PRINTED: 01/10/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING ______ B. WING ______	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR EXTENDED CARE FACILITY	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

(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
F 000	INITIAL COMMENTS The facility was found to be in compliance with the Medicare/Medicaid Long Term Care regulations, 42 CFR part 483, subpart B during the recertification survey of 1/9/2013.	F 000		

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

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	345182	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR EXTENDED CARE FACILITY	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

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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 II construction, one story, without a complete automatic sprinkler system. The facility is aware of the August 2013 date for a complete sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K012 ***Corrective action for resident affected:*** The bead-board in the corridor and inside the sunroom will be coated with flame retardant paint; Fire hazard classification, ASTME-84 (NFPA 255), Class "A" Flame-spread rating. Has been ordered and should be in by 2-15-13.	2-22-13
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) By observation on 1/30/13 at approximately noon the following construction type was non-compliant, specific findings include, flame spread rating on the beadboard in the corridor and inside the sunroom could not be confirmed. East end.	K 012	***Corrective action to prevent recurrence for other potential residents:*** Add to PM program to recoat every 5 years. ***Measure put into place to ensure that deficient practice will not occur:*** Add to PM program to recoat every 5 years. ***Indicate how the facility plans to monitor its performance to make sure solutions are sustained:***	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is	K 018	The maintenance supervisor and safety director will monitor and report to QA every month.	2-4-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Yeomans
TITLE: Administrator
(X6) DATE: 2-8-13

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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	345182	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/30/2013

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K 018	Continued From page 1 no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/30/13 at approximately noon the following corridor door was non-compliant, specific findings include, a roller latch on the corridor door to the chapel.	K 018	***K018*** ***Corrective action for resident affected:*** Chapel door roller latch has been removed and replaced with cylindrical door handle latch. ***Corrective action to prevent recurrence for other potential residents:*** All doors have been inspected and no roller latches exist. ***Measure put into place to ensure that deficient practice will not occur:*** Check for door "Roller latch" has been added to regular door PM. ***Indicate how the facility plans to monitor its performance to make sure solutions are sustained:*** The maintenance supervisor and safety director will monitor PM completion to verify compliance.	2-1-13
K 038 SS=D	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) By observation on 1/30/13 at approximately noon the following exit access was non-compliant, specific findings include, east exit past physical therapy was not paved to a public way. This exit	K 038	***K038*** ***Corrective action for resident affected:*** This exit was returned back to a "not an exit" door with approval of Local Fire Marshall.	

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K 038	Continued From page 2 was previously identified as not and exit.	K 038	***Corrective action to prevent recurrence for other potential residents:*** No monitoring required due to Local Fire Marshall approval to remove as an exit.	