(N. 3 0 2013

PRINTED: 07/19/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345363	B. WNG _		07/11/2013
NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HAWFIELDS			**	STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION DATE
F 253 SS=D	The facility must promaintenance services anitary, orderly, and This REQUIREMENT by: Based on observative record reviews the repair items necess common use shows shower room) and in (A-17; C-3). The firm on 07/08/2013 and it conducted. During observations were the resident room Awall socket under the observed to be looselectrical box by 1 easily seen due to to the bed (A bed) observed lying on the next to window. In the bathroom of resident's toilet was running.	ovide housekeeping and es necessary to maintain a ad comfortable interior. It is not met as evidenced ions, staff interviews, and facility failed to identify and/or eary for resident use in 1 of 2 er rooms (C hall common use in 2 of 66 resident rooms indings include: Initial tour of the facility was the tour the following made: If the air conditioning unit 's he A/C unit and window was see and hanging from the escrew - the socket wires were the hanging socket. A wheel hext to the room's door was he unoccupied bed (B bed) resident room C-3 the sobserved to be continuously	F 2		Hawfields of the ies and correction to mary of orrect and in pliance with rovisions of dents. The abmitted as a compliance. Hawfields ment of of correction ment with the ies nor does sion that any Further, Hawfields of ute any ement of
	the C hall the center operational. An intail aid in the bath/sho	amon use bath/shower room on er shower stall was not erview was conducted with the wer room. The aid indicated d not worked in a long time		dispute resolution, for and/or other administr procedures.	l

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.

7/25/2013

Facility ID: 923499

PRINTED: 07/19/2013 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 SL COMPLE	
	345363	B. WNG _		07/11	/2013
NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HA	AWFIELDS	5	STREET ADDRESS, CITY, STATE, ZIP COE 2502 S NC 119 MEBANE, NC 27302	DE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation record reviews the fact repair items necessar common use shower shower room) and in (A-17; C-3). The find On 07/08/2013 an initic conducted. During the observations were maintenance in the conducted of the observed to be loose electrical box by 1 scensily seen due to the tothe bed (A bed) need to the observed lying on the observed lying on the next to window. In the bathroom of regressident's toilet was conducted to the conducted in the center operational. An internal in the bath/shower in the conducted in the conducte	ide housekeeping and a necessary to maintain a comfortable interior. is not met as evidenced ans, staff interviews, and cility failed to identify and/or by for resident use in 1 of 2 arooms (C hall common use 2 of 66 resident rooms ings include: Itial tour of the facility was be tour the following ade: If the air conditioning unit 's and hanging from the rew - the socket wires were be hanging socket. A wheel ext to the room's door was a unoccupied bed (B bed) Isident room C-3 the observed to be continuously and use bath/shower room on	F 2	Presbyterian Home of will continue to striv facility's wall socket working order, the R are not continuously shower stalls all are and beds with all who All in-house Resider continue to have their housekeeping and m services met to inclus sockets are securely wall, all wheels attackeds, toilets not contrunning and all issue repaired except show Shower stall part has Air conditioners, was also be checked more routine maintenance. Since all in-house rethe potential to be in issue, the RNC's, Do Maintenance Depart Housekeeping Depart designee will conductive of all concern retraining session for	of Hawfields the to ensure the sare in the esidents' toilet trunning, the operational the eels attached. In this will the entry aintenance de wall the entry attached to the en	/25/2013 Except for shower that will be impleted by /08/13

