MAR U & 2013

PRINTED: 02/28/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	ED
		345297	B. WING _		1	C <b>0/2013</b>
	OVIDER OR SUPPLIER		s	REET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE CORRECTIVE ACTION SHOU REFERENCED TO THE AP DEFICIENCY)	LD BE CROSS- PROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
F 248 SS=D	complaint investigation Event #BFRB11.  483.15(f)(1) ACTIVIT INTERESTS/NEEDS  The facility must proof activities designed the comprehensive at the physical, mental, of each resident.  This REQUIREMENT by: Based on observation interviews, the facility for a resident (resident sampled residents. From Resident #49 was addiagnosis of adult fail Minimum Data Set (Authat resident #49 requirements)	vide for an ongoing program to meet, in accordance with ssessment, the interests and and psychosocial well-being is not met as evidenced in, record review and staff failed to provide activities in the staff failed to provide activities in the sinclude:  mitted 10/5/10 with the ure to thrive. The quarterly IDS) dated 2/8/13 indicated dired total assistance for all ly living (ADL) and had	F 24	AD is performing an activity evaluation/assessment with upon admission (see "Activattached) by day 14. This eincludes resident preference patterns as well as physical psychosocial evaluation. A "Activity Interest Survey" (seeing completed by AD in fluid with the resident to delopindividualized and person a activity plan. This is reflectives identicate plan.  AD is maintaining for each in "Individual Resident Activities and be a manifer and activity attached) to manifer and activity attached to a	n each resident ity Evaluation" valuation es and pursuit , cognitive, and formalized see attached) is arther interview the ppropriate ed in the resident an ies" log (see	
ABORATORY	#49 remained on hos attend activities due to that she was able to awhile but tired easily son and daughter in I monthly activity caler. There was no eviden resident #49 about he	I 5/21/12 stated that resident pice care and unable to o her pain. The note stated olerate talking once in the noted stated that her aw came everyday to visit. A oldar was posted in her room. It is to state that AD spoke with the ractivity preferences.	E	attached) to monitor and a participation. Special attengiven to bedridden and cog impaired residents to assurappropriate activities are of ducted. All residents are bettiev would like to leave the opportunity to do so is being the composition of the compositio	tion is being nitively e that ffered and con- eing asked if eir room and	(X8) DATE

