A. BUILDING 01 - MAIN BUILDING 01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRAHAM HEALTHCARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

811 SNOWBIRD ROAD
ROBBINSVILLE, NC 28771

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</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 000</td>
<td></td>
<td>INITIAL COMMENTS</td>
<td>K 000</td>
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<td>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 III(211) 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 licensed bed capacity = Total Certified Bed Count = 80 Census = 74 The deficiencies determined during the survey are as follows:</td>
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<tr>
<td>K 012</td>
<td>SS=E</td>
<td>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 August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is a mechanical supply outlet that is not equipped with a ceiling fire damper - located in the kitchen pantry roof/ceiling assembly. Note: Ceiling fire damper shall be installed in accordance with the manufacturer's installation instructions.</td>
<td>K 012</td>
<td>SS=E</td>
<td>K012 A ceiling fire damper will be installed in the mechanical supply outlet located in the kitchen pantry in accordance with the manufacturer's installation instructions on or before Sept 11, 2016. An audit was performed by the Maintenance Supervisor and all fire dampers in the storage rooms, except for one mentioned above are working properly.</td>
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</tbody>
</table>

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.

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

Electronically Signed

08/22/2016
**Summary Statement of Deficiencies**

K 012 Continued From page 1

NFPA 101, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

This deficiency affects 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.

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 1½-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, 19.3.7.7

This STANDARD is not met as evidenced by:

42 CFR 483.70 (a)

Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:

There are holes in the cross corridor smoke barrier doors - located near room 22.

NFPA 101, 19.3.7.5, 19.3.7.6, 19.3.7.7

A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure all smoke dampers to include the kitchen pantry weekly X 4 weeks, then a monthly audit will be conducted by Maintenance Supervisor or designee to ensure all smoke dampers are working properly.

The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.

The holes in the cross corridor smoke barrier doors located near room 22 were repaired with fireproofing caulking on August 5, 2016.

A audit of all doors has been completed and no holes were found in any other doors.
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>K 027</td>
<td>Continued From page 2</td>
<td>This deficiency potentially affects two 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.</td>
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<tr>
<td>K 029</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>One hour fire rated construction (with one 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 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: Fire door to central supply would not self latch without manual intervention - located beside front entrance conference room. NFPA 101, 19.3.2.1</td>
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</table>

A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure all doors are free of holes weekly for 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure no holes are found in any doors.

The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.
<table>
<thead>
<tr>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>K029</td>
<td>Continued From page 3</td>
<td>This deficiency affects one of two smoke compartments.</td>
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<tr>
<td>K029</td>
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<td></td>
<td>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</td>
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<tr>
<td>K032</td>
<td>SS=E</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<tr>
<td>K032</td>
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<td>Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2</td>
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<tr>
<td>K032</td>
<td></td>
<td>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</td>
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<td>K032</td>
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<td>Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:</td>
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<tr>
<td>K032</td>
<td>SS=E</td>
<td>The chain link fence with gate assembly creates an enclosed courtyard with travel distance exceeding fifty feet; also, the area is using outdoor furniture in the required means of egress from exit discharge near resident room #60.</td>
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<tr>
<td>K032</td>
<td></td>
<td>Chain link fence and gate was removed on 8-5-16 located in back courtyard near room #60 by Maintenance Supervisor.</td>
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<tr>
<td>K032</td>
<td></td>
<td>An audit was conducted by the Maintenance Supervisor to check all areas around the facility to ensure areas are free of fencing and gates.</td>
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<tr>
<td>K032</td>
<td></td>
<td>A weekly audit will be conducted by</td>
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Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2
### SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<td>K 032</td>
<td></td>
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<td>Maintenance Supervisor or designee to ensure areas around the facility are free of fences and gates weekly for 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure areas around facility are free of fences and gates. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.</td>
</tr>
<tr>
<td>K 061</td>
<td>SS=E</td>
<td></td>
<td>Two main sprinkler control valves in the outside sprinkler vault are to be removed on or before Sept. 11, 2016 by Pye Barker Fire &amp; Safety Inc. An audit was conducted by Maintenance Supervisor to ensure no other sprinkler control valves were outside around facility. A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure areas around facility are free of sprinkler control valves weekly X 4 weeks, then a monthly audit will be conducted by</td>
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</tbody>
</table>

**K 032 Continued From page 4**

**NFPA 101, 19.2.4.1, 19.2.4.2, 7.1.10**

This deficiency potentially affects 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.