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

Facility ID: 923499

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) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	SURVEY PLETED
		345363	B. WNG		07.	/11/2013
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 253	cracked or broken p no signage indicatin out of order. Multiple during 07/08/2013 a bringing residents ir room conducting resident. On 07/09/2013 at 1 were re-observed: In resident room A- wall socket under th observed to be loos electrical box by 1 s still easily seen due wheel to the bed (A was observed to be bed (B bed) next to in the bathroom of a resident's toilet was continuously runnin In the resident com the C hall the cente operational and the the shower stall wa On 07/10/2013 at 4 were re-observed: In resident room A- wall socket under th observed to be loos electrical box by 1 still easily seen due wheel to the bed (A was observed to be bed (B bed) next to bed (B bed) next to	as an issue with either ipes in the wall. There was g the center shower stall was e observations were made and aids were observed ato and out of the bath/shower sident daily baths/shower. 1:15 a.m. the following areas 17 the air conditioning unit's are A/C unit and window was are and hanging from the screw - the socket wires were to the hanging socket. The bed) next to the room's door estill lying on the unoccupied window. The sobserved to still be g. The was no signage to indicate is out of order. 1:20 p.m. the following areas 17 the air conditioning unit's are A/C unit and window was see and hanging from the screw - the socket wires were at the hanging socket. The bed) next to the room's door as till lying on the unoccupied window was see and hanging from the screw - the socket wires were at the hanging socket. The bed) next to the room's door as till lying on the unoccupied	F 28	request slip.	be used for times a week iewed at ON, RNC view the QA onth for three the action	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345363	B. WING			07/1	1/2013
	OVIDER OR SUPPLIER	IAWFIELDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	L	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	resident's toilet was continuously running in the resident commithe C hall the center operational and ther the shower stall was On 07/11/2013 at 7: were re-observed: in resident room A-1 wall socket under the observed to be loose electrical box by 1 s still easily seen due wheel to the bed (A was observed to be bed (B bed) next to in the bathroom of resident's toilet was continuously running in the resident commithe C hall the center operational and their the shower stall was On 07/11/2013 at 8: were observed with manager. In resident room A-1 wall socket under the observed to be loose electrical box by 1 s (A bed) next to the religious on the unoccu window. The maint the wheel was off odoor. In the bathrood operation in the bathrood of the pathrood of the	observed to still be non use bath/shower room on shower stall was still not e was no signage to indicate out of order. 15 a.m. the following areas 7 the air conditioning unit's e A/C unit and window was e and hanging from the crew - the socket wires were to the hanging socket. The bed) next to the room's door still lying on the unoccupied window. esident room C-3 the observed to still be g. mon use bath/shower room on r shower stall was still not re was no signage to indicate	F	253			

CENTER	OT ON MEDIOMINE &	MEDIO AD CEITATOLO					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		345363	B. WNG		and the second s	07	/11/2013
	OVIDER OR SUPPLIER	IAWFIELDS		2502	T ADDRESS, CITY, STATE, ZIP CODE		
				MEE	BANE, NC 27302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IÓ PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 253	indicated the tank's findicated the water to resident's common upon to the center should be composed in the center should be composed in the center should be cause it is shower would not be manager could not see the cause it is shower would not be caused to the center of the cause it is shower would not be caused to the cause it is shower would not be caused to the cause it is shower would not be caused to the cause it is shower would not be caused to the cause it is shower would not be caused to the caused to the cause it is shower would not be caused to the cause of the cause of the caused to th	e 3 The maintenance manager lapper valve may be leaking continuously run. In the use bath/shower room on the ower stall was observed to be a maintenance manager own about the shower not year. The maintenance me wall would have to be the pipes in the wall and he was too costly to repair the explain why there was no he shower stall was closed	F	253			
