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

PRINTED: 02/29/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345070		345070	B. WING			02/17/2012	
NAME OF PROVIDER OR SUPPLIER  GRACE HEALTHCARE OF DURHAM			•		TREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO		o		
	The facility is in correquirements of 42 Long Term Care Fa Survey).	mpliance with the CFR Part 483, Subpart B for acilities (General Health					
						:	
.ABORATOR)	OIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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.

/ DEPARTI	MENT OF HEALTH	I AND HUMAN SERVICES		FORM OMB NO	: 03/10/2012   APPROVED   0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION (X3) DATE SCOMPL (COMPLETE COMPLETE COMPLICATION COMPLETE COMP	ETEU	
		345070	B, WING		08/2012
NAME OF PR	OVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE B LASALLE STREET	
	EALTHCARE OF DU	JRHAM		RHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 000	conducted as per at 42CFR 483.70(a Care section of the	TS ode(LSC) survey was The Code of Federal Register a); using the Existing Health building is Type III construction, omplete automatic sprinkler	K 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used.	
K 012 SS=D	are as follows:   NFPA 101 LIFE S	etermined during the survey  AFETY CODE STANDARD  Ion type and height meets one 9.1.6.2, 19.1.6.3, 19.1.6.4,	K 012	the Finh of Coulding in any subsequent against the facility in any subsequent administrative or civil proceeding.  K 012  1. The facility maintenance director serviced and caulked the penetration in the ceiling outside room number 9 and 10 with fire resistant caulking on 3/9/12. The caulking was re-inspected by the maintenance director on 03/10/11.	4/6/12
SS=D	CFR 483.70(a) By observation or the following build non-compilant, sp penetration in the #10 does not mer rating. NFPA 101 LIFE S  Doors protecting required enclosus hazardous areas those constructe wood, or capable minutes. Doors required to resist no impediment to	Is not met as evidenced by:  a 3/8/12 at approximately noon ling construction type was pecific findings include; the celling outside room #9 and et the required fire resistance  SAFETY CODE STANDARD  corridor openings in other than res of vertical openings, exits, or are substantial doors, such as d of 1% inch solid-bonded cors to of resisting fire for at least 20 in sprinklered buildings are only the passage of smoke. There is to the closing of the doors. Doors	;	<ol> <li>The facility maintenance director inspected all ceiling areas in the main corridors on 03/09/12 to insure no penetration were noted in the ceilings.</li> <li>The administrator in-serviced the maintenance director and the maintenance department on 03/09/12 regarding preventive maintenance and inspection frequency of ceilings integrity.</li> </ol>	(X6) DATE
	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE S SI	GNATURE	inter of Nursing	3/23/12
Any deficie other safeg following the	ncy statement ending v	/ith an asteriek (*) denotes a delicioney v	rhich the institut ons.) Except for For nursing ho If deficiencies	ion may be excused from correcting providing it is roursing homes, the findings stated above are dismes, the above findings and plans of correction are cited, an approved plan of correction is requisit	determined that closable 90 days a disclosable 14 to to continued

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES		•		FORM	; 03/10/2012 APPROVED , 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  37ATEMENT OF DEFIGIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED	
		345070	B, Wil	1G			8/2012
	ROVIDER OR SUPPLIER	IRHAM		411	ET ADDRESS, CITY, STATE, ZIP CC S LASALLE STREET RHAM, NC 27705	DDE	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOOLD BE	(X6) COMPLETION OAYE
:	the door closed. Dare permitted.	means sultable for keeping utch doors meeting 19.3.6.3.6 3.3.6.3 orohibited by CMS regulations	K	018	4. All ceiling areas in the ma will be inspected once we weeks and then monthly the maintenance director penetrations and/or 100 are noted in the ceilings, this audit will be brought reviewed by the maintenathe monthly Quality Ass Performance Improveme meeting. The Quality As Performance Improveme consists of the Administra Director of Nursing, Staff Coordinator, MDS Coordinator, Admission Coordinator,	ckly for 4 for 2 months by to insure no % compliance The results of to and more director in ummee nt Committee ssummee nt Committee stor, the F Development Jinator,	
K 051 \$8¤D	By observation on the corridor doors findings include do storage room at maround the door had not been also as the storage room at maround the door had not been also as the storage room at manual fire alarm extinguishing systematical patient sleeping a that manual pull sinurse's stations. The path of egress. Express are available power is provided maintained in acc	Is not met as evidenced by:  3/8/12 at approximately noor were non-compliant, specific rors to the dining room and urses station #1 had gaps ardware.  AFETY CODE STANDARD  In with approved components, ent is installed according to I Fire Alarm Code, to provide of fire in any part of the buildir g. complete fire alarm system is by initiation, automatic detection or em operation. Pull stations in reas may be omitted provided tations are within 200 feet of Pull stations are located in the fectronic or written records of A reliable second source of Fire alarm systems are ordance with NFPA 72 and peans are kept readily available.	and the second s	051	Admission Coordinator, Manager, Medical Director Social Services, Environa Director of Maintenance, Manager, and the Activiti  1. The facility maintenance of installed Cover and Strike the door hardware to the and stonge room at nurse on 03/10/12. 2. All doors were inspected maintenance director on of insure no gaps were aroun hardware. No other door to be affected. 3. The administrator in-serv maintenance director and maintenance depactment regarding preventive mai inspection frequency of o	or, Director of mental Services, Dietary es Director, plates around dining room es station #1 by the 13/10/12 to ad the door es were found liced the 1	4/6/12