**K 061 NFPA 101 LIFE SAFETY CODE STANDARD**

Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72

This STANDARD is not met as evidenced by:

42 CFR 483.70 (a)

Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:

- There are two main sprinkler control valves without electrical supervision in the outside sprinkler vault - located to the left of front entrance area.
- NFPA 101, 9.7.2.1

This deficiency potentially affects all smoke compartments.
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<tr>
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<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 061</td>
<td>Continued From page 5</td>
<td>K 061</td>
<td>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</td>
<td>K 061</td>
<td></td>
<td></td>
<td>the Maintenance Supervisor or designee to ensure areas around facility are free of sprinkler control valves. The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.</td>
</tr>
<tr>
<td>K 070</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 070</td>
<td>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)</td>
<td>K070</td>
<td>SS=E</td>
<td></td>
<td>The portable space heater was removed from Medical Records Office on 8-4-16 and discarded. An audit was conducted by the Maintenance Supervisor to ensure no space heaters were in the facility. A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure areas in the facility are free of space heaters weekly X 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor or designee to ensure areas in the facility are free of space heaters. The results of the audit will be reviewed</td>
</tr>
</tbody>
</table>

Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:

- There is an exposed element, high temperature, portable space heater with temperature of heating elements exceeding 212 degrees Fahrenheit - located in medical records office.
- NFPA 101, 19.7.8
- This deficiency affects 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.
# Statement of Deficiencies and Plan of Correction

## Name of Provider or Supplier

**Graham Healthcare and Rehabilitation Center**

### Facility Information
- **Street Address, City, State, Zip Code:** 811 Snowbird Road, Robbinsville, NC 28771
- **Provider Identification Number:** 345355
- **Date Survey Completed:** 08/04/2016

### Summary Statement of Deficiencies

**K 070**

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**K 144**


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).

This STANDARD is not met as evidenced by:

- 42 CFR 483.70 (a)

Based on observations, on August 4, 2016 at approximately 9:00 AM onward, the following deficiencies were noted:

1. There is no emergency task lighting covering emergency generator access panels inside fenced enclosure - existing emergency light is located outside enclosure and fails to provide illumination due to obstructions by wood fence.

2. There is no documentation of weekly checks of generator battery electrolyte levels and specific gravity readings.

NFPA 101, 9.1.2, NFPA 99, 3-4-4-1, 8-4.2, NFPA 110, Chapter 6

This deficiency potentially affects all smoke compartments.

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

### Provider's Plan of Correction

**K 070**

by the Administrator in the monthly QI Committee Meeting.

**K 144**

- 1. Emergency task lighting to be installed by S & S Electrical co. on or before Sept. 11, 2016 to cover the emergency generator area.

A weekly audit will be conducted by the Maintenance Supervisor or designee to ensure task lighting at the emergency generator is working properly weekly X 4 weeks, then a monthly audit will be conducted by the Maintenance Supervisor of designee to ensure emergency task lighting is working properly to cover generator area.

The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.

**K 144**

- 1. Maintenance Supervisor will document generator battery testing on the corrected form weekly on or before Sept.
Weekly audits will be conducted by the Maintenance Supervisor or designee to ensure generator battery testing has been done on a weekly basis.

The results of the audit will be reviewed by the Administrator in the monthly QI committee meeting.

Continued From page 7

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11, 2016 and documented correctly.