	conducted with the f manager. The main to explain the mainte something was obse needing repair. The indicated the facility each nursing station facility's staff would issue was found or of maintenance to repair manager indicated to would place the fille in the maintenance. The maintenance maintenance maintenance manageneeded parts to con- notify the administration the items needed con-	45 a.m., an interview was acility's maintenance tenance manager was asked enance process when erved or found by staff maintenance manager had blank work orders at (A/B hall and C/D hall). The fill out a work order when an observed that required air. The maintenance he facility's staff member dout work order request form box at the nursing station. anager indicated he would veral times a day and retrieve conduct the repairs. The ger indicated if the repair applete the work he would alter and defer the repair so ould be ordered and received.					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345363	B. WNG			07/11/	/2013
• • • • • • • • • • • • • • • • • • • •	OVIDER OR SUPPLIER	HAWFIELDS		250	ET ADDRESS, CITY, STATE, ZIP CODE 2 S NC 119 BANE, NC 27302		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 253	completed and the value of the observed iter common use bathromanger indicated orders to be completed). The masked if he had known eeding repair exceptably or by work asked if he had known eeding repair exceptably or by work of the observed iter common use bathromanager indicated	v all work orders that were not inducted with the facility's ger. The maintenance he had no outstanding work sted (all work requested order request were aintenance manager was wn about the items observed to maintenance manager know about any of the things bet the C hall's common use shower that was broken but the maintenance manager have any work orders for any mis including shower stall in the form. The maintenance that since he was told it would pair the shower he never filled	F	253			
	conducted with the concerning the info hall being too costle indicated the show bathroom was need	:35 p.m. an interview was facility's administrator rmation of the shower in the C y to repair. The administrator er in the C hall common use ded by the staff to conduct ents showers) and was going			<u>F441</u>	08	/08/2013
F 441 SS=D	483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Plants afe, sanitary and control Plants afe, sanitary afe, sanitary afe, sanitary and control Plants afe, sanitary	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission	F	441	Presbyterian Home of Hawfield will continue to strive to ensure residents are provided a safe, sanitary and comfortable environment and to help preventhe development and transmissi	e the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	CONSTRUCTION	COMPLETED		
		345363	B. WNG		07/11/2013		
	OVIDER OR SUPPLIER	HAWFIELDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 441	Program under which (1) Investigates, corn in the facility; (2) Decides what proshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infective determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will tr (3) The facility must hands after each din hand washing is incorposessional practic (c) Linens Personnel must hand	Program sablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 441	of disease and infection. Since all Residents have the potential to be include in thi RNC's, MDS Coordinator, and DON will conduct a retraining session on all employees and visual review of employees entering an isolation room by Presbyterian Home of Hawf staff and visitor to ensure Is Precautions are being follow. A QA Audit Tool will be use three (3) times per week for month and reviewed at least weekly by the DON, Administrator, and/or designed QA Committee will review Action Plan once a month for (3) months and revise the action plan to ensure continued compliance. Nurse #1 was reeducated and counseled.	is issue; and/or ing d a by fields olation ved. sed one t nee. the QA or three etion		
	by: Based on observa record reviews the	NT is not met as evidenced tions, staff interviews, and facility failed to follow Contact as for 1 of 4 residents (resident					

