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

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345481	B. WIN	۱G		07/1	9/2012
	ROVIDER OR SUPPLIER	HABILITATION CENTER		40	EET ADDRESS, CITY, STATE, ZIP CODE 00 PELT DRIVE AYETTEVILLE, NC 28301	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs	F	000			
	The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).						
				1			
LAROPATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		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.

PRINTED: 08/20/2012 PARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED TERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION-(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 345481 08/17/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 PELT DRIVE** WOODLANDS NURSING & REHABILITATION CENTER FAYETTEVILLE, NC 2830似落图清洁。 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Woodlands Nursing and Rehabilitation K 000 Center acknowledges receipt of the K 000 I INITIAL COMMENTS Statement of Deficiency and proposes the plan of correction to the extent that the This Life Safety Code(LSC) survey was summary of findings is factually correct conducted as per The Code of Federal Register and in order to maintain compliance with at 42CFR 483.70(a); using the Existing Health applicable rules and the provision of Care section of the LSC and its referenced quality care to residents. The plan of publications. This building is Type V construction, correction is submitted as written one story, with a complete automatic sprinkler allegation of compliance. system. The below response to the Statement of The deficiencies determined during the survey Deficiency and plan of correction does not are as follows: denote agreement with the citation by K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 Woodlands Nursing and Rehabilitation SS=D Center. The facility reserves the right to Building construction type and height meets one submit documentation to refute the stated of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, deficiency through informal appeals 19.3.5.1 procedures and/or other administrative or legal proceedings. K012 The penetration in the celling This STANDARD is not met as evidenced by: at the 100 hall nurses station 42 CFR 483.70(a) By observation on 8/16/12 at approximately noon was repaired. the following building construction was non-compliant, specific findings include; An audit of the ceiling throughout penetrations in the ceiling at the 100 hall nurses station. the facility was completed K 014 NFPA 101 LIFE SAFETY CODE STANDARD K 014 and any penetrations were repaired. SS=E Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as The maintenance director or designee fixed or movable walls, partitions, columns, and will conduct a monthly audit of the ceilings has a flame spread rating of Class A or facility cellings to identify and repair 19.3.3.1, 19.3.3.2 Class B. any penetrations.

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

The field (Natural) (Administrator) 8-30-

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.

If continuation sheet Page 1 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345481			1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		B. Wil	B. WING			08/17/2012	
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	ands nursing & Re	EHABILITATION CENTER	,		00 PELT DRIVE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL . REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION SHOULD FREFIX (EACH CORRECTIVE ACTION SHOULD FREE CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
K 014 K 015 SS=D	This STANDARD (42 CFR 483.70(a)) By observation on the following corridor specific findings independent of the following corridor walls in the rooms 110 & 112, the following NFPA 101 LIFE SA Interior finish for rocorridors or exitway surfaces of building walls, partitions, co flame spread rating fully sprinklered buildings A, Class B, Class A, Class B, Compared the control of the following t	s not met as evidenced by: 8/16/12 at approximately noon or walls were non-compliant, clude; penetrations in the efollowing areas: Between petween rooms 108 & 106, g. AFETY CODE STANDARD oms and spaces not used for ys, including exposed interior as such as fixed or movable lumns, and cellings, has a gof Class A or Class B. (In Ildings, flame spread rating of or Class C may be continued in eparated in accordance with		014	Results of the audit will be reviat the Quality Assurance meets monthly x 3 months, then quarx3 quarters. K014 The penetrations in the corridor Walls in the following areas: Be Rooms 110 & 112, between row & 106, near 100 hall dining we completed and any penetration repaired. The maintenance director or dewill conduct a monthly audit of any penetrations.	ng terly or etween oms 108 re repaired as ns were esignee	9-4-12
K 018 SS=D	42 CFR 483.70(a) By observation on the following interior specific findings incorpair in the storage NFPA 101 LIFE SAR Doors protecting co	s not met as evidenced by: 8/16/12 at approximately noon or wall was non-compliant, slude; wall-removed and under e room next to room 207. FETY CODE STANDARD orridor openings in other than es of vertical openings, exits, or	.· K	·. 018	Results of the audit will be revi at the Quality Assurance meeti monthly x 3 months, then quar x3 quarters.	ng terly	
	hazardous areas at those constructed of wood, or capable o	re substantial doors, such as of 1% inch solid-bonded core fresisting fire for at least 20 sprinklered buildings are only			The wall in the storage room no to room 207 was replaced and		9-7-12

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES (X1) PRO	VIDER/SUPPLIER/CLIA ITIFICATION NUMBER:	1'	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
, 345		345481	B. WING		08/1	08/17/2012	
NAME OF PROVIDER OR SU WOODLANDS NURSIN	NG & REHABILIT	·		STREET ADDRESS, CITY, STATE, ZIP CO 400 PELT DRIVE FAYETTEVILLE, NC 28301		L	
PREFIX (EACH DE	MARY STATEMENT OF FICIENCY MUST BE DRY OR LSC IDENTI	OF DEFICIENCIES PRECEDED BY FÜLL FYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X6) COMPLETION DATE		
required to a no impedim are provided the door clo are permitte	An audit of all storage rooms was completed to ensure all walls are intact. An audit of all storage rooms was completed to ensure all walls are intact. The maintenance director or designee will conduct a monthly audit of all storage rooms to ensure walls are intact and repairs are made timely. Results of the audit will be reviewed in the monthly Quality Assurance meeting x 3 months, then quarterly x 3 quarters.		Is are r designee it of all alls are intact reviewed arance	9-7-12			
42 CFR 48 By observat the following specific find A. The doo did not close B. The doo across from NFPA 101 L Required at continuously condition ar periodically, 25, 9.7.5	3.70(a) ion on 8/16/12 a g corridor doors ings include; r to storage roor e and latch prop r hardware to the 100 hall dining LIFE SAFETY Contomatic sprinkle y maintained in id are inspected 19.7.6, 4.6.1	e new public restroom room was missing. ODE STANDARD er systems are reliable operating		K018 The door to the storage root to room 207 was adjusted to properly. The door hardware to the restroom across from 100 has installed. An audit was conducted on in the facility to ensure the and have appropriate hardware to maintenance director of will conduct a monthly aud doors to ensure proper late hardware.	o latch new public nall dining all doors y latch properly ware, or designee It of all facility	9-7-12	

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(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345481 08/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 PELT DRIVE WOODLANDS NURSING & REHABILITATION CENTER FAYETTEVILLE, NC 28301** PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Results of the audit will be reviewed K 062 Continued From page 3 K 062 in the monthly Quality Assurance 42 CFR 483.70(a) meeting x 3 months, then quarterly By observation on 8/16/12 at approximately noon the following automatic sprinkler system was x 3 quarters. non-compliant, specific findings include; A. The sprinkler escutcheon plate for the K062 refrigerator was not fastened properly. The sprinkler escutcheon plate for the 19-4-12 B. There was storage within eighteen inches of refrigerator was fastened properly. the sprinkler head in the freezer. the storage in the freezer was moved below eighteen inches of the sprinkler head. An audit of the escutcheon plates was completed on all sprinkler heads in thefacility to ensure proper fastening. The maintenance director or designee will Conduct a monthly audit of the sprinkler escutcheon plates throughout the facility to ensure proper fastening. The maintenance director or designee will conduct a monthly audit of the freezer to ensure all products are stored below eighteen inches of the sprinkler head. Results of the audit will be reviewed in the monthly Quality Assurance meeting x 3 months, then quarterly x 3 quarters.