STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(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
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey) No deficiencies were cited as a result of the complaint investigation Event ID # F6EH11.	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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(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 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Woodland Hill Center Genesis** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following building construction type was non-compliant, specific findings include; A. 3" PVC pipe to panel EMAA in the courtyard mechanical room penetrated ceiling without a metal collar. B. Penetration in the ceiling of the chemical storage room, sprinkler riser room, corridor near room 402 and near attic access at nurses station #1 does not meet the required fire resistance rating.	K 012	A.The metal collar for the panel EMAA in the courtyard mechanical room was ordered through State Electric on 1/30/14. When the metal collar is received it will be installed by the Maintenance Director and the Property Manager. B. Don Sweat Painting was contacted on 1/29/14 for repairs to the ceilings in chemical storage room, sprinkler riser room, corridor near room 402 and near attic access at the #1 nurse's station. Don Sweat Painting repaired all affected ceilings on 2/11/14. Once the metal collar is installed the Maintenance Director will perform checks of the EMAA panel and the ceilings throughout the facility to assure compliance 2 x weekly x 1 month then weekly x 2 months. (See attached next page)	2/28/14
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029	A new door knob was replaced to the laundry service/laundry chemical storage room on 2/10/14. FEB 17 2014	2/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William B. [illegible] | TITLE: ADMINISTRATOR | (X6) DATE: 2/13/14

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.

DRS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345277	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/28/2014

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			K012 Continued from previous page 1 of 5 The Maintenance Director will report findings every month x 3 months to the Performance Improvement Committee.	

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K 029	Continued From page 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. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following hazardous area was non-compliant, specific findings include; door to the "laundry service/laundry chemical storage" room did not close and latch tightly in it's frame.	K 029	The Maintenance Director did an audit throughout the facility to ensure that all doors closed and latched tightly in their frames. The Maintenance Director will perform checks of the laundry service/chemical storage door 2 x weekly x 1 month then weekly x 2 months to assure compliance The Maintenance Director will report findings every month x 3 months to the Performance Improvement Committee.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following exit egress was non-compliant, specific findings include; A. The doors exiting the kitchen to the dining room and the door to dry storage had a dead bolt that required more than one range of motion to exit the area. Doors shall be operable with not	K 038	A. The Maintenance Director removed the cylinders out of the dead-bolt locks to the doors exiting from the kitchen to the dining room and the dry storage room on 2/10/14 making it a single motion door knob. B. The Maintenance Director and Property Manager in-serviced facility staff on 1/28/14 through 2/10/14 on the master emergency door release. The Maintenance Director will audit doors throughout the facility to assure that all doors have single motion door knobs. Employees have been in-serviced on the location of the master emergency door release and all new employees will be educated on the location of the master emergency door release.	2/28/14

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K 038	Continued From page 2 more than one releasing operation. B. Employees questioned at both nurses station were not aware of the master emergency release located at the nurses station.	K 038	The Maintenance Director will perform checks of door knobs throughout the facility to assure compliance 2 x weekly x 1 month, then weekly x 2 months. (See attached next page)	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following emergency lighting was non-compliant, specific findings include; the residents lounge near nurses station #2 would leave the patient in darkness.	K 046	The emergency lighting in the resident lounge near #2 nurses station was connected to the emergency power on 2/11/14. The Maintenance Director audited all resident areas throughout the facility to assure that emergency lighting was present and working. The Maintenance Director will do audits 2 x weekly x 1 month, then weekly x 2 months to assure emergency lights are working in resident areas audits 2 x weekly x 1 month, then weekly x 2 months to assure emergency lights are working in resident areas. (See attached next page)	2/28/14
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following fire drill procedure was non-compliant, specific findings include;	K 050	The individual employee was re-educated on the Fire Drill procedure on 1/28/14 by the Maintenance Director. Employees were in-serviced starting on 1/28/14 by the Maintenance Director on the fire drill procedure and the synonyms of RACE and PASS. All new employees will be in-serviced by the Maintenance Director on the fire drill procedure and synonyms of RACE and PASS. The Staff Development Coordinator (SDC) will record the attendance of employees attending the In-service training on their permanent record. The SDC will audit for employees that have not received the Fire Drill Training weekly x 3 months and will report to the Performance Improvement Committee monthly x 3 months.	2/28/14

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			K038 Continued from previous page 3 of 5 The Maintenance Director will do random audits with staff 2x weekly x 1 month, then weekly x 2 months for the location of the master emergency door release. The Maintenance Director will report findings every month x 3 months to the Performance Improvement Committee. K046 Continued from previous page 3 of 5 The Maintenance Director will report findings monthly x 3 months to the Performance Improvement Committee.	

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K 050	Continued From page 3 employee questioned was not familiar with the facility fire drill procedure.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following automatic sprinkler system was non-compliant, specific findings include; A. The post indicator valve (PIV) did not give an audible signal at the main fire alarm panel when tested. B. There was not a hi & low air pressure switch located on the sprinkler riser. C. There was not documentation of the five year obstruction testing.	K 062	A. The post indicator valve (PIV) was repaired on 1/31/14 by Asheboro Fire and Security. B. The hi & lo air pressure switch located on the sprinkler riser was installed on 2/10/14 by Sentry Fire and Protection and was wired by Asheboro Fire and Security on 2/10/14. C. The obstruction testing of the sprinkler system is scheduled for 2/18/14 by Sentry Fire and Protection. The Maintenance Director was re-educated by the Property Manager on 1/28/14 on making sure the post indicator value was working properly, how to audit the hi & lo switch on the sprinkler riser after being installed, and the visual obstruction inspection of the sprinkler system is done every 5 years and placed in tels. (See attached next page)	2/28/14
K 144 SS=D	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.	K 144	Cummings Atlantic was notified on 1/28/14 for repair of the generator on 2/3/14. A representative of Cummings Atlantic did a complete tune-up and inspection on 2/3/14 The Maintenance Director was re-educated by the Administrator on 1/28/14 as to appropriate generator start and transfer load time of less than 10 seconds. The Maintenance Director will test the generator for start and transfer load time 2 x weekly x 1 month and then weekly thereafter. The Maintenance Director will report test results to the Performance Improvement Committee x 3 months.	2/28/14

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			K062 Continued from previous page 4 of 5 The Maintenance Director will audit the PIV and the hi/lo switch 2 x weekly x 1 month, then weekly x 2 months. When the visual inspection is completed the report will be placed in teles. The Maintenance Director will report findings to the Performance Improvement Committee monthly x 3 months.	

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 1/28/14 at approximately noon the following emergency generator was non-compliant, specific findings include; the emergency generator did not crank and transfer within 10 seconds upon loss of power.	K 144		