OCT 0 5 2012

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

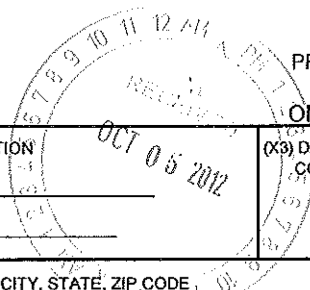
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. BUILDING ______ B. WING ______	C 09/13/2012

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 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to develop a comprehensive care plan that addressed the current dental and feeding assessments, elopement risk, and body alarm status of 2 of 18 residents sampled. (Residents # 113, #56) Findings included: An unannounced annual survey and complaint investigation was conducted at the facility on September 10 - 13, 2012.	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 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 **Tag F280** **#1 (Dentures)** **For Resident #113:** • Care Plan for potential for weight loss updated by MDS Coordinator on 9/13/12 to reflect that resident no longer wears dentures. • Resident Care Guide reviewed and updated, if applicable, by MDS Coordinator on 9/13/12. **For Resident #113 and all other in-house residents:** • Audit completed by DON/Designee of all in-house residents to determine current use of dentures. • Care Plans of all in-house residents audited and updated, if applicable, by DON/MDS Designee as related to current denture use. • Resident Care Guides for all in-house residents audited and updated by MDS/DON/Designee as related to current denture use. **#1 (Feeding)** **For Resident #113:** • Care Plan for potential for weight loss updated by MDS Coordinator on 9/13/12 to reflect that resident is totally dependent for feeding as per most recent MDS. • Resident Care Guide reviewed and updated, if applicable, by MDS Coordinator on 9/13/12. (continued on next page)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judith A. Bullard
TITLE: Administrator
(X6) DATE: 10/3/12

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.



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F 280	Continued From page 1 1. Resident # 113 was admitted to the facility on 10/15/10 with a readmission on 7/1/11. He had cumulative diagnoses which included advanced dementia, recurrent aspiration pneumonia, acute respiratory failure, and dysphagia. The resident was observed being fed by staff in his room for all meals during the survey. A review of the resident's Quarterly Minimum Data Set (MDS) assessment dated 7/13/12 revealed the resident had severely impaired decision making skills, was totally dependent on staff for all areas of daily care, and was non ambulatory. Resident # 113 could rarely understand or be understood. His speech was garbled and staff had to anticipate his needs. The resident had a steady decline in weight due to disease process. A review of the resident's comprehensive care plan last reviewed on 7/18/12 indicated the resident was at risk for weight loss. Interventions care planned for Resident #113 included: top denture plate in every morning and make sure it is in for all meals; provalue cup with all meals / divided tray with all meals to increase self feeding; assist resident to eat. A review of Resident #113's care guide posted inside his closet door did not list dentures. The care guide indicated the resident required feeding by staff. An interview was conducted with Nursing Assistant (NA) #1 on 9/13/12 at 9:05 AM while he was feeding Resident #113. The NA reported he	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 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 (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. (continued on next page)	

