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 _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE AT TAYLOR PLACE	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) COMPLETIO 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 12/04/2013.	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.

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 01 - MAIN BUILDING 01 B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE AT TAYLOR PLACE	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
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 II(211) construction, one story with a complete automatic sprinkler system. The Deficiencies determined during the survey are as follows:	K 000	K018: Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection resident room doors 205 and 306 did not close and latch for smoke tight seal. Facility corrected the two resident room doors that did not close and latch properly. This was completed on January 15, 2014. **How will facility identify other life safety issues having the potential to affect residents by the same deficient practices.**	JAN 27 2014
K 018 SS=E	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 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:	K 018	Maintenance Director audited resident room doors for proper closure and latch. Facility found no other doors that were out of compliance. Audit was completed by January 15, 2014 See attached Resident Room Audit **What measures or systematic changes will be put in place to ensurethat the deficient practice will not recur.** Maintenance Director or Maintenance Assistant will audit resident room doors monthly for the first three months, then facility will audit 15 resident rooms each quarter for the remainder of the year for compliance. 2nd audit will be completed by February 15, 2014 **How will the corrective actions be monitored for compliance.** Maintenance Director, Maintenance Assistant and / or Administrator will spot check 15 resident room doors monthly for compliance. Facility will review for a period of three (3) months at their monthly Performance Improvement meetings.	1/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 1/22/14

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.

CW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE AT TAYLOR PLACE	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
K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings include: residents bedroom doors 205 and 306 did not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 018	K045: Illumination of means of egress, including exit discharge is arranged so that failure of any single lighting fixture will not leave area in darkness **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection day room by main dining room leaves area in darkness to exit discharge. Facility repaired light fixture to remain on during exit discharge. This was completed on January 15, 2014 **How will facility identify other life safety issues having the potential to affect residents by the same deficient practices.** Maintenance Director audited common area rooms for any single light fixture that will not leave area in darkness. Facility found no other common area rooms that were out of compliance. Audit was completed by January 15, 2014 See attached Common Room Lighting Audit **What measures or systematic changes will be put in place to ensure that the deficient practice will not recur.** Maintenance Director or Maintenance Assistant will audit common room lighting monthly for the first three months, then facility will audit each quarter for the remainder of the year for compliance. 2nd audit will be completed by February 15, 2014 **How will the corrective actions be monitored for compliance.** Maintenance Director, Maintenance Assistant and / or Administrator will spot check common room lighting monthly for compliance. Facility will review for a period of three (3) months at their monthly Performance Improvement meetings.	1/15/14
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings include: day room by main dining room leaves area in darkness to exit discharge.	K 045		
K 066	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 066	K066: Smoking regulations are adopted and include no less than the following provisions. Metal containers with self-closing devices into which ashtrays can be emptied are readily available to all areas where smoking is prohibited. **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection proper ashtrays or self-closing metal devices were not made available in areas that staff were smoking. **How will facility identify other life safety issues having the potential to affect residents by the same deficient practices.** As of this inspection facility has decided to be a smoke free facility and staff, residents or families cannot smoke on facility property. Inservice was conducted with staff on January 16, 2014 **What measures or systematic changes will be put in place to ensure that the deficient practice will not recur.** As of this inspection facility has decided to be a smoke free facility and staff, residents or families cannot smoke on facility property. Signs will be posted designating facility as a smoke free facility. Signs will be completed by January 31, 2014 **How will the corrective actions be monitored for compliance.** Maintenance Director, Director of Health Services and / or Administrator will monitor facility common areas for compliance of a smoke free facility. Facility will review for a period of three (3) months at their monthly Performance Improvement meetings.	1/31/14
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING			

