DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCT 0 5 2012

PRINTED: 09/25/2012 FORM APPROVED OMR NO 0938-0391

| CENTER | S FOR MEDICARE & | VIEDICAID SERVICES | | | - 4-712 | T OMP IND | . 0930-0391 |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | | B. WIN | IG . | | | 1 |
| | | 345349 | | | | 09/13 | /2012 |
| NAME OF PR | OVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| WOODBIII | RY WELLNESS CENTER | INC | | 2 | 778 COUNTRY CLUB DRIVE | | |
| 1100000 | | | | ŀ | AMPSTEAD, NC 28443 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION S | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 280 SS=B | The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and the A comprehensive care within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and of disciplines as determined and, to the extent prathe resident, the resident incomprehensive in the resident in the r | right, unless adjudged vise found to be ne laws of the State, to g care and treatment or reatment. | LL. | 280 | Preparation and submission of this plan of correction the CMS Form 2567 from the 09/13/12 survey. It do an agreement or admission by Woodbury Wellness C of the facts alleged or of the correctness of the coreth the statement of deficiency. The facility reserves all the deficiencies, findings, conclusions and actions of Plan of Correction (and the attached documents) also facility's credible allegation of compliance Tag F280 #1 (Dentures) For Resident #113: • Care Plan for potential for loss updated by MDS Coogless of the properties of the plan of the properties. • Resident Care Guide revisupdated, if applicable, by Coordinator on 9/13/12. For Resident #113 and all other is residents: • Audit completed by DON of all in-house residents to current use of dentures. • Care Plans of all in-house audited and updated, if applicable, if applicable and updated, if applicable and updated and updated, if applicable and updated and updated and updated. | es not constitute enter of the truth sistens stated on rights to contest the Agency. This functions as the register ordinator on ident no ewed and MDS n-house I/Designee o determine eresidents oplicable, | |
| | by: Based on observatio interviews the facility comprehensive care current dental and fee elopement risk, and be residents sampled. (F | olan that addressed the | | | Resident Care Guides for house residents audited at by MDS/DON/Designee current denture use. #1 (Feeding) For Resident #113: Care Plan for potential for loss updated by MDS Cog/13/12 to reflect that residently dependent for feed. | nd updated as related to r weight ordinator on ident is | |
| | | ual survey and complaint ducted at the facility on 012. | | | most recent MDS. Resident Care Guide revi updated, if applicable, by Coordinator on 9/13/12. (continued on next page) | 1 | · |

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

TITLE

Facility ID: 923206

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

| DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I | | (3) 10 II | PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391 |
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| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | OS DATE SURVEY COMPLETED C 09/13/2012 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP | CODE |