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F 280	Continued From page 2 had been working at the facility for 4 months and he had fed the resident every meal on his shifts. He indicated the resident could not feed himself. The NA stated the resident had a top denture plate but could not wear it. NA#1 revealed if staff put the dentures in the resident's mouth he would not open his mouth any more to be fed or to drink. The NA indicated the dentures made the resident's mouth bleed in two places. An interview was conducted with NA #2 on 9/13/12 at 9:25 AM. She stated she did not think the resident had dentures. The NA revealed she fed the resident all meals when he was assigned to her. During an interview with the Unit Coordinator on 9/13/12 at 9:45 AM she stated the resident had been a total feed by staff for a least six months. She revealed the resident could not wear dentures due to mouth sores. An interview was conducted with the MDS Coordinator on 9/13/12 at 10:06 AM. She stated the change in the resident's feeding status and inability to wear his dentures should have come up during the interdisciplinary team / care plan meeting that was held quarterly. She indicated nursing should have presented the information at the meeting so the care plan could have been updated. An interview was conducted with the Administrator on 9/13/12 at 11:25 AM. She stated it was her expectation all facility residents would have an accurate and updated care plan based on their current health status at all times.	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 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 (continued from previous page) **For Resident #113 and all other in-house residents:** • Care Plans of all in-house residents to be audited and updated, if applicable, by DON/Designee as related to current elopement risk status and current physicians orders related to elopement risk to ensure accuracy • Resident Care Guides for all in-house residents to be audited and updated by DON/Designee as related to current elopement risk status and current physicians orders related to elopement risk to ensure accuracy. **#3 (body alarm status)** **For Resident #56** • Updated Fall Risk Assessment completed by MDS Coordinator on 9/13/12. • Physicians order received on 9/13/12 to DC PBA based on updated Fall Risk Assessment, resident status and no recent history of falls. • Care Plan for Activities for Daily Living updated by MDS Coordinator on 9/13/12 to reflect DC of PBA. • Resident Care Guide reviewed and updated, if applicable, by MDS Coordinator on 9/13/12. (continued on next page)	

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F 280	Continued From page 3 2. Resident # 113 was admitted to the facility on 10/15/10 with a readmission on 7/1/11. He had cumulative diagnoses which included advanced dementia, recurrent aspiration pneumonia, acute respiratory failure, and dysphagia. The resident was observed to be in his room either in bed or in a reclining chair throughout the survey. A review of the resident's Quarterly Minimum Data Set (MDS) assessment dated 7/13/12 revealed the resident had severely impaired decision making skills, was totally dependent on staff for all areas of daily care, and was non ambulatory. Resident # 113 could rarely understand or be understood. His speech was garbled and staff had to anticipate his needs. The resident had impaired range of motion on one side of his body and he received services from Occupational Therapy and Restorative Staff. The resident was dependent on staff for locomotion. A review of the resident's care plan revised on 7/18/12 revealed the resident was care planned for risk of elopement. Interventions listed included frequent visual checks, to apply and maintain Wanderguard on left wrist, to redirect resident when wandering, to counsel resident on wandering, and to ensure name and picture were on list of wanderers. A review of Resident #113's medical record revealed a doctor's order to discontinue the Wanderguard on 1/25/12. An interview was conducted with Nursing Assistant (NA) #1 on 9/13/12 at 9:05 AM. He	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 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 (continued from previous page) **For Resident #56 and all other in-house residents.** • Audit completed by DON/Designee of all in-house residents to ensure PBA's are in place as ordered by physician and body alarm status is appropriate based on resident status and fall history. • Care Plans of all in-house residents audited and updated, if applicable, by MDS/DON/Designee as related to body alarm status and physicians orders to ensure accuracy. • Resident Care Guides for all in-house residents audited and updated by DON/Designee as related to current body alarm status to ensure accuracy. **For Resident #113, #56, all in-house residents, and all future residents:** • Comprehensive care plans to be completed by Care Plan Team/MDS Coordinator on Admission and reviewed by same with updates at least quarterly and with a significant change to include assessment of denture use, feeding status, elopement risk and body alarm status, with update to Resident Care Guide, if applicable. • Care Plan Team/MDS Coordinator inserviced by Nurse Consultant on 10/3/12 regarding care plan process to include updating and accuracy of care plans and resident care guide. (continued on next page)	

