STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. The facility is utilizing speical locking systems. In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type V Protected Constructed: 1991 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 80 Census - 45 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations and document review on 5/21/2015 at approximately 9:30 AM onward, the following deficiencies were noted: The facility failed to meet the requirement for a properly sealed rated ceilings.	K 012	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	5/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 1 The facility has unsealed penetrations in the rated ceiling in the following locations: 1. Mechanical room in the dietary department 2. Janitor's closet in the dietary department near the rear exit from the kitchen 3. Center mechanical room in the dining room Ref: NFPA 101 Section 19.1.6.2	K 012	plan of correction. The plan of correction constitutes the facility¿s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. K 012 SS=D Corrective Action Unsealed penetrations in the rated ceiling in the following locations were sealed: 1) Mechanical Room Dietary Department 2) Janitor¿s closet Dietary Department 3) Center Mechanical Room in Dining Room Identification of related safety hazards potentially affecting Residents Inspections were conducted by the Environmental Services Director on 5/22/15. The rated ceilings are intact in all mechanical rooms and janitor¿s closets. Systemic Changes Monthly inspections will be conducted by the Environmental Services Director of Mechanical Rooms and Janitor Closets. Any unsealed penetrations in the rated ceilings will be corrected immediately. Quality Assurance The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the monthly HVAC Check List. This will be done monthly ongoing. Reports will be given to the weekly Quality of Life- QA committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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: 42 CFR 483.70 (a) Based on observations and document review on 5/21/2015 at approximately 9:30 AM onward, the following deficiencies were noted: The facility failed to meet the requirement for supplying adequate exit discharge lighting. The required exit from the 300 hallway does not meet the requirement by not having exit discharge lighting on the emergency circuit leading from exit path of 300 hallway to the front parking lot/ public way.	K 045	K045 SS=E Corrective Action Two new exterior lights were installed on the emergency circuit that supply adequate exit discharge lighting leading from the exit path of the 300 hall to the front parking lot/public way. See attachment#1 Identification of related safety hazards potentially affecting Residents Emergency exterior lighting on the emergency circuit for all other required	5/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 3 This deficiency affects 1 of approximately 6 required exit from the facility. Ref: NFPA 101 Section 19.1.6.2	K 045	exits are in place. Systemic Changes Rounds on the emergency lighting system will be conducted on a monthly basis by the Environmental Services Director. Any areas noted to need repair will be corrected immediately. Quality Assurance The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the monthly Emergency Lighting Check List. This will be done monthly ongoing. Reports will be given to the weekly Quality of Life- QA committee 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.	