**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
NC STATE VETERANS HOME-BLACK MOUNTAIN

**STREET ADDRESS, CITY, STATE, ZIP CODE**
62 LAKE EDEN ROAD
BLACK MOUNTAIN, NC  28711

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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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 III(211) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration.

At time of survey the licensed bed capacity = 100
Total Certified Bed Count = 100
Census = 94

The deficiencies determined during the survey are as follows:

**K 012 NFPA 101 LIFE SAFETY CODE STANDARD**

Building construction type and height meets one of the following:
18.1.6.2, 18.1.6.3, 18.3.5.1.
This STANDARD is not met as evidenced by:
42 CFR 483.70 (a)

Based on observations, on July 28, 2016 at approximately 10:00 AM onward, the following deficiencies were noted:

- The standard is non-compliant, specific findings include:
  - There is a hole in the rated roof/ceiling assembly beside pendant sprinkler in resident room C208.
  - NFPA 101, 18.1.6.2, 18.1.6.3, 18.3.5.1

This deficiency affected one of two smoke compartments.

1. Corrective action accomplished by the facility to correct practice.
   - The facility sealed the hole in the rated roof/ceiling assembly beside pendant sprinkler in resident's room C208 on 7/28/2016.

2. Identification of life safety issue having the potential to affect others.
   - The facility completed a facility wide check of all ceilings beside the pendant sprinkler to ensure no other holes where identified.

3. Systemic changes to ensure practice

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

K 070 9/9/16

**NFPA 101 LIFE SAFETY CODE STANDARD**

Portable space heating devices shall be prohibited in all health care occupancies. Except
it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C).

18.7.8, 19.7.8

This STANDARD is not met as evidenced by:

42 CFR 483.70 (a)

Based on observations, on July 28, 2016 at approximately 10:00 AM onward, the following deficiencies were noted:

The standard is non-compliant, specific findings include:

There is a high temperature portable space heater with elements exceeding 212 degrees Fahrenheit - located in rehabilitation office.

1. Corrective action accomplished by the facility to correct practice.

The High Temperature portable space heater was removed from the rehabilitation office on 7/28/2016.

2. Identification of Life Safety issue having the potential to affect others.

The Maintenance Director and Maintenance department inspected all areas of the facility and no other space
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NFPA 101, 18.1.6.2, 18.1.6.3, 18.3.5.1

This deficiency affected one of two smoke compartments.

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

heaters where identified in the facility.

3. Systemic changes to ensure practice will not recur.
   The Maintenance Director and Maintenance Department checks all areas of the facility for space heaters weekly for four weeks then monthly thereafter until three consecutive months of compliance are met.

4. Quality Assurance / Performance Improvement.
   The Maintenance Director will present the findings of the monthly facility check for space heaters to Quality Assurance and Performance Improvement Committee for review and recommendations as needed.