Clarul Litchfood

administrator

03/04/13

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIF	PLE CONSTRUCTION	(X3) DATE SUR	
ANDFLANO	CORRECTION	IDENTIFICATION NUMBER.	A. BUIL	DINO.			
		345297	B. WIN	G		1	0/2013
	ROVIDER OR SUPPLIER		·	2	REET ADDRESS, CITY, STATE, ZIP CODE 2000 ELM DRIVE LAURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F 248	A review of resident a 8/22/12 in the Care A indicated that resider mood and psychosociack of activity particilack of activity to participe than personal choice.  A activity note dated #49 continued to stay services continued. The last evidence that activity for the made at the time.  The last evidence that #49 is activities prefered and that she was activity note resident #49 was still Resident #49 was in stopped in daily. The #49 would talk if awas the activity director was resident #49 was jugactivities."  On 2/18/13 at 12:40 jugactivities."	d49 's annual MDS dated area Assessment (CAA) at #49 triggered for activities, cal well being related to her pation. The rationale for the pation indicated that resident esident and that she where her needs were met ars. Activities was not care to e CAA because resident #49 ate due to end of life rather for exclusion.  8/22/12 stated that resident in bed and that hospice the family and grandchildren aften. The staff continued to resident and no changes  at the AD reviewed resident therences was 8/29/12. The ant #49 continued to stay in	i	248	Resident refusal or change of mindocumented on the Individual Reseascessment of evaluation and survey will be conducted by AD owith resident upon re-admission, annually, and on significant chan Changes will be reflected in indiversident care plan and in QA report AD has revisited resident #49 and completed reassessment as detain DON and Resident Services Direct conduct monthly activity audits in March 2013 for at least 6 months assure procedures are being followed in the control of the conduct months.  Corrective action implemented:	interest one on one , quarterly, ge. ridual orting. d iled above. stor will beginning ths to owed for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	COMPLETI	ED
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	OVIDER OR SUPPLIER	•		2:	EET ADDRESS, CITY, STATE, ZIP CODE 200 ELM DRIVE AURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
F 248	aide was not engaging resident #49 but rath assisting resident #40 On 2/18/13 at 4:25 probserved in her room. There was not televing Resident #49 appearoused. Resident #40 experiencing any part when she had been #49 stated she would room if possible.  On 2/19/13 at 945 at in her room lying on closed. She was eas pain and expressed playing in the room. Watching the televising what she was watch was not watching it to was on.  On 2/19/13 at 3:30 problems on the stated she did not ke regarding who attent wrote a note in the more included 3 activity note at the stated she did not be regarded in the room. The would benefit resident attended are included 3 activity note in the room. The would benefit resident resident attended in the room. The would benefit resident resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room. The would benefit resident attended are included 3 activity note and the room attended at	ng in conversation with er watching television while	F	248			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIP	PLE CONSTRUCTION	(X3) DATE SUI	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	.DING	·	COMPLET	ED
			B. WIN	G		1	С
		345297		·		02/2	0/2013
	ROVIDER OR SUPPLIER			22	EET ADDRESS, CITY, STATE, ZIP CODE 200 ELM DRIVE AURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE ( REFERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X6) COMPLETION DATE
F 248	verify any one on one activities with resider provide any evidence were done or taken to that the family visited On 2/19/13 at 345 pm (DON) stated that resident #4 On 2/19/13 at 3:50 pm unaware if resident #4 her room for any activity attendance or attempattend any out of room On 2/19/13 at 5:00 pm awareness that there activity notes to verificate and church seed on 2/19/13 at 9:00 at the weekends she ware sident #49 up to a side of the sident did not appear to sit at the nurses stresident did not appear to be sleeping but was on and playing to be sleeping but was activity calendar was room but resident #49 up to a sident was on and playing to be sleeping but was activity calendar was room but resident #49 up to a sident #49 up to a sident did not appear to be sleeping but was on and playing to be sleeping but was activity calendar was room but resident #49	e activities or out of room at #49. The AD was unable to a that any in room activities o resident #49. She stated resident #49 often.  In, the director of nursing sident #49 was on hospice ay. The DON stated it was 49 to get out of bed.  In, nurse #1 stated she was 49 ever got up or was out of vities .Resident #49 she to get out of bed and leave she enjoyed listening to rvices.  In, the DON stated were no activity logs or v attendance of any activity at to get resident #49 to m activity.  In, nurse #2 stated that on orks she has the staff get reclining chair if only briefly ation. Nurse #2 stated, ar to be in pain and tolerated iods	F.	248			

NAME OF PROVIDER OR BUPPLIER SCOTIA VILLAGE-SINF  SUMMARY STATEMENT OF DEFICIENCIES PREPER GRAPH OF PROVIDER SUMMARY STATEMENT OF DEFICIENCIES PREPER GRAPH OF PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREPER TAG  SUMMARY STATEMENT OF DEFICIENCIES PREPER GRAPH OF PROVIDER OF THE APPROVING INFORMATION TAG  PROVIDER OF THE APPROVING PROPERTY OF THE APPROVING INFORMATION TAG  F 248  Continued From page 4 On 2/20/13 at 11:50 am, the DON stated her expectation for cellvilles for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity be considered or offered.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  SCOTIA VILLAGE-SNF  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248  Continued From page 4 voiced interest in music and religious services.  On 2/20/13 at 11:50 am, the DON stated her expectation for activities for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity  STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352  PROVIDER'S PLAN OF CORRECTION (EACH PROPISION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 248  F 248  STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352  F 248  PROVIDER'S PLAN OF CORRECTION (EACH PROPISION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 248  F 248  On 2/20/13 at 11:50 am, the DON stated her expectation for activities for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity							С
SCOTIA VILLAGE-SNF  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248  Continued From page 4 voiced interest in music and religious services.  On 2/20/13 at 11:50 am, the DON stated her expectation for activities for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity			345297	B. WING		o:	
F 248  Continued From page 4 voiced interest in music and religious services.  On 2/20/13 at 11:50 am, the DON stated her expectation for activities for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity					2200 ELM DRIVE		
voiced interest in music and religious services.  On 2/20/13 at 11:50 am, the DON stated her expectation for activities for bedridden residents was for them to be offered to attend but a refusal should be documented and an alternate activity	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI)	CORRECTIVE	ACTION SHOULD BE CROSS- ED TO THE APPROPRIATE	(X5) COMPLETION DATE
	F 248	On 2/20/13 at 11:50 a expectation for activit was for them to be of should be documented.	sic and religious services.  am, the DON stated her  iles for bedridden residents fered to attend but a refusal and an alternate activity	F 2	48		

