to weekly Quality of Life- QA commit	d ceiling aled: epartment artment Dining cards at the closets. Attended by stor of losets. Fated at ely. TELS ely AVAC anthly the		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345407 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1719 SWAN QUARTER ROAD **CROSS CREEK HEALTH CARE** SWANQUARTER, NC 27885 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 012 Continued From page 2 K 012 following the monthly review for three months or until resolved by the committee. Corrective action will be initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Environmental Services Director and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting. NFPA 101 LIFE SAFETY CODE STANDARD K 045 5/28/15 K 045 SS=E Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: K045 SS=F 42 CFR 483.70 (a) Based on observations and document review on Corrective Action 5/21/2015 at approximately 9:30 AM onward, the Two new exterior lights were installed on following deficiencies were noted: the emergency circuit that supply adequate exit discharge lighting leading The facility failed to meet the requirement for from the exit path of the 300 hall to the supplying adequate exit discharge lighting. front parking lot/public way. See attachment#1 The required exit from the 300 hallway does not meet the requirement by not having exit Identification of related safety hazards discharge lighting on the emergency circuit potentially affecting Residents leading from exit path of 300 hallway to the front Emergency exterior lighting on the emergency circuit for all other required parking lot/ public way.

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K 045	,	s 1 of approximately 6 facility.	K 04	exits are in place. Systemic Changes Rounds on the emergency lighting syswill be conducted on a monthly basis the Environmental Services Director. areas noted to need repair will be corrected immediately. Quality Assurance The monitoring is included in the TEL System Preventative Maintenance Schedule as part of the monthly Emergency Lighting Check List. This be done monthly ongoing. Reports w given to the weekly Quality of Life- Ox committee following the monthly revier for three months or until resolved by t committee. Corrective action will be initiated as appropriate. The QOL/QA committee is the main quality assurant committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, ME Coordinator, Environmental Services Director and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	by Any S will iill be A w ne ce	