TATEMENT O	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	,	B. WNG			0	7/11/2013
	OVIDER OR SUPPLIER	345363	1	2502 S	DDRESS, CITY, STATE, ZIP CODE NC 119 NE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ԾՄՐԹ ℞⊨	(X5) COMPLETION DATE
F 441	The Presbyterian Ho Initiating Transmission and procedure revision page 35: Transmission Based when there is reason has a communicably Transmission based Contact Precaution Airborne Precaution 1. If a resident is such aving a communication Charge Nurse or Northe Infection Control Control Sased Food and the Attending Transmission Based Food and the Control Coordinates should occur after discontinuation are 5. When Transmission and 5. When Transmission implemented, the (or designee) shall notice on the room front of the resident will be aware of proposition of the resident will be aware of proposition about room. Resident #5's charted 15/13/2013 documents of the resident will be aware of propositive for Edated 15/13/2013 documents of the resident will be positive for Edated 15/13/2013	ation. The findings include: ome of Hawfields - Isolation - on Based Precautions policy and August 2007 read in part d Precautions will be initiated on to believe that a resident e infectious disease. d Precautions may include s, Droplet Precautions, or ons. uspected of or identified as eable infectious disease, the ursing Supervisor shall notify of Coordinator and the g Physician for appropriate precautions. ased Precautions will remain in onding Physician or Infection or discontinues them which pertinent criteria for	F	441	ilty ID: 923499	le actions	tion sheet Page 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTM	ENT OF REALITION	MEDICAID SERVICES					SURVEY	
	F DEFICIENCIES	I AN PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD!	ING .				
		345363	B. WNG			07/	11/2013	
		L		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	OVIDER OR SUPPLIER				2502 S NC 119			
THE PRES	BYTERIAN HOME OF H	IAWFIELDS		L	MEBANE, NC 27302	DECTION	(X5)	
(X4) ID PREFIX TAG	ALL DECIOIENT	(ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΉX	PROVIDER'S PLAN OF COR- (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION	
F 441	lab report. Sampled Contact Isolation proplaced on the resident #5 was on and staff will wash heartering the room a	I resident # 5 was placed on ecautions and signage was ent's door indicating sampled Contact Isolation Precautions nands and glove prior to nd if there is the possibility of a the resident or the bed, and		: 44				
	o7/10/2013 at 8:35 medication pass was hall with nurse # 1. resident # 5's medi resident #5 was on signage on the resident will wash hand the room and if the contact with the reresident's items, a was observed to exashing her hand observed to make resident's bed with changing the resident's bed and she leaned over the control unit and o observed to contact with her arms as towards the wall placing the medications the rediginister events.	a.m. an observation of a as conducted on the facility's B While nurse #1 prepared cation it was also observed contact precautions per the ident's door (Contact Isolation, it is and glove prior to entering it is the possibility of making sident or the bed, and gown will be worn). The nurse inter the resident's room after and gloving. The nurse was made contact with the interies and arms while lent's head of bed (HOB) is ed's electronic controller laying de of the bed, making contact sheets/blanket with her legs as the bed to pick up the electronic perate it. The nurse was also act the resident's bedside table she moved the table back to provide more room and cations and cup of water on the inistering the resident's period to the resident's purse was observed to room to the resident by leaning						
	aver and touchin	g the bed and the resident's left th her scrubs (clothing) and right						
					Facility ID: 923499	If continuation	n sheel Page 8	