PRINTED: 03/10/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A BUILDING B. WING 03/08/2012 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET GRACE HEALTHCARE OF DURHAM DURHAM, NC 27705 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PREFIX TAG DEFICIENCY) TAG All door hardware will be inspected once a week times 3 months and/or 100 K 051 K 051 Continued From page 2 % compliance by the maintenance There is remote annunciation of the fire alarm director. The inspection results will be brought to and reviewed monthly in our system to an approved central station. Quality Assurance Performance 9.6 Improvement Committee by the Maintenance Director. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. This STANDARD is not met as evidenced by: K051 4/6/12 42 CFR 483.70(a) By observation on 3/8/12 at approximately noon A certified technician installed a the Fire Alarm Control Panel (FACP) was dedicated electrical circuit on 03/14/12. non-compliant, specific findings include the FACP The dedicated electrical circuit voltage not wired to a dedicated electrical circuit. The was tested on 3/14/12. circuit EM1B #4 labeled fire alarm, when turned The facility maintenance Director on 03/14/12 tested The dedicated electrical off, will drop power to the FACP but also the circult and when turned off the mechanical smoke dampers outside room #9 and mechanical dampers outside room #9 #10 will close. and # 10 closed. NFPA 101 LIFE SAFETY CODE STANDARD K 062 The dedicated electrical circuit will be K 062 5 inspected weekly times four weeks and SS≃D i then monthly for two months and/or Required automatic sprinkler systems are 100% compliance by the Maintenance continuously maintained in reliable operating Director. condition and are inspected and tested The inspection results will be brought to 19.7,6, 4.6.12, NFPA 13, NFPA periodically. and reviewed monthly in our Quality 25, 9.7.5 Assurance Performance Improvement Committee by the Maintenance Director.

42 CFR 483.70(a)

This STANDARD is not met as evidenced by:

By observation on 3/8/12 at approximately noon

the regulred automatic sprinkler system was

documentation of the sprinkler certification

non-compliant, specific findings include

The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing,

Staff Development Coordinator, MDS

Coordinator, Admission Coordinator,

Director, Director of Social Services,

Environmental Services, Director of

Maintenance, Dietary Manager, and the

Rehabilitation Manager, Medical

Activities Director.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 03/08/2012 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET GRACE HEALTHCARE OF DURHAM DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (X4) ID PREFIX TAG TAG DEFICIENCY) K062 K 062 K 062 ! Continued From page 3 1. The sprinkler heads were evaluated in central supply and the deficiencles are as follows: staff lounge. Two sprinkler heads were plugged in central supply and one A. "Engineering survey of the central supply and sprinkler head was plugged in the staff staff lounge room on spacing of sprinkler heads' lounge on 03/09/12. The sprinklers should be evaluated. are spaced appropriately. B. "Replace painted sprinkler head" in unit The maintenance Director installed a new sprinkler head in the Unit coordinators office. K 067i Coordinator office on 03/09/12. NFPA 101 LIFE SAFETY CODE STANDARD K 067 SS≃D Heating, ventilating, and air conditioning comply The facility maintenance director with the provisions of section 9.2 and are installed inspected all sprinkler heads on in accordance with the manufacturer's 03/09/12 to insuce that all sprinkler 19.5.2.1, 9.2, NFPA 90A, specifications. heads were spaced accordingly to specification. 19.5.2.2 All sprinkler heads were inspected for paint on 03/09/12 to insure there was no paint on other sprinkler heads. This STANDARD is not met as evidenced by: The administrator in-serviced the 42 CFR 483,70(a) maintenance director and the By observation on 3/8/12 at approximately noon maintenance department on 03/09/12 the following Heating, Ventilating, and Air regarding preventative maintenance Conditioning system (HVAC) was non-compliant; and inspection frequency of sprinkler specific findings include heads. This inspection will be conducted once weekly for three A. The HVAC system dld not shut down with fire weeks and then monthly for three menths and/or 100% compliance by alarm activation. the Maintenance Director. B. There was not an emergency shut down switch located at a readily observed stallon. C. The facility was using the corridor as a return air plenum. Note: If a walver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped : with smoke detectors. (2) There must be a complete corridor smoke detection system. (3)