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| | ROVIDER OR SUPPLIER | INC | | 27 | EET ADDRESS, CITY, STATE, ZIP CODE 1778 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443 | |
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| F 280 | 1. Resident # 113 wa 10/15/10 with a readnoumulative diagnoses dementia, recurrent a respiratory failure, and The resident was obshis room for all meals. A review of the resident decision making skills staff for all areas of drambulatory. Resident understand or be und garbled and staff had resident had a steady disease process. A review of the resident plan last reviewed on resident was at risk for care planned for Resident understand for Resident was at risk for all meals; prodivided tray with all meding; assist reside A review of Resident inside his closet door care guide indicated to by staff. An interview was con Assistant (NA) #1 on | as admitted to the facility on hission on 7/1/11. He had which included advanced spiration pneumonia, acute d dysphagia. erved being fed by staff in during the survey. Int's Quarterly Minimum sement dated 7/13/12 had severely impaired a was totally dependent on ally care, and was non the 113 could rarely erstood. His speech was to anticipate his needs. The redecline in weight due to anticipate his needs. The redecline in weight due to morning and make sure it value cup with all meals / eals to increase self int to eat. #113's care guide posted did not list dentures. The he resident required feeding | F | 280 | Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 09/13/12 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statentent of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance (continued from previous page) For Resident #113 and all other in-house residents: • Audit completed by DON/Designee of all in-house residents most recent MDS to determine coding of Eating/Self Performance (G0110 H1). • Care Plans of all in-house residents audited and updated, if applicable, by DON/Designee as related to current Eating/Self Performance MDS coding. • Resident Care Guides for all in-house residents audited and updated by DON/Designee as related to current Eating/Self Performance MDS coding. #2 (elopement risk) For Resident #113: • Care Plan for potential for elopement was DC'd on 9/13/12 by MDS Coordinator as resident is no longer an elopement risk and does not have current physician order for a wander guard. • Resident Care Guide reviewed and updated, if applicable, by MDS Coordinator on 9/13/12. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER RY WELLNESS CENTER | INC | • | 27 | EET ADDRESS, CITY, STATE, ZIP CODE 178 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443 | | |
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| F 280 | had been working at the had fed the reside He indicated the reside He indicated the reside The NA stated the resident but could not we put the dentures in the not open his mouth a drink. The NA indicaresident's mouth blee An interview was con 9/13/12 at 9:25 AM. the resident had dent fed the resident all meto her. During an interview was condended the resident to her. During an interview was condended the resident the resident all meto her. During an interview was condended the resident feed by some storage in the residentures due to mouth the change in the resinability to wear his dup during the interdismeeting that was held nursing should have the meeting so the caupdated. An interview was condended. An interview was condended. An interview was condended. An interview was condended. | the facility for 4 months and int every meal on his shifts. Ident could not feed himself, sident had a top denture ear it. NA#1 revealed if staff e resident's mouth he would my more to be fed or to ted the dentures made the d in two places. Iducted with NA #2 on She stated she did not think ures. The NA revealed she eals when he was assigned with the Unit Coordinator on the stated the resident had staff for a least six months. Ident could not wear the sores. Iducted with the MDS 12 at 10:06 AM. She stated ident's feeding status and entures should have come ciplinary team / care plan d quarterly. She indicated presented the information at are plan could have been | F | 280 | Preparation and submission of this plan of correction is the CMS Form 2567 from the 09/13/12 survey. It does an agreement or admission by Woodbury Wellness Ce of the facts alleged or of the cornectness of the conclus the statement of deficiency. The facility reserves all rit the deficiencies, findings, conclusions and actions of it Plan of Correction (and the attached documents) also facility's credible allegation of compliance (continued from previous). For Resident #113 and all other in residents: Care Plans of all in-house to be audited and updated, applicable, by DON/Design related to current elopement status and current physician related to elopement risk to accuracy Resident Care Guides for a house residents to be audit updated by DON/Designet to current elopement risk to current physicians orders are elopement risk to ensure a #3 (body alarm status) For Resident #56 Updated Fall Risk Assessing completed by MDS Coordinator on 9/13/12. Physicians order received to DC PBA based on updated for the properties of the properties of the properties of the properties on 9/13/12 to reflect DC on 9/13/12 to reflect DC on Physicians or on 9/13/12. Resident Care Guide reviewed to DC Resident Care Guide reviewed updated, if applicable, by Coordinator on 9/13/12. (continued on next page) | residents infigure as infigure infig | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | [` ' | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| F 280 | 2. Resident # 113 10/15/10 with a real cumulative diagnost dementia, recurrent respiratory failure, at the resident was on either in bed or in a survey. A review of the reside decision making sk staff for all areas of ambulatory. Residunderstand or be ungarbled and staff hieraident had impaired of his body and Occupational There resident was dependent was dependent was dependent of the respiration of the res | was admitted to the facility on dmission on 7/1/11. He had es which included advanced to aspiration pneumonia, acute and dysphagia. It beserved to be in his room to reclining chair throughout the dent's Quarterly Minimum sessment dated 7/13/12 and had severely impaired ills, was totally dependent on foility care, and was nonent # 113 could rarely inderstood. His speech was ad to anticipate his needs. The red range of motion on one do he received services from apy and Restorative Staff. The indent on staff for locomotion. Ident's care plan revised on the resident was care planned int. Interventions listed is ual checks, to apply and uard on left wrist, to redirect dering, to counsel resident on ensure name and picture were seen to the facility of the faci | F. | 280 | Preparation and submission of this plan of correct the CMS Form 2567 from the 09/13/12 survey. an agreement or admission by Woodbury Welfin of the facts alleged or of the correctness of the outer statement of deficiency. The facility reserves the deficiencies, findings, conclusions and action Plan of Correction (and the attached documents) facility's credible allegation of compliance (continued from previous page) For Resident #56 and all other residents. • Audit completed by D of all in-house resident PBA's are in place as physician and body als appropriate based on a and fall history. • Care Plans of all in-house audited and updated, i by MDS/DON/Design body alarm status and orders to ensure accur. • Resident Care Guides house residents audited by DON/Designee as current body alarm status and orders to ensure accur. • Resident #113, #56, a residents, and all future recompleted by Care Place Coordinator on Admis reviewed by same with least quarterly and with change to include assed denture use, feeding selopement risk and both status, with update to Guide, if applicable. • Care Plan Team/MDS inserviced by Nurse Out 10/3/12 regarding care to include updating are care plans and resider (continued on next page) | it does not constitute asses Center of the truth sorchusions stated on sall rights to contest as of the Agency. This also functions as the in-house ON/Designee to ensure ordered by arm status is esident status suse residents of applicable, applicable, are as related to physicians acy. for all indicated to and updated related to atus to ensure all in-house residents: blans to be an Team/MDS ssion and h updates at the a significant essment of tatus, day alarm Resident Care a Coordinator consultant on e plan process and accuracy of | | |

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| F 280 | wear a Wanderguard worked with the reside Resident #113 had no during that time. During an interview w 9/13/12 at 9:45 AM should be bound now and chair. She indicated that ambulate nor propel revealed he was not did not wear a wander the Director of Nursi interview on 9/13/12. "He is not going to el resident was no long eloping and no longer An interview was cor Administrator on 9/13. Resident #113 was not medical condition. Sexpectation all facility accurate and update current health status. 3. Resident #56 was 06/24/10 and had dia | ad a body alarm but did not. He indicated he had ent for four months and ot had a Wanderguard on with the Unit Coordinator on the stated the resident was only got up in a reclining he resident could not himself in a wheelchair. She onger an elopement risk and orguard. Ing (DON) stated in an at 11:40 AM, ope." She indicated the er physically capable of r wore a Wanderguard. Inducted with the facility 3/12 at 11:25 AM. She stated into an elopement risk due to the stated it was her or residents would have an d care plan based on their admitted to the facility on | | 280 | Preparation and submission of this plan of correction the CMS Form 2567 from the 69/13/12 survey. It do not a greement or admission by Woodbury Wellness of the facts alleged or of the correctness of the concit the statement of deficiency. The facility reserves all the deficiencies, findings, conclusions and actions or Plan of Correction (and the attached documents) als facility's credible allegation of compliance (continued from previous page) • All nursing staff inservice DON/Designee on 10/3/importance of reporting changes in resident status denture use, feeding state elopement risk and body status, to Care Plan Tear Coordinator. Any nursing inserviced on this date were inserviced by DON/Designee on 10/2/random selection and autofour in-house Resident Coand correlating Resident for review of current defined in the status with respect to the continuous co | ces not constitute Center of the truth tusions stated on Inghts to contest of the Agency. This of functions as the ced by 12 regarding of any s, to include us, alarm m/MDS ng staff not vill be ignee in 0/11/12. developed by 12 to include dit of at least Care Plans care Plans care Plans care Plans care Guides inture use, int risk and eporting of re Plan r for update. ed by 12 on (Care to be eekly for four four weeks | |
| | Hemiparesis. The Annual Minimun | n Data Set (MDS) | | | (continued on next page) | | |

