STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. BUILDING _____ B. WING _____	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	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)	(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) recertification investigation survey conducted on 08/17/11.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	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)	(X5) COMPLETION DATE
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. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/16/11 at approximately noon the emergency generator was non-compliant, specific findings include the generator failed to crank when power was transferred.	K 144	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 09/16/11 survey. It does not constitute an agreement or admission by Woodbury Wellness Center, Inc. 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, finding, conclusions and actions of the Agency. This plan of correction and the attached documents also functions as the facility's credible allegation of compliance. Tag K144 For Generator that failed to crank on September 16, 2011: • Maintenance Contractor for Generator Service called by Maintenance Supervisor at approximately 12:15 pm, while survey still in progress, for emergency response to inspect generator. Generator was inspected and fully operational by 6:00 pm September 16, 2011. • Maintenance Contractor for Generator Service to do full system inspection on generator by October 7, 2011. • Generator Test Log reviewed by NHA on September 16, 2011 to ensure inclusion of weekly and monthly generator inspection requirements. • Generator (Crank) Test log developed and implemented by NHA on 9/19/11. • Generator to be cranked three times weekly times 4 weeks with documentation on Generator (Crank) Test Log and weekly thereafter with documentation on monthly summary Generator Test Log by Maintenance Supervisor/Designee to ensure proper cranking of generator. • NHA to review Generator (Crank)Test Log weekly times four weeks and Generator Test Log monthly thereafter to ensure required weekly generator testing completion with proper cranking of generator. • Results of Generator Test Logs to be reviewed in next scheduled Quality Management Committee Meeting and quarterly thereafter. • **Completion Date: October 7, 2011**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judith B. Liberati	NHA	9/29/11

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