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PRINTED: 03/10/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING. 03/08/2012 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET GRACE HEALTHCARE OF DURHAM DURHAM, NC 27705 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) The inspection results will be brought to and reviewed monthly in K 067 K 067 : Continued From page 4 our Quality Assurance Performance Smoke detectors must be wired to the fire alarm Improvement Committee by the system. (4) Fire alarm system must shut down Maintenance Director. The Quality Assumance Performance all air handling units when activated. Improvement Committee consists of NFPA 101 LIFE SAFETY CODE STANDARD K 069 K 069 the Administrator, the Director of Nucsing, Staff Development SS≍D Cooking facilities are protected in accordance Coordinator, MDS Coordinator, with 9,2.3. 19.3.2.6, NFPA 96 Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of This STANDARD is not met as evidenced by: Maintenance, Dietary Manager, and 42 CFR 483.70(a) the Activities Director. By observation on 3/8/12 at approximately noon the facility's cooking system was not protected in K067 accordance with NFPA 96 - Ventilation Control Simplex Grinnell evaluated the and Fire Protection of Commercial Cooking HVAC system on 03/19/12. Operations. The kitchen hood had grills that did not cover the length of the exhaust hood and did Simplex Grinnell will install not have a drip pan. relays and emergency shutdown K 072 NFPA 101 LIFE SAFETY CODE STANDARD K 072 button on 04/06/12 to ensure the HVAC system will shut down. SS=D Means of egress are continuously maintained free. We are requesting a waiver for K067 and submit the following,: of all obstructions or impediments to full instant Simplex Grinnell to install two use in the case of fire or other emergency. No smoke detectors in air handling units furnishings, decorations, or other objects obstruct on 4/6/12. exits, access to, egress from, or visibility of exits. There is a complete corridor 7.1.10 smoke detector system tied into the fire alacm system. Air handlers shut down upon activation of the fire system by installation of relays by simplex Grinnell on 4/6/12.

This STANDARD is not met as evidenced by: 42 CFR 483,70(a)

By observation on 3/25/09 at approximately noon the following means of egress was observed as noncompliant: specific findings include corridor door to storage room between exit #10 and the independent dining room swing into the corridor without a listed closure and the door does not

Facility ID: 923264

The fire slarm system will shut

down all air handling units when

activated, installation of smoke

detectors and relays on 4/6/12.

If continuation sheet Page 6 of 6

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B, WING \_\_ 03/08/2012 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET GRACE HEALTHCARE OF DURHAM DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX DATE TAG DEFICIENCY) TAG The maintenance director will test the emergency shutdown button to K 072 K 072 | Continued From page 5 ensure the HVAC system will shut down. swing 180 degrees but leaves a projection into This audit will be conducted weekly times two weeks, then monthly times two the corridor. NFPA 7.2.1.4,4 states during its months. The results of this audit will be swing, any door in a means of egress shall leave brought to and reviewed by the not less than one-half of the required width of an maintenance director in the monthly alsle, corridor, or landing unobstructed and shall Quality Assurance Performance not project more than 7 in. (17.8 cm) into the Improvement Committee meeting. The required width of an aisle, corridor, passageway, Quality Assurance Performance Improvement Committee consists of the or landing, when fully open. Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Reliabilitation Manager, Medical Director, Director of Social Services, Unvironmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. K 069 The facility maintenance director installed a stainless steel strip to cover to the length of the exhaust hood and drip pans were installed on each end on 03/15/12. The facility maintenance director reinspected the installation of the stainless steel strip and drip pans on 03/16/12 to insure all areas of kitchen hood/exhaust were covered. The administrator in-serviced the maintenance director and the maintenance department on 03/15/12 regarding preventive maintenance and inspection frequency of the kitchen hood.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING 03/08/2012 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET **GRACE HEALTHCARE OF DURHAM** DURHAM, NC 27705 (X6) COMPLETION PROVIDER'S PLAN OF CORRECTION ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The kitchen/exhaust hood will be inspected weekly times four weeks and then K 072 K 072 | Continued From page 5 monthly for two months and/or 100% compliance by the Maintenance Director. swing 180 degrees but leaves a projection into The inspection results of this audit will be the corridor. NFPA 7.2.1.4.4 states during its swing, any door in a means of egress shall leave brought to and reviewed by the maintenance director in the monthly not less than one-half of the required width of ar Quality Assumnce Performance aisle, corridor, or landing unobstructed and shall Improvement Committee meeting. The not project more than 7 in. (17.8 cm) into the Quality Assurance Performance required width of an alsle, corridor, passageway. Improvement Committee consists of the Administrator, the Director of Nursing, or landing, when fully open. Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director. K072 The adjustable door closures for the corridor door to storage room between exit # 10 and the independent dining room was installed on 03/09/12 by the Maintenance Director. All facility door closures were inspected by the Maintenance Director on 03/09/12. The administrator in-serviced the maintenance director and maintenance department on 03/09/12 regarding inspection frequency of door closures. All door closures will be inspected once weekly for three weeks and then monthly for three months by the Maintenance Director and/or 100% compliance. The inspection results will be brought to and reviewed monthly in our Quality Assurance Performance Improvement Committee by the Maintenance Director. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, illon sheet Page 6 of 6 Environmental Services, Director of Event ID: Y/UZ21 FORM CMS-2587 (02-99) Previous Versions Obsolete Maintenance, Dietary Manager, and the

Activities Director.

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