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| F 280 | resident had moderal required extensive as MDS showed that the extremities had impa MDS showed that the the last assessment occupational Therap The Care Area Asset Loss dated 06/02/11 was intermittently dis and time and had showed that cognitive status and CAA for Falls dated oresident had been from the company of the moderal body alarm when she attempted The resident's Care is showed that the resident had the resident had been from the moderal body alarm when she attempted The resident's Care is showed that the resident intermonfusion. The Care living showed that the mobility and required activities of daily living was for the resident alarm while up in the | 5/24/12 showed that the te cognitive impairment and seistance with transfers. The eresident's upper and lower imment on one side. The eresident had no falls since and received no Physical or y. sement (CAA) for Cognitive showed that the resident soriented to person, place or term memory problems. At the resident had impaired function due to the CVA. The D6/02/11 showed that the efform falls since the last that showed that the resident had a for assistance with all stated that the resident had a for safety and to alert staff to get up without assistance. Plan updated 07/19/12 dent had impaired thought mittent disorientation and Plan for activities of daily eresident had impaired if extensive assistance with all ng. Among the interventions to have a personal body e chair. | F | 280 | response to the CMS Form 250 / Iron the wood does not constitute an agreement or admission Wellness Center of the truth of the facts alleg correctness of the conclusions stated on the selections. The facility reserves all rights to deficiency: findings, conclusions and action This Plan of Correction (and the attached do functions as the facility's credible allegation (continued from previous pag) Random auditing of resir related to denture use, fee elopement risk and body to be completed by DON weekly times four weeks monthly times two mont Thereafter, (Care Plan) will be audited monthly. Charge Nurse or DON/I ensure Care Plan and Refunde are accurate and a as related to denture uses status, elopement risk an alarm status. Care Plan and Care Guide will be upda Coordinator if indicated. Results of (Care Plan) A and random audits to be next scheduled Quality I Committee Meeting and following quarter, with determination at that time continued monitoring. | ged or of the statement of contest the nest the Agency currents) also of compliance (e) dents as seeding status, alarm status (Designee s and ths. Audit Tool by the Designee to esident Care appropriate s, feeding and Resident tated by MDS (Audit Tool e reviewed in Management I again the one for need of | |
| | the resident's closet weakness of her righ | Guide posted on the inside of showed that the resident had nt arm and both legs. The cluded a place to check if the | | | (continued on next page) | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE S' COMPLE | |
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| F 280 | section did not inclure resident had an alar. A review of the phys September, 2012 re 02/15/11 for the resident (PBA) while u A review of the resident administration record 09/30/12 showed the personal body alarm. On 09/13/12 at 10:3 observed sitting in a There was not a per resident or the chair. On 09/13/12 at 10:4 conducted with the (ADON) and Nurse there was an order to current care plan. To was not on the Resident of the resident did not have resident did not have remember the resident stated that the resident did not have remember the resident did not have remembe | m and the type of alarm. This de information that the m. ician's monthly orders dated vealed an order dated dent to have a personal body p in the chair. Ient's medication d dated 09/01/12 through at the resident was to have a n while up in the chair. O AM, Resident #56 was wheelchair in her room. Is sonal body alarm on the sonal body alarm on the sonal body alarm on the mean and it was on the he ADON stated that for a PBA and it was on the he ADON stated that the PBA dent Care Guide so the would not be looking for one, at he went to the resident's ent did not have a PBA. Nurse esident had not had any falls year. The NA assigned to the interview and stated that the e a PBA and that she did not ent ever having one. The NA lent did not try to get up rang her call bell when she bathroom. The ADON | F 280 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| FOR MEDICARE & | MEDICAID SERVICES | | | | |), 0938-0391 | |
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| | | F | 280 | | | THE TAXABLE PROPERTY OF TAXABL | |
| an interview that at of take her oxygen off a was put on the reside that when a decision PBA an order was walarm and the MDS is copy of the order and update the care plan stated she was not s was but maybe the copassed on to the MD on 09/13/12 at 11:16 fall assessment had no longer at risk for the notified for an ord 483.25(d) NO CATH RESTORE BLADDE Based on the reside assessment, the fact resident who enters indwelling catheter is resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident specification as possible of this REQUIREMENT. | ne time the resident would and try to get up and a PBA ent. The MDS Nurse stated was made to discontinue a ritten to discontinue the Nurses would get the yellow of the MDS nurse would and the care guide. She ure where the breakdown order did not get written and so nurses. So AM the ADON stated that a been done, the resident was falls and the physician would ler to discontinue the PBA. ETER, PREVENT UTI, is not catheterized unless the indition demonstrates that necessary; and a resident foliadder receives appropriate test to prevent urinary tract attore as much normal bladder. | Li | · 315 | | | | |
| | Continued From page could be discontinued From page could be discontinued from the take her oxygen off a was put on the reside that when a decision PBA an order was walarm and the MDS from the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and update the care plan stated she was not s was but maybe the copy of the order and to fall assessment had no longer at risk for the notified for an order sidently continued to catheterization was who is incontinent or treatment and service infections and to rest function as possible. This REQUIREMEN by: Based on record re | OVIDER OR SUPPLIER RY WELLNESS CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 could be discontinued. On 09/13/12 11:07 AM, MDS Nurse #1 stated in an interview that at one time the resident would take her oxygen off and try to get up and a PBA was put on the resident. The MDS Nurse stated that when a decision was made to discontinue a PBA an order was written to discontinue the alarm and the MDS Nurses would get the yellow copy of the order and the MDS nurse would update the care plan and the care guide. She stated she was not sure where the breakdown was but maybe the order did not get written and passed on to the MDS nurses. On 09/13/12 at 11:16 AM the ADON stated that a fall assessment had been done, the resident was no longer at risk for falls and the physician would be notified for an order to discontinue the PBA. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced | CORRECTION (X1) PROVIDERSUPPLIER (X2) M A BUIL BENTIFICATION NUMBER: 345349 DOUDER OR SUPPLIER RY WELLNESS CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 could be discontinued. On 09/13/12 11:07 AM, MDS Nurse #1 stated in an interview that at one time the resident would take her oxygen off and try to get up and a PBA was put on the resident. The MDS Nurse stated that when a decision was made to discontinue a PBA an order was written to discontinue the alarm and the MDS Nurses would get the yellow copy of the order and the MDS nurse would update the care plan and the care guide. She stated she was not sure where the breakdown was but maybe the order did not get written and passed on to the MDS nurses. On 09/13/12 at 11:16 AM the ADON stated that a fall assessment had been done, the resident was no longer at risk for falls and the physician would be notified for an order to discontinue the PBA. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 could be discontinued. On 09/13/12 11:07 AM, MDS Nurse #1 stated in an interview that at one time the resident would take her oxygen off and try to get up and a PBA was put on the resident. The MDS Nurse stated that when a decision was made to discontinue a PBA an order was written to discontinue the alarm and the MDS Nurses would update the care plan and the care guide. She stated she was not sure where the breakdown was but maybe the order did not get written and passed on to the MDS nurses. On 09/13/12 at 11:16 AM the ADON stated that a fall assessment had been done, the resident was no longer at risk for falls and the physician would be notified for an order to discontinue the PBA. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff | F DEFICIENCIES CORRECTION (X1) PROVIDER RESULPTIENCIA 345349 STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443 STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443 CAN MULTIPLE CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 could be discontinued. On 09/13/12 11:07 AM, MDS Nurse #1 stated in an interview that at one time the resident would take her oxygen off and try to get up and a PBA was put on the resident. The MDS Nurse stated that when a decision was made to discontinue a PBA an order was written to discontinue the alam and the MDS nurses would get the yellow copy of the order and the MDS nurses would update the care plan and the care guide. She stated she was not sure where the breakdown was but maybe the order did not get written and passed on to the MDS nurses. On 09/13/12 at 11:16 AM the ADON stated that a fall assessment had been done, the resident was no longer at risk for falls and the physician would be notified for an order to discontinue the PBA. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff | IN DEPLICATION (X1) PROVIDERS/REPLIERCULA (X2) PARESULATION NUMBER: 345349 DIVIDER OR SUPPLIER RY WELLINESS CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 could be discontinued. On 09/13/12 11:07 AM, MDS Nurse #1 stated in an interview that at one time the resident would take her oxygen off and try to get up and a PBA was put on the resident. The MDS Nurse stated that when a decision was made to discontinue a PBA an order was written to discontinue the alarm and the MDS nurse would quale the care plan and the MDS nurse would update the care plan and the care guide. She stated she was not sure where the breakdown was but maybe the order did not get written and passed on to the MDS nurses. On 09/13/12 at 11:16 AM the ADON stated that a fall assessment had been done, the resident was no longer at risk for falls and the physician would be notified for an order to discontinue the PBA. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility written enters the facility without an indivelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | |

PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

| SANAEMENT OF DEFICIENCIES (ADD PLAN OF CORRECTION) 345349 STREET ADDRESS, CITY, STATE, AIP COMP 2778 COUNTRY CLUB DRIVE HAMPSTEAD, N.C. 24443 STREET ADDRESS, CITY, STATE, AIP COMP 2778 COUNTRY CLUB DRIVE HAMPSTEAD, N.C. 24443 STREET ADDRESS, CITY, STATE, AIP COMP 2778 COUNTRY CLUB DRIVE HAMPSTEAD, N.C. 24443 PROVIDER'S PLAN OF CORRECTION (PAR OF CORRECTION (PAR OF PROVIDER'S PLAN OF CORRECTI | OFMIT | O I OI MEDIONIL G | MICDIONID OF LANGED | | | | | |
|--|--------|---|--|------|---------------|--|---|--------|
| NAME OF PROVIDER OR SUPPLIER WOODBURY WELLINESS CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC. 24443 FOR DEPARTMENT OF DEFICIENCIES GENERAL STREEM OF DEFICIENCY TAG FOR CONTINUE APPROPRIATE TAG FOR CONTINUE APPROPRIATE TAG FOR CONTINUE APPROPRIATE TAG FOR CONTINUE APPROPRIATE CONTINUE AND CONTINUE APPROPRIATE CONTINUE AND APPROPRIATE CONTINUE APPROPRIATE CONTINUE APPROPRIATE CONTINUE AND APPROPRIATE CONTINUE APPROPRIATE CONTINUE APPROPRIATE CONTI | | | | [` ' | | | | |
| NAME OF PROVIDER OR SUPPLIER WOODBURY WELLNESS CENTER INC SUMMARY STATELIEM OF DEFICIENCIES (APPLIED BY THE PROVIDERS PLAN OF CORRECTION PROJECT OR PROJECT OR PROJECT OR PROJECT OR PROVIDERS PLAN OF CORRECTION PROJECT OR PROJECT OR PROVIDERS PLAN OF CORRECTION PROVIDED PROVIDERS PLAN OF CORRECTION PROVIDED PROVIDED PROVIDERS PLAN OF CORRECTION PROVIDED PROVIDED PROVIDERS PLAN OF CORRECTION PROVIDED PR | | | | | | | 1 | - |
| WOODBURY WELLNESS CENTER INC A D SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG | _ | | 345349 | | - | | 09/1 | 3/2012 |
| (X4) D PRETEX TAGS F 315 Continued From page 8 care for a resident after an incontinent episode for 1 of 1 resident's observed during incontinence care (Resident #114). The findings include: Resident #114 was admitted to the facility on 11/0/10, re-admitted to the facility on 11/0/10/10/10/10/10/10/10/10/10/10/10/10 | | | RINC | | 27 | 78 COUNTRY CLUB DRIVE | | |
| F 315 Continued from page 8 care for a resident after an incontinent episode for 1 of 1 resident's observed during incontinence care (Resident #114). The findings include: Resident #114 was admitted to the facility on 11/01/10, re-admitted to the facility on 20/05/12 and had diagnoses including Neurogenic Bladder. The Annuel Minimum Data Set (MDS) Assessment dated 07/30/12 showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident had moderate cognitive impairment. The MDS showed that the resident was frequently incontinent of bowel and bladder and had an indwelling urinary catheter. The CAA for urinary incontinence as howed that the resident was frequently incontinent of bowel and bladder and had an indwelling urinary catheter. The CAA for urinary incontinence as howed that the resident care duide dated 09/05/12 posted inside the resident's closed door under Toleting Program instructed staff to provide catheter care every shift and as needed. The facility policy titled Catheter Care, Urinary, dated September 2005, under Steps in the Procedure read: "For the male: cloanse around the measus. Cloanse and rinse the catheter from insertion site to approximately four inches outward." Continued from previous page) Tag F315 For Resident #114: • Director of Nursing provided additional incontinent care for resident #114 and others: • Inservice of first care for least-field additional incontinent care at fall for no facility Catheter Care at fall for na facility Policy and Procedure are with catheter care. • In | | | | | H | AMPSTEAD, NC 28443 | | |
| F 315 Continued From page 8 care for a resident after an incontinent episode for 1 of 1 resident's observed during incontinence care (Resident #114). The findings include: Resident #114 was admitted to the facility on 11/01/10, re-admitted to the facility on 09/05/12 and had diagnoses including Neurogenic Bladder. The Annual Minimum Data Set (MDS) Assessment dated 07/30/12 showed that the resident had moderate cognitive impairment. The MDS showed that the resident required extensive assistance for bed mobility, toileting and personal hygiene. The Care Area Assessment (CAA) for activities of daily living dated 08/10/12 showed that the resident was frequently incontinent of bowel and bladder and had an indivelling uninary catheter. The CAA for urinary incontinent of bowel and bladder and had an indivelling urinary catheter. The Resident Care Guide dated 09/05/12 posted inside the resident's closet door under Toileting Program instructed staff to provide catheter care every shift and as needed. The facility policy titled Catheter Care, Urinary, dated September 2005, under Steps in the Procedure read: "For the maile: cleanse around the meatus. Cleanse and rinse the catheter from insertion site to approximately four inches outward." Catheter Care) Audit Tool to be completed two times weekly for four weeks, then weekly for four weeks by Charge Nurses or DOM/Dasignee. | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE ROPRIATE | |
| outward." Out 2012 140 at 0.47 AM the treetment pure 1100 | | Continued From page care for a resident affor 1 of 1 resident's o care (Resident #114) The findings include: Resident #114 was a 11/01/10, re-admitted and had diagnoses in The Annual Minimum Assessment dated 0 resident had modera MDS showed that the assistance for bed mygiene. The Care Area Assedially living dated 08/resident was frequent bladder and had an inthe CAA for urinary resident was frequent bladder and had an inthe Resident Care Coinside the resident's every shift and as need to be the facility policy titled dated September 20/Procedure read: "Fothe meatus. Cleanse | dmitted to the facility on to the facility on O9/05/12 including Neurogenic Bladder. Data Set (MDS) 7/30/12 showed that the te cognitive impairment. The excident required extensive obility, toileting and personal continent of bowel and indwelling urinary catheter. Incontinent of bowel and indwelling urinary catheter. Incontinent of bowel and indwelling urinary catheter. Incontinence showed that the try incontinent of bowel and indwelling urinary catheter. Incontinence showed that the try incontinent of bowel and indwelling urinary catheter. Stude dated 09/05/12 posted closet door under Toileting taff to provide catheter care eded. Determined the catheter care december of the male: cleanse around and rinse the catheter from | | | Preparation and submission of this plan of correction the CMS Form 2567 from the 09/13/12 survey. It do an agreement or admission by Woodbury Wellness of the facts alleged or of the correctness of the concentres statement of deficiency. The facility reserves all the deficiencies, findings, conclusions and actions or Plan of Correction (and the attached documents) als facility's credible allegation of compliance (continued from previous page) Tag F315 For Resident #114: • Director of Nursing provadditional incontinent caresident on 9/12/12 folioobservation, to include of the incompliance of the care facility Policy and Procedures and all direct care facility Policy and Procedures of all direct care facility Policy and Procedures of all direct care facility and Procedures, administration of catheter care incontinent episode not in serviced on this diserviced in person or via DON/Designee by 10/1 • Catheter Care Audit Too by DON/Designee on 10/3, facility Catheter care. • Charge Nurses in service DON/Designee on 10/3, facility Catheter Care Procedure and (Catheter Tool. • (Catheter Care) Audit Too completed two times we weeks, then weekly for | ces not constitute. Cool to be ceekly for four four weeks | |
| | | | AM the treatment nurse was | | | (continued on next page) | v | |