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F 280	Continued From page 4 stated the resident had a body alarm but did not wear a Wanderguard. He indicated he had worked with the resident for four months and Resident #113 had not had a Wanderguard on during that time. During an interview with the Unit Coordinator on 9/13/12 at 9:45 AM she stated the resident was bed bound now and only got up in a reclining chair. She indicated the resident could not ambulate nor propel himself in a wheelchair. She revealed he was no longer an elopement risk and did not wear a wanderguard. The Director of Nursing (DON) stated in an interview on 9/13/12 at 11:40 AM, "He is not going to elope." She indicated the resident was no longer physically capable of eloping and no longer wore a Wanderguard. An interview was conducted with the facility Administrator on 9/13/12 at 11:25 AM. She stated Resident #113 was not an elopement risk due to medical condition. She stated it was her expectation all facility residents would have an accurate and updated care plan based on their current health status. 3. Resident #56 was admitted to the facility on 06/24/10 and had diagnoses including Cerebrovascular Accident (CVA) with Right Hemiparesis. The Annual Minimum Data Set (MDS)	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 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 (continued from previous page) • All nursing staff inserviced by DON/Designee on 10/3/12 regarding importance of reporting of any changes in resident status, to include denture use, feeding status, elopement risk and body alarm status, to Care Plan Team/MDS Coordinator. Any nursing staff not inserviced on this date will be inserviced by DON/Designee in person or via phone by 10/11/12. • (Care Plan) Audit Tool developed by DON/Designee on 10/2/12 to include random selection and audit of at least four in-house Resident Care Plans and correlating Resident Care Guides for review of current denture use, feeding status, elopement risk and body alarm status with reporting of any discrepancies to Care Plan Team/MDS Coordinator for update. • Charge Nurses in serviced by DON/Designee on 10/3/12 on (Care Plan) Audit Tool. • (Care Plan) Audit Tool to be completed two times weekly for four weeks, then weekly for four weeks by Charge Nurse or DON/Designee. (continued on next page)	

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F 280	Continued From page 5 Assessment dated 05/24/12 showed that the resident had moderate cognitive impairment and required extensive assistance with transfers. The MDS showed that the resident's upper and lower extremities had impairment on one side. The MDS showed that the resident had no falls since the last assessment and received no Physical or Occupational Therapy. The Care Area Assessment (CAA) for Cognitive Loss dated 06/02/11 showed that the resident was intermittently disoriented to person, place and time and had short term memory problems. The CAA showed that the resident had impaired cognitive status and function due to the CVA. The CAA for Falls dated 06/02/11 showed that the resident had been free from falls since the last assessment. The CAA showed that the resident was unable to ambulate independently and that staff encouraged her to call for assistance with all transfers. The MDS stated that the resident had a personal body alarm for safety and to alert staff when she attempted to get up without assistance. The resident's Care Plan updated 07/19/12 showed that the resident had impaired thought processes with intermittent disorientation and confusion. The Care Plan for activities of daily living showed that the resident had impaired mobility and required extensive assistance with all activities of daily living. Among the interventions was for the resident to have a personal body alarm while up in the chair. The Resident Care Guide posted on the inside of the resident's closet showed that the resident had weakness of her right arm and both legs. The section titled Falls included a place to check if the	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 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 (continued from previous page) • Random auditing of residents as related to denture use, feeding status, elopement risk and body alarm status to be completed by DON/Designee weekly times four weeks and monthly times two months. Thereafter, (Care Plan) Audit Tool will be audited monthly by the Charge Nurse or DON/Designee to ensure Care Plan and Resident Care Guide are accurate and appropriate as related to denture use, feeding status, elopement risk and body alarm status. Care Plan and Resident Care Guide will be updated by MDS Coordinator if indicated. • Results of (Care Plan) Audit Tool and random audits to be reviewed in next scheduled Quality Management Committee Meeting and again the following quarter, with determination at that time for need of continued monitoring. • **COMPLETION DATE: 10/11/12** (continued on next page)	

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F 280	Continued From page 6 resident had an alarm and the type of alarm. This section did not include information that the resident had an alarm. A review of the physician's monthly orders dated September, 2012 revealed an order dated 02/15/11 for the resident to have a personal body alarm (PBA) while up in the chair. A review of the resident's medication administration record dated 09/01/12 through 09/30/12 showed that the resident was to have a personal body alarm while up in the chair. On 09/13/12 at 10:30 AM, Resident #56 was observed sitting in a wheelchair in her room. There was not a personal body alarm on the resident or the chair. On 09/13/12 at 10:45 AM an interview was conducted with the Assistant Director of Nursing (ADON) and Nurse #1. The ADON stated that there was an order for a PBA and it was on the current care plan. The ADON stated that the PBA was not on the Resident Care Guide so the nursing assistants would not be looking for one. The ADON stated that he went to the resident's room and the resident did not have a PBA. Nurse #1 stated that the resident had not had any falls since the first of the year. The NA assigned to the resident joined the interview and stated that the resident did not have a PBA and that she did not remember the resident ever having one. The NA stated that the resident did not try to get up unassisted and she rang her call bell when she needed to go to the bathroom. The ADON instructed Nurse #1 to complete a falls assessment on the resident to see if the PBA	F 280		