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		345363	B. WING			07/11/2013	
	OVIDER OR SUPPLIER			2502	ADDRESS, CITY, STATE, ZIP CODE S NC 119 ANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 441	arm. The nurse was room and indicated administer the reside. The nurse then re-e with the liquid medic hands and gloving. a 2nd time contactin legs while she re-act resident's bed via th nurse then leaned contacting the bed from the cup with the An interview was contact lisolation plant the observation pass to resident #5 indicated she was gown when in the recontact with the resident the facility's protocols with resident why she diprecautions. On 07/10/2013 at made with resident ma	s then observed to exit the she had forgotten to ent her liquid medication. Intered the resident's room cation only after washing her Nurse #1 leaned over the beding the resident's bed with her dijusted the elevation of the ne electronic control unit. The over the resident's bed so the resident could drink ne liquid medication. Inducted with nurse #1 on a.m. concerning resident #5's recaution signage on the door not of her during the medication is Nurse #1 acknowledged and supposed to be wearing a room as she was making sident, the resident's bed, and enurse indicated she had a Contact Isolation precaution dent #5 and may have clothing. The nurse could not do not follow the contact 10:31 a.m. phone contact was at #5's Attending Physician	F	441			
	physician indicate result on 05/13/20 she contacted the coordinator on 07, have resident # 5' testing to see if the	sident's Contact Isolation. The d the resident had a positive lab of 3. The physician indicated facility's A/B hall unit 1/05/2013 and gave orders to be urine re-collected and sent for the resident could be taken off of ons. The physician indicated					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING) C	OMPLETED
		345363	B. WNG			07/11/2013
	NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HAWFIELDS			2502	TADDRESS, CITY, STATE, ZIP CODE 2 S NC 119 BANE, NC 27302	
(X4) ID PREFIX TAG	(EACH DESIG	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	interview and the Contact Isolation collected, tested An interview was Nursing (DON) of concerning his efollow the facility Precautions signentrance doors. facility's Infection expectations we infection control procedures, and the resident's roinformation to reamong the facilitindicated nurse prior to entering making contact resident, reside which may have 483.70(f) RESII ROOMS/TOILE. The nurses' staresident calls the from resident refacilities. This REQUIRE by: Based on obset	ived any results as of the resident was to remain on precautions until the urine was and results were received. Is conducted with the Director of on 07/10/2013 at 10:55 a.m. expectations of facility staff to respect to on the process of the proc		441	F-463 Presbyterian Home of Hawfields will continue to strive to ensure the call light system works properly. Since all Residents have the potential to be included in this issue; the RNC's, Housekeeping Department, Maintenance Department, and/or designee will conduct an inspection of the call bells in order to assure they work properly. The call light system in the shower room (C-Hall commo	1
	repair call light	the facility failed to identify and/or systems necessary for resident ommon use shower rooms (C hall			use shower room) and Residents' room (A-12) have been repaired.	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		(X3) DATE SURVEY COMPLETED
345363	B. WNG		07/11/2013
•		2502 S NC 119	DE
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
ower room) and in 1 of 66 (A-17). The findings include: an initial tour of the facility was ing the tour the following are made: A-17 room's call light button/cord oiled up on the night stand by the light button cord had exposed and the cord's plug piece was wall socket and had a hole where should be attached. common use bath/shower room on sobserved that the call light button nower stall was not operational, as conducted with the aid in the om. The aid indicated the call light enter shower stall had not worked. There was no signage indicating wer stall was out of order or that thon/switch was not working, ations were made during aids bringing residents into and out wer room conducting daily baths re. at 11:15 a.m. the following areas red: A-17 room's call light button/cord to still be coiled up on the night bed. The call light button cord still vires on one end and the cord's observed still in wall socket and		A QA Audit Tool wall areas three (3) time for one (1) month and least weekly by the I and/or Administrato QA Committee will Action Plan once as (3) months and revise plan to ensure continuous compliance.	nes per week nd reviewed at DON, RNC's r. review the QA month for three se the action
	OF HAWFIELDS RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL. YOR LSC IDENTIFYING INFORMATION) page 10 ower room) and in 1 of 66 (A-17). The findings include: an initial tour of the facility was ing the tour the following ere made: In A-17 room's call light button/cord oiled up on the night stand by the light button cord had exposed and and the cord's plug piece was wall socket and had a hole where should be attached. Common use bath/shower room on sobserved that the call light button hower stall was not operational. As conducted with the aid in the om. The aid indicated the call light enter shower stall had not worked There was no signage indicating ver stall was out of order or that ton/switch was not working. The read of the conducting daily baths re. at 11:15 a.m. the following areas red: A-17 room's call light button/cord to still be coiled up on the night	A BUILDING 345363 B. WING TOF HAWFIELDS RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL. TY OR LSC IDENTIFYING INFORMATION) Page 10 Ower room) and in 1 of 66 (A-17). The findings include: an initial tour of the facility was ing the tour the following ere made: In A-17 room's call light button/cord oiled up on the night stand by the light button cord had exposed and the cord's plug piece was wall socket and had a hole where should be attached. Common use bath/shower room on so observed that the call light button hower stall was not operational. The aid indicated the call light enter shower stall had not worked. There was no signage indicating ever stall was out of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that tton/switch was not working. The read of order or that the condition order	TOP HAWFIELDS TAG TOP HAWFIELDS TAG TAG TAG TAG TAG TAG TAG TA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	E CONSTRUCTION		TE SURVEY MPLETED
		345363	B. WING	*		07/11/2013
	OVIDER OR SUPPLIER	OF HAWFIELDS		REET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES FIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 463	was still not open indicating the cer or that the call lig working. On 07/10/2013 a were re-observed Resident room A was observed to stand by the B be had exposed wirplug piece was ohad a hole where attached. In the bath/shower root that the call light was still not open indicating the cer	button for the center shower stall ational. There was no signage nter shower stall was out of order that button/switch was still not at 4:20 p.m. the following areas	F 46			
	were observed we manager: Resident room A was observed to stand by the B b had exposed wire plug piece was contacted. In the bath/shower root that the call light was still not ope indicating the ce	at 8:35 a.m. the following areas with the facility's maintenance A-17 room's call light button/cord of still be coiled up on the night need. The call light button cord still res on one end and the cord's observed still in wall socket and the cord's wires should be resident common use of months C hall it was observed to button for the center shower stall trational. There was no signage enter shower stall was out of order ght button/switch was still not				