Event ID: ECC111

PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|----------------------------|------|--|---|----------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | *************************************** | C | |
| | | 345349 | B. WIN | G | | 1 - | /2012 |
| | ROVIDER OR SUPPLIER | RINC | | 27 | EET ADDRESS, CITY, STATE, ZIP CODE 178 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443 | ••• | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LDBE | (X5) COMPLETION DATE |
| F 315 | observed to provide that the resident over on his loft liquid, brown stool resident's buttocks a (NA) #2 was observed and water to clean the per-rectal area and in the resident over ont continued to clean starea, inner thighs an observed to have an The NA did not clear (catheter insertion sicatheter tubing. The these areas. On 09/12/12 at 10:1 with NA #2. When the care was done, the loft observe the care. The had seen the care so NA at that time. An interview was continued to poly and Nursing (ADON) on DON stated that she cleaned with soap at that with liquid stool | wound care for Resident s observed to turn the left side and a large amount was observed on the nd linens. Nursing Assistant ed to use a towel with soap he resident's buttocks, nner thighs. The NA turned to his back and the NA tool from the resident's groin d scrotum. The resident was indwelling urinary catheter. In around the urinary meatus te) and did not clean the re was no visible stool on 9 an interview was conducted he NA was asked if catheter NA stated: "I wiped it off." 1 AM the Treatment Nurse w that the NA should have round the head of the penis ing. The Nurse stated that t of the room and did not he Nurse stated that if she he would have corrected the nducted with the Director of 109/12/12 at 10:51 AM. The would expect the area to be and water. The ADON stated there was the possibility of the nand the area should have | F | 315 | Preparation and submission of this plan of correction in the CMS Form 2567 from the 09/13/12 survey. It does an agreement or admission by Woodbury Wellness Co of the facts alleged or of the correctness of the conchibite the statement of deficiency. The facility reserves all it the deficiencies, findings, conclusions and actions of Plan of Correction (and the attached documents) also facility's credible allegation of compliance (continued from previous page • Random auditing of incorporate and monthly times are care/catheter care of reside indwelling Catheter to be by DON/Designee weekly weeks and monthly times months. Thereafter, the (Care) Audit Tool will be a monthly by the Charge N DON/Designee and one real catheter needing inconting will be directly observed. Charge Nurse/DON/Designee and one real catheter needing inconting the survey of the correct Catheter care for a with a catheter have catheter than a catheter have catheter than a catheter have catheter and appropriate a correct Catheter care for a with a catheter have catheter and again the following of determination at that time continued monitoring. • COMPLETION DATE (continued on next page) | interest the truth sions stated on lights to contest he Agency. This functions as the light to contest he Agency. This functions as the light to contest he Agency. This functions as the light to contest he Agency. This functions as the light to contest he Agency. This functions as the light to complete day times four two Catheter audited turse or esident with ment care by the gene. This sident Care are are as related to all residents eter care are as related to all residents eter care sode. E) Audit o be ed Quality Meeting juarter, with e for need of | |

Facility ID: 923206

PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICARD SERVICES | | | | | | | |
|--|---|---|-------------------|-----|--|--|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345349 | B. WIN | IG | - | 09/13 |) 3/2012 |
| | OVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE 178 COUNTRY CLUB DRIVE | 1 00716 | 72012 |
| WOODBU | RY WELLNESS CENTER | INC | | H | AMPSTEAD, NC 28443 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | • | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) Preparation and submission of this plan of correction. | LD BE DPRIATE is in response to | (X5) COMPLETION DATE |
| F 371 SS=E | 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, di under sanitary condition of the colling facility failed to main the failed to main | CURE, ERVE - SANITARY Is sources approved or ry by Federal, State or local stribute and serve food ions It is not met as evidenced one and staff interviews the ain sanitary conditions in the lean ceiling vents over two of and the dish machine area ation from microorganisms. Derature observation on ceiling vent located over the ed-covered with black dust lation cover and spreading - 6 inches from each vent foot ceiling ventilation grate od preparation table and aster was observed covered black grime and dust feet of space between the above the dish machine erved covered with gray dust | | 371 | DEFICIENCY) Preparation and submission of this plan of correction. the CMS Form 2567 from the 09/13/12 survey. It do an agreement or admission by Woodbury Wellness C of the facts alleged or of the correctness of the conchit the statement of deficiency. The facility reserves all the deficiencies, findings, conclusions and actions of Plan of Correction (and the attached documents) also facility's credible allegation of compliance (continued from previous page) Tag F371 Vents and ceiling area about preparation of compliance (continued from previous page) Tag F371 All other vents and surrous ceiling areas were inspected Dietary Manager on 9/13/12. All other vents and surrous ceiling areas were inspected Dietary Manager on 9/13/12 by Dietary Manager to include obsert cleaning, if applicable. Cooks Closing List Audit revised on 9/28/12 by Dietary Cooks in serviced Manager to include obsert cleaning, if applicable, of surrounding ceiling area. is to be completed daily be Dietary Cooks in serviced Manager on 10/1/12 on recooks Closing List audit implementation on 10/1/11 Cooks not in serviced on will be in serviced in persphone by 10/5/12 by Diet Manager. All Dietary Staff in servic Dietary Manager on 10/1 routine cleaning of vents to ensure cleanliness. An staff not in serviced in person of by 10/5/12 by Dietary Manager to do Q Assurance audits two time for two weeks and weekly to include observation of | es not constitute enter of the truth sisons stated on rights to contest the Agency. This finnctions as the ove food nine area ager on unding ted by /12 and sheet etary vation and vents and This audit by Cook. 1 by Dietary evised sheet, with 2. Any this date son or via tary ced by /12 on and ceiling by dietary is date will or via phone anager. uality tes weekly y thereafter, | |
| | particles and multiple measuring ½ inch or | e hanging gray dust strings longer. | | | ceiling in kitchen area to cleanliness. (continued on next page) | | |