		AND HUMAN SERVICES  & MEDICAID SERVICES	8	· ·	ORM APPROVED 3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X 01 - BUILDING 0104	3) DATE SURVEY COMPLETED
		345297	B. WING		03/19/2013
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 200 ELM DRIVE APR 0 8 2013	W
SCOTIA	VILLAGE-SNF		1 .	AURINBURG, NC 28352	4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  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 APPROPRIA DEFICIENCY)	COMPLETION DATE
K 000	INITIAL COMMENT	rs .	K 000		
	conducted as per T at 42 CFR 483.70(a Health Care section publications. This fe	ode (LSC) survey was he Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced acility is Type II protected s equipped with an automatic			•
K 029 SS=E	One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prothe approved autonoption is used, the other spaces by sm doors. Doors are sfield-applied protect	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 029		±
	Based on the obse on 3/19/2013 the for observed as nonco include: Nursing A- now a storage roon	s not met as evidenced by: ervations and staff interviews flowing Life Safety item was mpliant, specific findings dministration Room is also in greater than 100 square feet. by not equipped with a door		One hour fire rated door with self-closure ordered, to be installed no later than 04/30/13. In-servicing f staff will be conducted prior to 04/30/13 concerning requirement that door remains closed and unobstructed. Spot checks will be conducted for 2 weeks (through 05/10/13) to assure compliance.	or
	OBRECTOR'S OR PROVIE Will Litel	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	Gaministrato e	04/05/13
<u> </u>	www / jack	yer bring			of the section of the me

uny 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 allowing 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued and plans of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction is requisited to continued an approved plan of correction and correction approved plan of correction and correction are corrected and correction approved plan of correction and correction are corrected and correction are corrected and correction and correction are corrected and corrected and correction are corrected and corrected and correction are corrected and rogram participation.

Facility ID: 923445

PRINTED: 03/25/2013

DEPART CENTER	TMENT OF HEALTH	AND HUMAN SERVICES			ON	FORM MB NO.	03/25/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE	E CONSTRUCTION 01 - BUILDING 0104	(X3) DATI COM	E SURVEY PLETED
		345297	B. WING	·		03/	19/2013
	ROVIDER OR SUPPLIER VILLAGE-SNF			22	EET ADDRESS, CITY, STATE, ZIP CODE 200 ELM DRIVE AURINBURG, NC 28352		
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TATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION - BUILDING 0204		(X3) DAT	E SÜRVEY MPLETED
	·	345297	B. WING	·			03/	19/2013
	ROVIDER OR SUPPLIER			220	ET ADDRESS, CITY, STATE, ZI DELM DRIVE JRINBURG, NC 28352	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROP	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	TS .	K	000				*
	conducted as per T at 42 CFR 483.70(a Health Care section publications. This fa	ode (LSC) survey was he Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced acility is Type II protected s equipped with an automatic						
	There were no Life noted during the su	Safety Code Deficiencies rvey in this bullding.						•
	CFR#: 42 CFR 483	3.70 (a)						
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					which re-	·		(X6) DATE
_	aucl Litch	ERISUPPLIER REPRESENTATIVE'S SIGN LOND	IATURE		Administrato	U		X6) DATE Y/05/13

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If continuation sheet Page 1 of 1