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			TE SURVEY MPLETED		
		345363	B. WING		0	7/11/2013		
	OVIDER OR SUPPLIER BYTERIAN HOME OF I	HAWFIELDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 463	Continued From pag		F 463					
	conducted with the firmanager. The maint to explain the maint something was obsequently each nursing station facility's staff would issue was found or maintenance to reparamanager indicated the would place the fille in the maintenance manager indicated orders to be completed. An attempt to review yet repaired was completed and the becompleted. An attempt to review yet repaired was comaintenance manamanager indicated orders to be completed). The masked if he had known room C-17 and the bath/shower room in the some complete or the same completed.	naintenance manager was bwn about the call light buttons the C hall common use theeding repair. The						
496m 6 cc c c c c c c c c c c c c c c c c	in room C-17 and the bath/shower room in maintenance mana	he C hall common use						

Event ID: BZN011

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	SURVEY PLETED
		345363	B. WNG _			07.	/11/2013
	NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HAWFIELDS			250	ET ADDRESS, CITY, STATE, ZIP CODE 12 S NC 119 BANE, NC 27302		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 468 SS=D	either of the call li one had filled out they needed to be 483.70(h)(3) COF SECURED HAND	ne wall but was unaware of ght buttons not working and no a work order or verbally told him e repaired. RRIDORS HAVE FIRMLY DRAILS	F 4		F-468 Presbyterian Home of Hawfiel will continue to strive to ensur that all hand rails are securely attached/mounted to the wall.		07/25/2013
	by: Based on observation record reviews the rails were secure on 1 of 5 facility's On 07/08/2013 a conducted. During observation was The hand rail on next to resident of the toose on warevealing woods the wall) and the brackets attaching wall.	the right side of the C hallway common shower room was found all (board on the wall was loose crews between the board and hand rail was loose on the metal ag it to the board mounted to the			Since all Residents have the potential to be included in this issue; Housekeeping Departme and/or Maintenance Departme will conduct a visual assessme All hand rails have been check and fixed. New longer screws be used to fix loose hand rails. Also a retraining memo was utilized regarding filling out Maintenance Slip Request. A QA Audit Tool will be used all areas three (3) times a weel	ent ent. ked will	
	were re-observed. The hand rail on next to resident to be loose on we revealing wood at the wall) and the	t 11:15 a.m. the following areas d: the right side of the C hallway common shower room was found all (board on the wall was loose crews between the board and hand rail was loose on the metal ng it to the board mounted to the	a second		one (1) month and reviewed at least weekly by the DON, MD Coordinator, Administrator and designee. QA Committee will review the Action Plan one (1) month for	oS nd/or e QA	

Facility ID: 923499

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		CONSTRUCTION	COMPLETED		
	345363					07/11/2013		
	NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HAWFIELDS				EET ADDRESS, CITY, STATE, ZIP CODE 502 S NC 119 EBANE, NC 27302			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 468	were re-observed: The hand rail on the next to resident come to be loose on wall (revealing wood screethe wall) and the halt brackets attaching it wall. On 07/11/2013 at 7: were re-observed: The hand rail on the next to resident come to be loose on wall (revealing wood screethe wall) and the halt brackets attaching it wall. On 07/11/2013 at 8: was observed with the manager: The hand rail on the next to resident come to be loose on wall (revealing wood screethe wall) and the halt brackets attaching it wall. On 07/11/2013 at 8: was observed with the manager: The hand rail on the next to resident come to be loose on wall (revealing wood screethe wall) and the halt brackets attaching it wall.	right side of the C hallway mon shower room was found board on the wall was loose ws between the board and rail was loose on the metal to the board mounted to the 15 a.m. the following areas right side of the C hallway mon shower room was found board on the wall was loose ws between the board and rail was loose on the metal to the board mounted to the 35 a.m. the following area he facility's maintenance or right side of the C hallway mon shower room was found to the board mounted to the 15 a.m. the following area he facility's maintenance or right side of the C hallway mon shower room was found (board on the wall was loose was between the board and rail was loose on the metal to the board mounted to the 145 a.m., an interview was facility's maintenance	F	468	three (3) months and revise the action plan to ensure continued compliance.	1		
	to explain the maint	ntenance manager was asked enance process when erved or found by staff						

