

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

PRINTED: 08/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2011
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NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). Event ID#IMBK11..</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2011
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055	
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K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, on August 18, 2011 at approximately 2:00pm onward, the electromagnetic lock did not release with activation of smoke detector on 100 hall - exit door leading to Alzheimer unit courtyard.	K 051	RECEIVED SEP 01 2011 K051 Fire panel found to have PAM relay. Relay replaced on 8/19/11. tested by contractor all doors opening properly on fire alarm. Test weekly X4 then monthly during fire drills. Report findings to monthly QA meeting.	8/19/11
K 082 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 082		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 9/1/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055
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K 062	Continued from page 1 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 97.5 This STANDARD is not met as evidenced by: Based on observation, on August 18, 2011 at approximately 2:00pm onward, there is no electrical supervision of the sprinkler accelerator valve - valve is located in the sprinkler riser room, valves upstream of accelerator. 42 CFR 483.70(a)	K 062	K062 Sprinkler company installed 2 tamper switches to accelerator line. Inlet and outlet. 8/29/11 Fire panel company installed modules and wired to fire panel 8/31/11. Tested by contractor both working properly. Test weekly X4 then quarterly during sprinkler inspection. Report findings to monthly QA meeting.	8/31/11
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