

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

PRINTED: 11/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/14/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358		
(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 and complaint investigation survey conducted on 09/14/11.	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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358	
(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 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to dry storage room in kitchen would not close and latch.  42 CFR 483.70(a)	K 018	The listed door has been fixed by our maintenance department. No other doors have been identified as deficient. No resident was harmed by this deficiency. It is not necessary to add this to our quality assurance program since maintenance will monitor the doors on a quarterly basis. Completion date is 11-27-11.	11-27-11
K 038 SS=E	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	K 038	The doors exiting the courtyard back into the facility remain unlocked. No other exit doors have been identified as deficient. Staff have been educated on keeping the exit doors to courtyard	

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

TITLE

(X6) DATE

*Barbara Collins RN, MSN*

Director

10-28-11

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.

6W

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358	
(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 038	Continued From page 1  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview approximately 8:30 am onward, the following items were noncompliant, specific findings include: the doors exiting from courtyard back into the facility were lock on re-entry, also, both doors from pharmacy requires two motion of hand to open door to exit corridor.	K 038	unlocked at all times. This has been added to our daily check sheets to be maintained every shift by our nurses. No resident was harmed by this deficiency. This has been added to our quality assurance program to be <sup>performed</sup> monthly times three months then quarterly if 100% compliance is achieved. Completion date is 11-27-11.	11-27-11
K 056 SS=E	42 CFR483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at	K 056	has been identified. No resident has been harmed by this deficiency. It is not necessary to add this to our quality assurance program since maintenance will ensure all new doors and latches that come in facility meet the guidelines. Completion date is 11-27-11.	11-27-11
		K056	The storage has been removed from within 18 inches of the sprinkler head. No resident was affected by the deficiency. No other deficient areas have been identified. The staff have been educated on this deficiency. This will be added to our quality assurance program for our PI nurse to monitor monthly times three months, then quarterly if 100% compliance is reached. Completion date is 11-27-11.	11-27-11

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358		
(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 056	Continued From page 2 approximately 8:30 am onward, the following items were noncompliant, specific findings include: closet by Janitor/Soiled linen in kitchen had storage within 18 inches of sprinkler head.	K 056			
K 072 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Surveyor: 27B71 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: linen carts and boxes are blocking exit egress at Kitchen Dept.	K 072	The carts and boxes blocking the exit have been removed. No other areas have been identified as non-compliant. The staff have been educated on keeping all exits clear of storage and clutter. No resident was harmed by the deficiency. This will be added to our Quality Assurance program to be monitored monthly times three months then quarterly if 100% compliance is noted. Completion date is 11-27-11.	11-27-11	
K 144 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  <del>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.</del>	K-144	<i>wrong tag for Gordon wash bump for conversation w. the Gordon on 10-24-11. Barbara Collins</i>		

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358		
(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	Continued From page 3  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: objects stored on light fixtures in residents rooms 1209, 1215 and 1216.  42 CFR 483.70(a)	K 144	All items from light fixtures have been removed. All other light fixtures have been checked. No resident was harmed by this deficiency. This has been added to our Quality Assurance program to be monitored monthly times three months then quarterly if 100% compliance is noted. The staff have been educated on keeping all light fixtures clear of storage or clutter. The completion date is 11-27-11	11-27-11	

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2 B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358
--	---

(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 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: residents bedrooms doors 1101, 1103, 1109 and 1110 would not close and latch for smoke light seal.</p>	K 018	<p>The listed doors have been fixed by our maintenance department. No other doors have been identified as deficient. No resident was harmed by this deficiency. It is not necessary to add this to our Quality Assurance program since maintenance will monitor the doors on a quarterly basis. Completion date is 11-27-11.</p>	11-27-11
K 045 SS=E	<p>42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single</p>	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Darlene Collins RN, MSN* TITLE *Director* (X6) DATE *10-28-11*

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.

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2 B. WING _____		(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358		
(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 045	Continued From page 1 lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: day room on special care unit will leave residents in darkness.	K 045	The lighting on the unit has been fixed by maintenance to give continuous light. No other deficient areas have been identified. No resident was harmed by the deficiency. It is not necessary to add this to our quality assurance program since our maintenance department will monitor this on a quarterly basis. Completion date is 11-27-11.	11-27-11	
K 072 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: on 1100 hall by A152 door storage of boxes blocking exit egress. B/P machines are stored at nurse station blocking exit egress.  42 CFR 483.70(a)	K 072	The 1100 hall exit egress was cleared of all storage. No other deficient areas have been identified. No resident was harmed by this deficiency. Staff have been educated on keeping all exit corridors free of clutter. This has been added to our quality assurance program to be monitored every month times three months then quarterly if 100% compliance is achieved. completion date is 11-27-11.	11-27-11	

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

PRINTED: 10/17/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2 B. WING _____		(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  WOODHAVEN NURS & ALZHEIMER'S C			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE LUMBERTON, NC 28358		
(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	