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

PRINTED: 09/18/2013 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	
		345054	B. WING			09/18/2013	
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C				1150 PI	ADDRESS, CITY, STATE, ZIP CODE INE RUN DRIVE ERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	Long Term Care Fa	mpliance with the CFR Part 483, Subpart B for acilities (General Health tion Survey conducted on	FC	00	DEPICIENCY)		
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	<u>,l</u>	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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1		I AND HUMAN SERVICES				FORM	: 11/08/2013 APPROVED : 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
	345054		B. WING			11/05/2013	
	PROVIDER OR SUPPLIER  AVEN NURS & ALZHI	EIMER'S C		1150	ET ADDRESS. CITY, STATE. ZIP CODE PINE HUN DRIVE BERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION UAIL
K 000	: ; INITIAL COMMEN	rs	К	000			and
	conducted as per T at 42 CFR 483,70(a Health Care section publications. This b	de(LSC) survey was the Code of Federal Register a); using the 2000 Existing a of the LSC and its referenced uilding is Type V construction, mplete automatic sprinkler					
K 067 SS=E	are as follows; NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with	termined during the survey FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed the manufacturer's 0.5.2.1, 9.2, NFPA 90A,	-	2.	The smoke damper has be replaced: All smoke dampers have checked. Preventive maintenance be performed annually be maintenance: department a log will be maintained it is not necessary to	been will y the and	
	Surveyor: 27871 Based on observation approximately 9:00 items were noncominclude: smoke dan	ons and staff interview at am onward, the following pliant, specific findings iper's on Hall 1113 did not of fire alarm test(attic access 13 and 114).		5.	this to our quality assurance program. Completion date for thit tag is 11-18-13.	9	11-18-13
K 069 \$\$≂E		FETY CODE STANDARD e protected in accordance .6, NFPA 96	Κo	69   			
		ERISUPPLIER REPRESENTATIVE'S SIGN		i	Dicebr		(XB) DATE

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event II) 8MSF21

Laciny ID 923/101

To:919 733 6592

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 345054 B. WING . 11/05/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1150 PINE RUN DRIVE WOODHAVEN NURS & ALZHEIMER'S C LUMBERTON, NC 28358 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 069.1. The splash guard has been K 069 Continued From page 1 installed. 2. There are no more deep This STANDARD is not met as evidenced by: fryers in use in the kitchen. Surveyor: 27871 3. The dietary supervisor(Lorna Based on observations and staff interview at Kelly) will be responsible approximately 9:00 am coward, the following for issuing a work order for items were noncompliant, specific findings include:deep fat fryer in kitchen is not 16 inches a splash guard if another from adjacent equipment. Therefore, splash deep fryer is installed.in guard's be installed at a minimum of 8 inches on the kitchen. fryer. 4. It is not necessary to add this to our quality assurance 42 CFR 483.70(a) program. 5. Completion date for this tag is 11-18-13. 11-18-13

		AND HUMAN SERVICES					APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES						T -	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING 2	(X3) DATE SURVEY COMPLETED	
		345054	8 WING			11/0	15/2013
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
•					150 PINE RUN DRIVE		
WOODHAVEN NURS & ALZHEIMER'S C			LUMBERTON, NC 28358				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP DEFICIENCY)	) OE	(X5) COMPLÉTION DATF
K 000	INITIAL COMMEN	rs	κο	000			
	Surveyor: 27871 This Life Safety Co conducted as per T at 42 CFR 483.70(a Health Care section publications, This b one story, with a co system.	de(LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced building is Type V construction, amplete automatic sprinkler re determined during the		es dem tit stade dem en	NOV 1 9 20 CONSTRUCTION SE		
				<u>:</u>	: :		

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FORM CMS-2567(02-98) Provious Versions Obsolete

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

Event (D: 8MSF21

Facility ID: 923461

TITLE

If continuation sheet Page 1 of 1

(XA) DATE