

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2016
NAME OF PROVIDER OR SUPPLIER LUMBERTON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1555 WILLIS AVENUE LUMBERTON, NC 28358	
(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 V(III)construction, one story, with a complete automatic sprinkler system and using special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the: Total Certified Bed Count 122 Census 112 The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=E	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, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: walls in laundry room by the washing machines and dryer's, are not maintained in good condition(holes, sheet rock off of several corners). 2000 NFPA 101, 19.1.6.2	K 012	Criteria 1 Laundry room assessed for required repairs (holes, sheet rock, and corners) on 6/30/216 by Maintenance Director and Executive Director. Criteria 2 All other areas of facility audited by Maintenance Director and Executive Director to ensure no other structural repairs needed 6/30/2016. Scheduled repairs will be made to the laundry room walls/corners on or before August 14, 2016.	8/14/16

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

TITLE

(X6) DATE

Electronically Signed

07/14/2016

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	Continued From page 1 This deficiency affected laundry room only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	Maintenance Director educated 6/30/2016 to ensure weekly rounds include monitoring for structural repairs, specifically rounding in the laundry department each week. Laundry personnel will be educated on or before 8/14/16 by Executive Director to ensure any structural damage noted is reported to the Maintenance Director and/or Executive Director as soon as damage is noted. Criteria 3 Maintenance Director and/or Executive Director, in his absence, will conduct weekly monitoring of the laundry department to ensure no structural damage to walls/corners. Monitoring will begin on or before 8/14/16. Criteria 4 The results of the monitoring will be brought to the monthly QAPI meeting to ensure compliance and quality improvement for a minimum of 3 consecutive months or longer if deemed necessary based on the results of the monitoring.		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-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,	K 027		8/14/16	

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K 027	Continued From page 2 19.3.7.7 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: cross corridor doors in smoke wall on 800 hall did not close for smoke tight seal(gap at top). 2000 NFPA 101, 19.3.7.5 This deficiency affected one of nine smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 027	Criteria 1 800 hall cross corridor doors in smoke wall on 800 hall corrected to ensure tight seal 7/12/16 by Maintenance Director. Criteria 2 Maintenance Director educated on 6/30/16 to ensure all cross corridor doors in smoke walls have tight seals. All other cross corridors, in smoke walls will be assessed and corrected to ensure tight seal by Maintenance Director on or before 8/14/16. Criteria 3 Maintenance Director will audit cross corridor doors located within the smoke walls weekly to ensure tight seal maintained; monitoring will be begin on or before 8/14/16. Criteria 4 Results of the weekly monitoring will be brought to the monthly QAPI meeting for a minimum of 3 consecutive months or longer if deemed appropriate to ensure quality improvement.		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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		8/14/16	

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K 029	Continued From page 3 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: door to dry storage room in kitchen did not close and latch. 2000 NFPA 101,19.3.2.1 This deficiency affected kitchen area only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 029	Criteria 1 Door to dry storage room, located in the dietary department corrected by Maintenance Director July 11, 2016 to ensure self closing and latching. Criteria 2 Maintenance Director educated 6/30/16 to ensure doors deemed necessary are self closing and latching. All other doors audited 7/11/2016 by Maintenance Director to ensure self closing and latching, no other doors found to be affected. Criteria 3 Maintenance Director will audit doors monthly to ensure self closing and latching, monitoring will begin on or before August 14, 2016. Criteria 4 The results of the monthly monitoring will be brought to the monthly QAPI meeting for a minimum of 3 consecutive months to ensure compliance with quality improvement and longer if deemed necessary.		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was	K 038	Criteria 1 Fence Gate located within the Alzheimer's Care Unit corrected 6/30/16 to ensure gate would open with less than 15 lbs of pressure.	8/14/16	

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K 038	Continued From page 4 non-compliant, specific findings include: the fence gate door in for the Alzheimer unit, requires more than 15 lbs. of force to open gate door. 2000 NFPA 101, 19.2.1/7.1 This deficiency affected Alzheimer unit. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	Criteria 2 All other gates assessed on 6/30/16 by Maintenance Director to ensure all gates opened with less than 15 lbs of pressure, no other gates found to be affected. Criteria 3 Maintenance Director will monitor gates monthly to ensure all gates open with less than 15 lbs of pressure. Monitoring will begin on or before August 14, 2016. Criteria 4 The results of the monitoring will be brought to the monthly QAPI meeting for a minimum of 3 consecutive months to ensure quality improvement.	
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 will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: the exit discharge path to public way coming out of 700 hall is does not have required emergency egress lighting for safe passage to public way. 2000 NFPA 101, 19.2.8/7.8 This deficiency affected one of nine smoke compartments.	K 045	Criteria 1 Electrician assessed 700 hall outdoor emergency egress lighting, in order to correct to ensure safe passageway, 7/12/2016. Criteria 2 All exterior egress areas will have emergency lighting added on or before August 14, 2016. Criteria 3 Maintenance Director will monitor all external egress lighting monthly when conducting monthly generator function under load for 30 minutes, to ensure all	8/14/16

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K 045	Continued From page 5 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 045	external lights functioning under generator load and lit ensuring safe passageway to public area. Criteria 4 The results of the monitoring will be brought to the monthly QAPI meeting for a minimum of 3 consecutive months or longer if deemed necessary to ensure compliance.		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: standing in corridor on East wing at nurse station, you can only see one directional sign to an exit. Must be able to see two directional signs any where in a corridor (Unless the exit is obvious i.e. Front Lobby). 2000 NFPA 101, 19.2.10.1/7.10 This deficiency affected three of nine smoke compartments Failure to comply with minimum standards as referenced increases the risk of death or injury	K 047	Criteria 1 Maintenance Director added emergency directional signage to East wing nurse's station area to ensure 2 signs are visual within 1 corridor on July 8, 2016. Maintenance Director educated 6/30/16 to ensure 2 directional emergency signage is visual within 1 corridor. Criteria 2 Maintenance Director and Executive Director audited 100% of the facility July 12, 2016 to ensure 2 directional signage visual within each corridor. No other areas found affected. Criteria 3 Executive Director will monitor facility monthly to ensure 2 directional signage visual within each corridor. Monitoring will begin on or before August 14, 2016.	8/14/16	

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K 047	Continued From page 6 due to fire and/or smoke.	K 047	Criteria 4 The results of the monitoring will be brought to the monthly QAPI meeting for a minimum of 3 consecutive months to ensure compliance.	
K 144 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</p> <p>Based on observations, on 06/30/2016 at approximately 10:30 AM onward, the following deficiencies were noted: The standard was non-compliant, specific findings include: facility could not provide proper documentation that a weekly electrolyte test is being performed.</p> <p>Reference 1999 NFPA 110 6-3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.</p> <p>Reference 1999 NFPA 110 A-6-3.6, NFPA 70, National Electrical Code, Section 700-4(c) Maintenance of batteries should include checking and recording the value of the specific gravity.</p> <p>This deficiency affected entire facility.</p>	K 144	<p>Criteria 1 Maintenance Director educated 6/30/16 to ensure weekly electrolyte test is performed on generator battery.</p> <p>Criteria 2 Maintenance Director will conduct weekly electrolyte test on generator battery on or before August 14, 2016.</p> <p>Criteria 3 The weekly electrolyte tests with specific gravity will be recorded, on or before August 14, 2016 with ongoing documentation available upon request.</p> <p>Criteria 4 The results of the weekly electrolyte specific gravity tests will be brought to the monthly QAPI meetings for a minimum of 3 consecutive months to ensure compliance.</p>	8/14/16

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

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K 144	Continued From page 7 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144		