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	345182	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE AT TAYLOR PLACE	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
K 066	Continued From page 2 or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings include: at time of survey facility did not have proper ashtrays or self-closing metal containers in areas that staff were smoking. 42 CFR 483.70(a)	K 066	K076: Medical gas storage and administration areas are protected in accordance with NFPA 99 Standards for Health Care Facilities. **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection empty oxygen tanks were stored in front of the full oxygen tank storage area. Facility immediately corrected oxygen storage issues and posted signs noting "FULL" and "EMPTY". This was completed on January 8, 2014. **How will facilityidentify other life safety issues having the potential to affect residents by the same deficient practices.** Facility will inservice staff on proper storage procedures for oxygen tanks. Facility will purchase hard plastic signs that will be mounted to the wall reading "FULL" and "EMPTY" for proper oxygen storage. Inservice was conducted with staff on January 16, 2014 Hard plastic signs will be mounted by January 20, 2014 **What measures or systematic changes will be put in place to ensure that the deficient practice will not recur.** Maintenance Director or Maintenance Assistant will check oxygen tanks daily for proper storage compliance. This will begin immediately on January 9, 2014 and on going. **How will the corrective actions be monitored for compliance.** Maintenance Director, Director of Health Services, Nursing Staff and / or Administrator will monitor daily the oxygen storage area for compliance. Facility will review for a period of three (3) months at their monthly Performance Improvement meetings.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076		1/20/14

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K 076	Continued From page 3 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings include: empty oxygen tanks were in front of full tanks area in oxygen storage room at nurse station on 100 hall. 42 CFR 483.70(a)	K 076	K144: Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection "Temporary Generator" did not crank and transfer in 10 seconds on test. Facility immediately contacted SurGen Generator Company and ordered a new generator to be delivered and installed today January 8, 2014. New generator was delivered to facility by 7 p.m. on January 8, installed and tested under load for compliance with NC state regulations. State inspector was contacted approximately at 9 p.m. on January 8 to inform him of installation of "New Temporary Generator". This was completed on January 8, 2014. **How will facility identify other life safety issues having the potential to affect residents by the same deficient practices.** Facility will test "Temporary Generator" daily under load until the "Permanent Generator" is operable. This will begin on January 10, 2014 and will be on going.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings	K 144	**What measures or systematic changes will be put in place to ensure that the deficient practice will not recur.** Facility will test "Temporary Generator" daily under load until the "Permanent Generator" is operable. This will begin on January 10, 2014 and will be on going. When "Permanent Generator" is operable facility will follow State regulations of weekly generator load test for 30 minutes. **How will the corrective actions be monitored for compliance.** Facility will test "Temporary Generator" daily under load until the "Permanent Generator" is operable. This will begin on January 10, 2014 and will be on going. When "Permanent Generator" is operable facility will follow State regulations of weekly generator load test for 30 minutes. Facility will review for a period of three (3) months at their Monthly Performance Improvement meetings.	1/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HERITAGE HEALTHCARE AT TAYLOR PLACE	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

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K 144	Continued From page 4 include: temporary generator did not crank and transfer in 10 seconds on test. 42 CFR 483.70(a)	K 144	K147: Electrical wiring and equipment is in accordance with NFPA 70 National Electrical Code 9.1.2 **What Corrective action will be accomplished by the facility to correct the deficient practice.** At time of Inspection electrical outlets at sinks in all residents rooms on 100 Hall are not Ground Fault protected. 100 Hall is currently closed to all admissions until Ground Fault outlets are installed. Facility ordered Ground Fault Outlets for all residents' rooms on 100 Hall, on January 9, 2014. **How will facility identify other life safety issues having the potential to affect residents by the same deficient practices.** Facility installed Ground Fault outlets in all residents' rooms on 100 Hall at sinks. This was completed January 13, 2014 **What measures or systematic changes will be put in place to ensure that the deficient practice will not recur.** Facility installed Ground Fault outlets in all residents' rooms on 100 Hall at sinks. This was completed January 13, 2014 **How will the corrective actions be monitored for compliance.** Facility installed Ground Fault outlets in all residents' rooms on 100 Hall at sinks. This was completed January 13, 2014 Facility will review for a period of three (3) months at their Monthly Performance Improvement meetings. 1/13/14	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliance, specific findings include: electrical outlets at sinks in all residents rooms on 100 hall are not Ground Fault protected. 42 CFR 483.70(a)	K 147		