PRINTED: 03/25/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARD & MEDICAD SERVICES STATEMENT OF DEPOENDES A BUILDING 939 401 BUILDING 93 401 BUILDI	DEDAR	TMENT OF HEATTH	LAND HIMAN SERVICES			Р		03/25/2013
STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION  A SUBJECTION A BUILDING 93-8 BUILDING 93-94  STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURIBURG, NO. 28:352  PART OF PROVIDER SUMMARY STATEMENT OF DEFICIENCIES REQUIZATORY OR LSC IDENTIFYING INFORMATION)  K 000  INITIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and lits referenced publications. This facility is Type II protected construction, and is equipped with an automatic sprinkler system.  There were no Life Safety Code Deficiencies noted during the survey in this building.  CFR#: 42 CFR 483.70 (a)  BORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE  TITLE  OVER DEFICIENCY  STREET ADDRESS, CITY, STATE, ZIP CODE 200 PROVIDERS CITY, STATE, Z								
NAME OF PROVIDER OR SUPPLIER  SCOTIA VILLAGE-SNF    SUMMAPY STATEMENT OF DEPICENCIES   LAURINBURG, NC 28352	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DAT	TE SURVEY MPLETED
SCOTIA VILLAGE-SNF    XO   ID   PREFIX   CAUGI DEPOSITION MUST BE PRECIDED BY FULL TAGE   TAGE   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED AS A PROVIDER PLAN OF CORRECTION SHOULD BE CROSS REFERENCE ACTION SHOULD BE CROSS REF			345297	B, WING	<b>}</b>		03	/19/2013 -
SCOTIA VILLAGE-SNF  (KO) JUNITIAL COMMENTS  TAG  INITIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction, and is equipped with an automatic sprinkler system.  There were no Life Safety Code Deficiencies noted during the survey in this building.  CFR#: 42 CFR 483.70 (a)	NAME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		· · ·
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000  INITIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II protected construction, and is equipped with an automatic sprinkler system.  There were no Life Safety Code Deficiencies noted during the survey in this building.  CFR#: 42 CFR 483.70 (a)	SCOTIA	VILLAGE-SNF				•		
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noted during the survey in this building.  CFR#: 42 CFR 483.70 (a)  BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X8) DATE	ė.	conducted as per T at 42 CFR 483.70(a Health Care section publications. This fa construction, and is	he Code of Federal Register ); using the 2000 Existing of the LSC and its referenced cility is Type II protected	·				
		noted during the sur	vey in this building.					•
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Claret & fischford Gaministrator 04/05/13			<i>y</i> .	ATURE			-	, 1
	<u> </u>	ortel Sitchy	land			administrator	0	4/05/13

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Facility ID: 923445

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**DRM CMS-2567(02-99) Previous Versions Obsolete** 

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 04 - BUILDING 0404	CO	MPLETED
		345297	B. WING		03	/19/2013
	PROVIDER OR SUPPLIER VILLAGE-SNF		·	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 ELM DRIVE LAURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	(X5) COMPLETIO DATE
K 000	This Life Safety Co	de (LSC) survey was	K 00	00		
	at 42 CFR 483.70(a Health Care section publications. This fa construction utilizing	he Code of Federal Register ); using the 2000 Existing of the LSC and its referenced cility is Type II protected y North Carolina Special ts, and is equipped with an system.				A contract of the contract of
K 147 SS=E	Electrical wiring and	.70 (a) FETY CODE STANDARD equipment is in accordance onal Electrical Code. 9.1.2	K 14			
	Based on the obser on 3/19/2013 the foli observed as noncon include: The Facility range in the secured facility properly locked	not met as evidenced by: vations and staff interviews lowing Life Safety item was appliant, specific findings Did not have the restorative I unit kitchen area of the ed out to prevent accidental ge. The door to that area was position by a chair.		In-servicing for all nursing state concerning requirement that kitchen not be open or obstrution closing will be conducted to 04/30/13. Daily monitoring in-servicing will be conducted administrator for 2 weeks (thr 05/10/13) to assure compliance.	door to cted d prior g after by ough	
	CFR#: 42 CFR 483.	70 (a)				
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ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued organ participation.

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BFRB21

Facility ID: 923445

If continuation sheet Page 1 of 1