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	345363	B. WING		and the state of t	07/	11/2013
NAME OF PROVIDER OR SUPPLIER THE PRESBYTERIAN HOME OF HAWFIELDS			STREET ADDRESS, CITY, STATE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOULD B	3E	(X5) COMPLETION DATE
needing repair. The rindicated the facility in nursing station (A/B in facility's staff would fill when an issue was for required maintenance maintenance maintenance maintenance maintenance maintenance maintenance maintenance request and place it in the nursing stations. Indicated he would chad y and retrieve the the repairs. The main if the repair needed pwould notify the admisso the items needed received. When the inwould be completed would also be completed would also be completed would also be completed worders to be completed verbally or by work of completed). The main asked if he had known next to the C hall resist shower/bathroom. The indicated he did not known and had never resistance in the facility	maintenance manager had work orders at each hall and C/D hall). The ll out a blank work order bund or observed that he to repair. The er indicated the facility's staff the filled out work order in the maintenance box at the maintenance manager heck the boxes several times he work orders and conduct intenance manager indicated boarts to complete the work he inistrator and defer the repair could be ordered and items came in the work and the work order request heted. all work orders that were not ducted with the facility's had no outstanding work hed (all work requested reder request were intenance manager was an about the loose hand rail ident common use he maintenance manager know about the loose hand ceived a work order or was	F	468			
				•		
	CORRECTION OVIDER OR SUPPLIER BYTERIAN HOME OF H SUMMARY ST (EACH DEFICIENCE REGULATORY OR IT) Continued From page needing repair. The indicated the facility is nursing station (A/B is facility's staff would find when an issue was for required maintenance manage member would place request and place it is the nursing stations. Indicated he would clad a day and retrieve the the repairs. The main if the repair needed proceived. When the would notify the admission the items needed received. When the would be completed would also be completed worders to be completed worders to be completed worders to be completed worders to be completed). The manaked if he had known asked if he had known asked if he did not is rail and had never retold verbally the hand	OVIDER OR SUPPLIER BYTERIAN HOME OF HAWFIELDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 needing repair. The maintenance manager indicated the facility had work orders at each nursing station (A/B hall and C/D hall). The facility's staff would fill out a blank work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility's staff member would place the filled out work order request and place it in the maintenance manager indicated he would check the boxes several times a day and retrieve the work orders and conduct the repairs. The maintenance manager indicated if the repair needed parts to complete the work he would notify the administrator and defer the repair so the items needed could be ordered and received. When the items came in the work would be completed and the work order request would also be completed. An attempt to review all work orders that were not yet repaired was conducted with the facility's maintenance manager. The maintenance manager indicated he had no outstanding work orders to be completed (all work requested verbally or by work order request were completed). The maintenance manager was asked if he had known about the loose hand rail and had never received a work order or was told verbally the handrail was loose and needed	OVIDER OR SUPPLIER BYTERIAN HOME OF HAWFIELDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 needing repair. The maintenance manager indicated the facility had work orders at each nursing station (A/B hall and C/D hall). The facility's staff would fill out a blank work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility's staff member would place the filled out work order request and place it in the maintenance box at the nursing stations. 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An attempt to review all work orders that were not yet repaired was conducted with the facility's maintenance manager. The maintenance manager worders to be completed (all work requested verbally or by work order request were completed). The maintenance manager was asked if he had known about the loose hand rail next to the C hall resident common use shower/bathroom. The maintenance manager indicated he did not know about the loose hand rail and had never received a work order or was told verbally the handrail was loose and needed	OVIDER OR SUPPLIER BYTERIAN HOME OF HAWFIELDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR I.S. IDENTIFYING INFORMATION) COntinued From page 15 needing repair. The maintenance manager indicated the facility's staff would fill out a blank work order when an issue was found or observed that required maintenance to repair. The maintenance manager indicated the facility had vork order request and place it in the maintenance box at the ruraing stations. The maintenance manager indicated he work the boxes several times a day and retrieve the work orders and any order of the repair so the items came in the work would be completed and the work order request would also be completed. An attempt to review all work order request would also be completed. The maintenance manager indicated he had no outstanding work orders or saked if he had known about the loose hand rail and had never received a work order owas told verbally the handrall study loose hand rail and had never received a work order owas told verbally the handrall study loose hand rail and had never received a work order owas told verbally the handrall study loose and needed

FORM APPROVED

PRINTEL: 08/12/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0341 CENTERS FUR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 01 - MAIN BUILDING 01 345363 08/08/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2502 S NC 119 THE PRESBYTERIAN HOME OF HAWFIELDS MEBANE, NC 27302 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DISCLAIMER K 000 K 000 INITIAL COMMENTS **RESPONSE PREFACE:** This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register Presbyterian Home of Hawfields at 42 CFR 483.70(a); using the 2000 Existing Acknowledges receipt of the Health Care section of the LSC and its referenced statement of deficiencies and publications. This building is Type III protected construction, and is utilizing North Carolina proposes this plan of correction to Special Locking arrangements. The facility is the extent that the summary of equipped with an automatic sprinkler system. findings is factually correct and in order to maintain compliance with CFR#; 42 CFR 483.70 (a) applicable rules and provisions of K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 quality of care of Residents. The SS=D plan of correction is submitted as a Building construction type and height meets one written allegation of compliance. of the following, 19,1,6,2, 19,1,6,3, 19,1,6,4, 19.3.5.1 Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the This STANDARD is not met as evidenced by: Based on the observations and staff interviews statement of deficiencies nor does it on 8/8/2013 the following Life Safety Item was constitute an admission that any observed as noncompliant, specific findings deficiency is accurate. Further, include: There were unsealed penetrations Presbyterian Home of Hawfields around the sprinkler head in the activities office near the light fixture in the office. reserves the right to refute any deficiency on this statement of CFR#: 42 GFR 483,70 (a) deficiencies through informal

wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only

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 1% inch solid-bonded core

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

procedures.

