

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

PRINTED: 09/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301
---	--

(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	<p>INITIAL COMMENTS</p> <p>The facility was found to be in compliance with the Medicare/Medicaid Long Term Care Regulations 42 CFR Part 483, Sub part B during a recertification survey</p>	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

PRINTED: 10/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED OCT 30 2012 10/17/2012
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301	
(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 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 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V unprotected construction, is utilizing North Carolina Special Locking arrangements and is equipped with an automatic sprinkler system.	K 000		
K 012 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 10/17/2012 the following Life Safety item was observed as noncompliant with the rated ceiling in the facility, specific findings include: There were unsealed penetrations in the rated ceiling at the 400 hall mechanical room where piping insulation had dropped from the piping it was protecting. NOTE: This mechanical room was accessed by going through a linen room on the hallway. CFR#: 42 CFR 483.70 (a)	K 012	1. The insulation was replaced, covering the pipe. 2. All ceilings were inspected to ensure the insulation was in place for all piping. 3. The building will be inspected monthly by the Maintenance Director, using the Quality Assurance, Building Inspection Tool. Results of the audits will be discussed in the monthly Quality Assurance meetings and acted upon accordingly.	10/19/12 10/24/12 10/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carolina Bree LNHHA Administrator* TITLE _____ (X6) DATE 10/30/12

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: 345348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WHISPERING PINES NUR B. WING _____ <i>Oct 30 2012</i>	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301	
(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 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 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III unprotcted construction, is utilizing North Carolina Special Locking arrangements and is equipped with an automatic sprinkler system.	K 000		
K 056 SS=D	CFR#: 42 CFR 483.70 (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: Based on the observations and staff interviews on 10/17/2012 the following Life Safety item was observed as noncompliant, specific findings include: The facility had a sprinkler head blocked by a light fixture in the linen room on the staff hallway/ small service hall near the new wing	K 056	K056 1. The light fixture was changed to a smaller fixture to allow for more room between it and the sprinkler head. 2: a. The building was inspected to ensure there were no obstructions to the sprinkler system. b. Staff was in-serviced to keep any objects at least 18 inches from the sprinkler heads. 3. The building will be inspected monthly times 3 months by our Maintenance Director, as part of our Quality Assurance Program using the Building Observation Tool. The results of the audit will be discussed at the monthly Quality Assurance meeting.	10/24/12 10/2412 10/24/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Catherine Bore LNAHA, Administrator* TITLE _____ (X6) DATE 10/30/12

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: 345348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WHISPERING PINES NUR B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301		
(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 1 nurses station. CFR#: 42 CFR 483.70 (a)	K 056			

MCS