Facility ID: 923206

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | DING | | COMPLET | |
|--------------------------|---|--|--------------------|------|---|---|----------------------------|
| | | 345349 | B, WING | G | | | 3/2012 |
| | OVIDER OR SUPPLIER | RINC | | 27 | EET ADDRESS, CITY, STATE, ZIP CODE 178 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 371 | PM revealed the kitch condition. During a third observe revealed the kitchen condition. During an interview 9/13/12 at 10:05 AM been busy lately, the | e 11 servation on 9/12/12 at 3:30 hen ceiling was in the same vation on 9/13/12 at 10:00 AM ceiling was in the same with the Dietary Manager on she indicated that we have ceiling tiles should not look taken care of this afternoon. | F | 371 | Preparation and submission of this plan of correction: the CMS Form 2567 from the 09/13/12 survey. It do an agreement or admission by Woodbury Wellness C of the facts alleged or of the correctness of the concluthe statement of deficiency. The facility reserves all the deficiencies, findings, conclusions and actions of Plan of Correction (and the attached documents) also facility's credible allegation of compliance (continued from previous page) Results of Cooks daily at Quality Assurance audits reviewed in next schedule Management Committee and again the following of determination at that time continued need for monit Completion Date: 10/5/ | es not consume tenter of the truth ssions stated on rights to contest the Agency. This functions as the udits and a to be ed Quality Meeting quarter, with e for foring. | |

PRINTED: 11/08/2012

11/01/2012

FORM APPROVED OMB NO. 0938-0391

OVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

345349

A BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

B. WING

NAME OF PROVIDER OR SUPPLIER

WOODBURY WELLNESS CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

| (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) | (XS) COMPLETION DATE |
|--------------------------|--|---------------------|---|---|
| K 000 | INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: | K 000 | Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 11/01/12 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance | der ter der der der der der der der der der d |
| K 012 SS=E | 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 | K 012 | Tag K012 Smoke wall in attic area above kitchen to have any unsealed penetrations sealed in such a way as to meet fire resistance rating by Maintenance Supervisor/Designee Audit of all smoke walls in the attic area to be audited by the | |
| | This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: smoke wall in attic above kitchen has unsealed penetrations that does not meet the fire resistance rating. 42 CFR 483.70(a) | | Maintenance Director/Designee to ensure all penetrations are scaled in such a way as to meet fire resistance rating. Any unsealed penetrations revealed on audit will be sealed by Maintenance Director/Designee. Maintenance POC Audit Tool | |
| K 062 SS=E | | K 062 | Developed by Administrator to include notation of unsealed penetrations in attic area smoke walls and completion of scaling in such a way as to meet fire resistance rating. (continued on following page) | |

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

Ochnistrator

(X6) DATE

Any deficiency statement ending with an esterisk (*) 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: 11/06/2012 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 SURVEY COMPLETED

345349 B. WING

01 - MAIN BUILDING 01

11/01/2012

NAME OF PROVIDER OR SUPPLIER

WOODBURY WELLNESS CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

| | | H | IAMPSTEAD, NC 28443 | |
|--------------------------|--|---------------------|---|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG 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 900 | INITIAL COMMENTS | K 000 | 11/01/12 survey. It does not constitute an agreement | |
| | This Life Safety Code(LSC) survey was | | or admission by Woodbury Wellness Center of the routh of the facts alleged or of the correctness of the | |
| ļ | conducted as per The Code of Federal Register | | conclusions stated on the statement of deficiency. The facility reserves all rights to contest the | |
| | at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced | , | deficiencies, findings, conclusions and actions of the | |
| | publications. This building is Type III(211) construction, one story, with a complete | | Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance | · |
| | automatic sprinkler system. | | (Continued from provious page) | |
| | The deficiencies determined during the survey | | Maintenance POC Audit Tool | |
| | are as follows: | | to be completed weekly times 4 | |
| K 012 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD | K 012 | weeks, and monthly thereafter by Maintenance | |
| | Building construction type and height meets one of the following. 19.1,6.2, 19.1,6.3, 19.1,6.4, | | Supervisor/Designee and provided to Administrator for review | |
| | 19,3,5,1 | | Results of Maintenance POC Audit Tool to be reviewed in next scheduled Quality | |
| | | | Management Meeting and again | |
| | This STANDARD is not met as evidenced by: Based on observations and staff interview at | | the following quarter to determine ongoing monitoring | |
| į | approximately 8:30 am onward, the following | | and frequency needed based on | |
| | items were noncompliant, specific findings | , | audit results. | |
| | include; smoke wall in attic above kitchen has | | Completion Date: November 21, | |
| | unsealed penetrations that does not meet the fire resistance rating, | | 21012 | 11)31/13 |
| | 42 CFR 483,70(a) | | | |
| 7 | NFPA 101 LIFE SAFETY CODE STANDARD | K 062 | Tag K062 | |
| SS≔E | Required automatic sprinkler systems are | | #1 - Sprinkler Head Compatibility: | |
| | continuously maintained in reliable operating | | Sprinkler Heads in Kitchen and Laundry area replaced by | |
| , | condition and are inspected and tested | | Sprinkler Vendor (Sunland) on | |
| | periodically. 19.7.6, 4.6.12, NFPA 13, NFPA | | November 12, 2012 to | |
| | 25, 9.7.5 | | compatible (like color, | |
| | | ļ | temperature activation) heads. (continued on next page) | |
| BOO (HON) | DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN | iori inc | TITLE | (X6) DATE |

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

TITLE

(X8) 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.

