<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>000</td>
<td>F</td>
<td>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities recertification and complaint investigation survey conducted on 3/28/13.</td>
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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.
**Autumn Care of Raeford**

**K 000 Initial Comments**

Surveyor: 27871
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 building is Type III (211) construction, one story, with a complete automatic sprinkler system. Facility is using NC: special locking system.

The deficiencies determined during the survey are as follows:

**NFP 101 Life Safety Code Standard**

One hour fire rated construction (with 3 hour fire-rated doors) of 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.

This STANDARD is not met as evidenced by:
Surveyor: 27871
Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to dry storage room in kitchen was being blocked from closing, from boxes. Also, main entrance door to kitchen was not closing.

**K 029**

On 5-3-2013, a box was found on the shelf blocking the door from closing in the dry storage room. This box was removed immediately upon discovery. All dietary staff was in-service on 5-13-2013 regarding not blocking door with any object.

To ensure ongoing compliance, the Food Service Director or her designee will audit the dry storage room daily for 4 weeks to ensure there is no object blocking the door from adequately closing. If substantial compliance is found, daily laboratory directors or provider/supplier representatives' signature.

**Conclusion Date**

Dannell Yate 5/17/13
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<th>ID</th>
<th>Prefix</th>
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<th>Summary Statement of Deficiencies</th>
<th>(X3) Date Survey Completed</th>
<th>(X5) Completion Date</th>
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<td>K 029</td>
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<td>42 CFR 483.70(a)</td>
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<tr>
<td>K 030</td>
<td>SS=E</td>
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<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<td>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1</td>
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<td>This STANDARD is not met as evidenced by: Surveyor: 27871</td>
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<td>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey staff was not knowledgeable of emergency release switch located on corridor.</td>
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<td>K 052</td>
<td>SS=E</td>
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<td>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</td>
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will continue to be conducted during periodic kitchen rounds conducted by the Food Service Director or Administrator to ensure on-going compliance.

The results of these audits and areas of concern will be discussed with Administrator in morning meeting each Friday for four weeks for monitoring purposes.

On 5-3-2013, the main entrance door to the kitchen was not closing and latching correctly. This was repaired by the Maintenance Director on 5-9-2013.

To ensure on-going compliance, the door will be tested weekly for 4 weeks. If substantial compliance is found, weekly monitoring will be discontinued.

For monitoring purposes, the Dietary Manager will report the weekly checks every Friday for 4 weeks to the Administrator in morning meeting.

K 038
On 5-3-2013, a staff member were questioned about the emergency release switch was not knowledgeable of its purpose. This was corrected immediately by In-servicing staff. Remaining staff was In-serviced over the following several days.
**Autumn Care of Raeford**

**K 052** Continued From page 2

This STANDARD is not met as evidenced by: Surveyor: 27871

Based on observations and staff interview at approximately 6:30 am onward, the following items were noncompliant, specific findings include: horn was not working on horn/strobe device on 500 hall at time of survey.

42 CFR 483.70(a)

NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1

**K 081**

42 CFR 483.70(a)

NFPA 101 LIFE SAFETY CODE STANDARD

This STANDARD is not met as evidenced by: Surveyor: 27871

Based on observations and staff interview at approximately 6:30 am onward, the following items were noncompliant, specific findings include: tamper #23 did not send signal to fire alarm control panel when tested.

**K 087**

42 CFR 483.70(a)

NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

**K 052**

Purpose of the emergency release switch will be discussed with all staff immediately following the next three fire drills on each shift. If substantial compliance is found, discussion of the emergency release station will return to a periodic basis.

Discussion of the emergency release stations following every fire drill will be reported to the Administrator at the Quarterly QA meetings.

**K 061**

On 5-9-2013, the strobe that had been found defective was serviced and repaired so that it flashed appropriately.

To ensure on-going compliance, the fire alarm system will be tested weekly for 4 weeks. If no deficiencies are found during weekly testing, we will return to regular quarterly testing on each shift.

Findings of weekly testing will be reported to the Administrator during morning meeting on Fridays for monitoring purposes.

**K 067**

On 05-09-2013, tamper switch #23 was serviced and repaired so that it appropriately sends signal to fire alarm control panel when tested.
**Autumn Care of Raeford**

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<th>K 067</th>
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This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: return fire/smoke dampers in facility have excess lent on them.

42 CFR 483.70(a)

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<th>K 067</th>
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<td>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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To ensure on-going compliance, tampers will be checked weekly for 4 weeks. If no deficiencies are noted, regular quarterly testing of system each shift will resume.

Results of the weekly testing of the tamper switch will be discussed with Administrator each Friday in morning meeting.

K 067
On 5-10-13 all dampers in facility were cleaned.

To ensure on-going compliance, Maintenance Director or his designee will clean dampers monthly. A cleaning schedule has been made as a means of documenting when dampers are cleaned.

For monitoring purposes, the Maintenance Director will report to Administrator every time the dampers are cleaned and turn in the damper cleaning schedule monthly for 3 months. If substantial compliance is found, results of monthly damper cleaning will return to being discussed with Administrator at the Quarterly QA meeting.