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F 280	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.	F 280		
F 315 SS=D	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 interviews the facility failed to provide catheter	F 315		

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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 indwelling urinary catheter. The CAA for urinary incontinence showed that the resident was frequently incontinent of bowel and bladder and had an indwelling 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 male: cleanse around the meatus. Cleanse and rinse the catheter from insertion site to approximately four inches outward." On 09/12/12 at 9:47 AM the treatment nurse was	F 315	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 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 (continued from previous page) **Tag F315** **For Resident #114:** • Director of Nursing provided additional incontinent care for resident on 9/12/12 following observation, to include catheter care. • In-service of direct care staff on facility Policy and Procedure for Catheter Care initiated on 9/12/12. **For Resident #114 and all others:** • In-service of all direct care staff by DON/Designee on 9/12/12 and 10/3/12 on facility Catheter Care Policy and Procedures, to include administration of catheter care with each incontinent episode. Any staff not in serviced on this date will be in serviced in person or via phone by DON/Designee by 10/11/12. • Catheter Care Audit Tool developed by DON/Designee on 10/2/12 to include observation of incontinent care with catheter care. • Charge Nurses in serviced by DON/Designee on 10/3/12 on facility Catheter Care Policy and Procedure and (Catheter Care) Audit Tool. • (Catheter Care) Audit Tool to be completed two times weekly for four weeks, then weekly for four weeks by Charge Nurse or DON/Designee. (continued on next page)	

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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 DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 9 observed to provide wound care for Resident #114. The nurse was observed to turn the resident over on his left side and a large amount of liquid, brown stool was observed on the resident's buttocks and linens. Nursing Assistant (NA) #2 was observed to use a towel with soap and water to clean the resident's buttocks, per-rectal area and inner thighs. The NA turned the resident over onto his back and the NA continued to clean stool from the resident's groin area, inner thighs and scrotum. The resident was observed to have an indwelling urinary catheter. The NA did not clean around the urinary meatus (catheter insertion site) and did not clean the catheter tubing. There was no visible stool on these areas. On 09/12/12 at 10:19 an interview was conducted with NA #2. When the NA was asked if catheter care was done, the NA stated: "I wiped it off." On 09/12/12 at 10:41 AM the Treatment Nurse stated in an interview that the NA should have cleaned the penis, around the head of the penis and the catheter tubing. The Nurse stated that she had stepped out of the room and did not observe the care. The Nurse stated that if she had seen the care she would have corrected the NA at that time. An interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 09/12/12 at 10:51 AM. The DON stated that she would expect the area to be cleaned with soap and water. The ADON stated that with liquid stool there was the possibility of droplet contamination and the area should have been cleaned.	F 315	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 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 (continued from previous page) • Random auditing of incontinent care/catheter care of residents with indwelling Catheter to be completed by DON/Designee weekly times four weeks and monthly times two months. Thereafter, the (Catheter Care) Audit Tool will be audited monthly by the Charge Nurse or DON/Designee and one resident with a catheter needing incontinent care will be directly observed by the Charge Nurse/DON/Designee. This will ensure Care Plan, Resident Care Guide and proper Catheter care are accurate and appropriate as related to correct Catheter care for all residents with a catheter have catheter care with each incontinent episode. • Results of (Catheter Care) Audit Tool and random audits to be reviewed in next scheduled Quality Management Committee Meeting and again the following quarter, with determination at that time for need of continued monitoring. • **COMPLETION DATE: 10/11/12** (continued on next page)	