dispute resolution, formal appeal,

and/or other administrative or legal

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 disclusable 90 days ollowing 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 program participation.

K 018

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

K 018

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Event ID; BZN021

Facility ID: 923499

If continuation sheet Page 1

(X6) DATE

PRINTED: 08/12/201 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			· (X3) DATE SURVEY		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		345363	B. WING			08/0	08/2013
	NAME OF PROVIDER OR SUPPLIEF: THE PRESBYTERIAN HOME OF HAWFIELDS			STREET ADDRESS, CITY, STAYE, ZIP CODE 2502 S NC 119 MEBANE, NC 27302			
(X4) ID PREFIX TAG	(EACH DEFICIENT)	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF YAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DAYE
K 000	INITIAL COMMEN	rs	K	000			
K 012 SS=D	conducted as per Tat 42 CFR 483.70(a Health Care section publications. This is construction, and is Special Locking and equipped with an a CFR#: 42 CFR 48 NFPA 101 LIFE SA Building construction.	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced building is Type III protected s utilizing North Carolina rangements. The facility is utomatic sprinkler system. 3.70 (a) AFETY CODE STANDARD on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4,		012	K 012 Presbyterian Home of Hawfie will continue to strive to ensuareas around the sprinkler her the activity office near the lig fixture in the office is sealed. Since all sprinkler heads have potential to be included in this issue; the Maintenance Direct designce will conduct a visua	re the ad in tht the the s tor or	08/19/13
K 018 SS=D	Based on the objection 8/8/2013 the followserved as nonconficted: There were around the sprinkle near the light fixture CFR#: 42 CFR 48 NFPA 101 LIFE \$14 Doors protecting correquired enclosure hazardous areas at those constructed (wood, or capable of the second structed structed of the second structed structed of the second structed of the second structed of the se		K)18	inspection of all sprinkler hear ensure they are sealed. A QA Audit Tool will be used (1) time each week for one (1) month and reviewed at least where the administrator, Mainten Director, and/or Designee. QA Committee will review the Action Plan once a month for (3) months and revise the action plan to ensure continued compliance.	d one) weekly nance ne QA three	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is differmined 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 disclosuble 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued)rogram participation,

FORM CMS-2667(02-99) Previous Versions Obsoicte

Event ID: BZN021

Facility ID; 823488

If continuation sheet Page 1 of 2

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

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTEL: 08/12/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01

345363 B. WING

(X3) DA TE SURVEY CCIMPLETED

08/08/2013

NAME OF PROVIDER OR SUPPLIEF

THE PRESBYTERIAN HOME OF HAWFIELDS

STREET ADDRESS, CITY, STATE, ZIP CODE 2502 5 NC 118

MEBANE, NC 27302

THE PRESBYTERIAN HOME OF HAWFIELDS			MEBANE, NC 27302			
(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) (COMP DEFICIENCY)	X5) LETION ATE		
K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means sultable 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.	K 01	Presbyterian Home of Hawfields will continue to ensure the door to the A/B Shower Room will close without dragging on the frame and will latch and seal property.	/19/2013		
			Since all doors have the potential to be included in this issue; the Maintenance Director or Designer will conduct a visual inspection of all doors to ensure they latch and seal properly.			
	This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 8/8/2013 the following Life Safety item was observed as noncompliant, specific findings include: The door to the A/B door to the shower room was dragging on the frame and would not close latch and soal properly when tested. CFR#: 42 CFR 483,70 (a)		A QA Audit Tool will be use one (1) time each week for one (1) month and reviewed at least monthly by the Administrator, Maintenance Director, and/or Designee.			
			QA Committee will Review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.			

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Event IO: BZN021

Facilly ID: 923499

If continuation sheet Page 2 of 2

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