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

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

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 11/06/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

A BUILDING 01 - MAIN BUILDING 01 B. WING 345349 11/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE **WOODBURY WELLNESS CENTER INC** HAMPSTEAD, NC 28443 Proparation und Ballantiskin OF (Dio BRIGOT ION action (X5) COMPLETION DATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX is in JEHOHLO OFFICE WEFORTON PHOHLINEE । ध्यापन्य क्रान्स्स्म्स्मित्स्य तस्य तस्य तस्य प्राप्त क्रियानिस्मित्र्य or admission by Wooder Admissio REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG the second of the surface of the concernes of the conclusions stated on the statement of deficiency, The facility reserves all rights to contest the K 062 Continued From page 1 K 062 deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached This STANDARD is not met as evidenced by: documents) also functions as the facility's credible Based on observations and staff interview at allegation of compliance (continued from previous page) approximately 8:30 am onward, the following Results of Maintenance POC items were noncompliant, specific findings Audit Tool to be reviewed in include: next scheduled Quality 1. provide documentation that the mixed heads in Management Meeting and again kitchen area and laundry room are compatible. the following quarter to 2. sprinkler heads throughout the facility have excessive lint on the heat sensitive element. determine ongoing monitoring 3, at time of survey facility could not provide and frequency needed based on audit results documentation that 5 year obstruction 11/21/12 Completion Date: November 21, investigation has been perform on sprinkler 21012 system. Tag K062 42 CFR 483.70(a) #3 - 5 year obstruction test 5 year obstruction test for sprinkler system scheduled by Administrator on November 6, 2012 to be conducted by vendor (Sunland) on November 12. 2012. Outcome of testing on November 12, 2012 will determine need for flushing of system and any additional scheduled work needed. Vendor to update facility scheduled maintenance to include 5 year obstruction testing of Sprinkler System. Results of 5 year obstruction test for sprinkler system to be reviewed in next scheduled Quality Assurance Committee Meeting and again the following quarter with determination for continued review at that time.

Completion Date: December 16,

PRINTED: 11/06/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B, WING __ 345349 11/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE **WOODBURY WELLNESS CENTER INC** HAMPSTEAD, NC 28443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (Ж5) СОМРЪЕТІОН (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRÉFIX DATE TAG TAG DEFICIENCY Proparation and submission of this plan of correction is in response to the CMS Form 2567 from the K 062 Continued From page 1 K 062 11/01/12 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the faces alleged or of the correctness of the This STANDARD is not met as evidenced by; conclusions stated on the statement of deficiency, Based on observations and staff interview at The facility reserves all rights to contest the approximately 8:30 am onward, the following deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached items were noncompliant, specific findings documents) also functions as the facility's credible include: allegation of compliance 1. provide documentation that the mixed heads in (Continued from previous page) kitchen area and laundry room are compatible. All sprinkler heads in facility 2. sprinkler heads throughout the facility have audited by Maintenance excessive lint on the heat sensitive element. Supervisor/Designee to ensure all 3. at time of survey facility could not provide fire compartments contain documentation that 5 year obstruction compatible (like color, investigation has been perform on sprinkler temperature activation) heads. system. Maintenance POC Audit Tool Developed by Administrator to 42 CFR 483,70(a) include observation of random fire compartments to ensure compatible (like color, temperature activation) heads are in place. Maintenance POC Audit Tool to be completed weekly times 4 weeks, and monthly thereafter by Maintenance Supervisor/Designee and provided to Administrator for review Results of Maintenance POC Audit Tool to be reviewed in next scheduled Quality Management Meeting and again the following quarter to determine ongoing monitoring and frequency needed based on audit results nlatha Completion Date: November 21,

21012

(continued on next page)

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11/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345349

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

Daily B

A BUILDING
B. WING

01 - MAIN BUILDING 01

NAME OF PROVIDER OR SUPPLIER

WOODBURY WELLNESS CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE

HAMPSTEAD, NC 28443

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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 Preparation and submittibile of Mix plan of correction | (X5) COMPLETION DATE |
| K 062 | Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8;30 em onward, the following items were noncompliant, specific findings include: 1. provide documentation that the mixed heads in kitchen area and laundry room are compatible. 2. sprinkler heads throughout the facility have excessive lint on the heat sensitive element. 3. at time of survey facility could not provide documentation that 5 year obstruction investigation has been perform on sprinkler system. 42 CFR 483.70(a) | K 082 | is in response to the CMS Form 2567 from the 11/01/12 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to content the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance (continued from previous page) Tag K062 #2 - Sprinkler Head Cleaning Sprinkler Heads throughout the facility noted on survey to have lint were cleaned on 11/5/12 by Maintenance Supervisor/Designee. Audit of all sprinkler heads throughout the facility completed by Maintenance supervisor/Designee on 11/6/12 to ensure they were free of lint. Any found on audit not meeting this criteria were cleaned by the Maintenance Supervisor/Designee at this time. Maintenance POC Audit Tool Developed by Administrator to include audit of random sprinkler heads to ensure they are free from lint. Maintenance POC Audit Tool to be completed weekly times 4 weeks, and monthly thereafter by Maintenance Supervisor/Designee and provided to Administrator for review (continued on next page) | |
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