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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 ______	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by failing to clean ceiling vents over two of two food prep tables and the dish machine area to prevent contamination from microorganisms. Findings include: During the meal temperature observation on 9/12/12 at noon the ceiling vent located over the tray line was observed covered with black dust particles on the ventilation cover and spreading out onto the ceiling 4- 6 inches from each vent corner. A 2 foot by 4 foot ceiling ventilation grate located above the food preparation table and directly above the toaster was observed covered with thick build up of black grime and dust particles. The eight feet of space between the ceiling vents located above the dish machine drying area was observed covered with gray dust particles and multiple hanging gray dust strings measuring ½ inch or longer.	F 371	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 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 (continued from previous page) **Tag F371** • Vents and ceiling area above food prep tables and dish machine area cleaned by Dietary Manager on 9/13/12. • All other vents and surrounding ceiling areas were inspected by Dietary Manager on 9/13/12 and cleaned, if applicable. • Cooks Closing List Audit sheet revised on 9/28/12 by Dietary Manager to include observation and cleaning, if applicable, of vents and surrounding ceiling area. This audit is to be completed daily by Cook. • Dietary Cooks in serviced by Dietary Manager on 10/1/12 on revised Cooks Closing List audit sheet, with implementation on 10/1/12. Any Cooks not in serviced on this date will be in serviced in person or via phone by 10/5/12 by Dietary Manager. • All Dietary Staff in serviced by Dietary Manager on 10/1/12 on routine cleaning of vents and ceiling to ensure cleanliness. Any dietary staff not in serviced on this date will be in serviced in person or via phone by 10/5/12 by Dietary Manager. • Dietary Manager to do Quality Assurance audits two times weekly for two weeks and weekly thereafter, to include observation of vents and ceiling in kitchen area to ensure cleanliness. (continued on next page)	

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	345349	A. BUILDING ______ B. WING ______	C 09/13/2012

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WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

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F 371	Continued From page 11 During a second observation on 9/12/12 at 3:30 PM revealed the kitchen ceiling was in the same condition. During a third observation on 9/13/12 at 10:00 AM revealed the kitchen ceiling was in the same condition. During an interview with the Dietary Manager on 9/13/12 at 10:05 AM she indicated that we have been busy lately, the ceiling tiles should not look like that. It will get it taken care of this afternoon.	F 371	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 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 (continued from previous page) • Results of Cooks daily audits and Quality Assurance audits to be reviewed in next scheduled Quality Management Committee Meeting and again the following quarter, with determination at that time for continued need for monitoring. • **Completion Date: 10/5/12**	

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

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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 ______	11/01/2012

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 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	
K 012 SS=E	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 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)	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 Maintenance Director/Designee to ensure all penetrations are sealed 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 Developed by Administrator to include notation of unsealed penetrations in attic area smoke walls and completion of sealing in such a way as to meet fire resistance rating. (continued on following page)	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

NOV 1 4 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judith A. Bulford
TITLE: Administrator
(X6) DATE: 11/13/12

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

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	345349	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/01/2012

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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 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 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	
K 012 SS=E	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 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)	K 012	(Continued from previous page) • 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. Completion Date: November 21, 21012	11/21/12
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	Tag K062 #1 – Sprinkler Head Compatibility: • Sprinkler Heads in Kitchen and Laundry area replaced by Sprinkler Vendor (Sunland) on November 12, 2012 to compatible (like color, temperature activation) heads. (continued on next page)	

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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345349	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/01/2012

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K 062	Continued From page 1 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: 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 062	Prepar[illegible]ection is in [illegible] survey. [illegible] 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 (continued from previous page) • 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 **Completion Date: November 21, 21012** Tag K062 #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, 2012**	11/21/12 12/16/12

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K 062	Continued From page 1 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: 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 062	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 (Continued from previous page) • All sprinkler heads in facility audited by Maintenance Supervisor/Designee to ensure all fire compartments contain compatible (like color, temperature activation) heads. • Maintenance POC Audit Tool Developed by Administrator to 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 **Completion Date: November 21, 21012** (continued on next page)	11/21/12

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K 062	Continued From page 1 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: 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 062	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 (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)	