

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

PRINTED: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055		
(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.	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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055 DEC 31 2013	
(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 Surveyor: 27871 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 building is Type 111 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 does not constitute an admission or agreement by the provider of the truth of facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under state and federal law.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliance, specific findings include: fire dampers in all return vents in facility had excess lent on damper/link.	K 067	This plan of correction will serve as the facility's allegation of substantial compliance. K067 The dampers were cleaned. The dampers were added to a routine cleaning schedule and as needed.	12-11-13 12-11-13
K 147 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	Monitoring of the damper cleaning schedule will be conducted through the TELS system quarterly. Findings will be reported to monthly QAPI meeting for three months to ensure substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET YADKINVILLE, NC 27055	
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K 147	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliance, specific findings include: 1. rooms 112 and 114 using extension cords to plug TV into. 2. surface mounted light fixtures in laundry room missing cover. 3. GFCI in Med. room did not trip on test(located at sink). 42 CFR 483.70(a)	K 147	K147 1. Extension cords were removed from rooms. An audit of all rooms was conducted to ensure that extension cords were in use. A weekly audit of resident rooms for extension cord use will be conducted weekly for four weeks, then monthly for three months. Findings will be reported to monthly QAPI for three months to ensure substantial compliance. 2. Light covers were replaced in the laundry room. A weekly audit will be conducted to ensure lights are covered for four weeks, then monthly for three months. Findings will be reported to monthly QAPI for three months to ensure substantial compliance. 3. The GFCI in the med room was replaced. The GFCI was tested and working properly. A test of the GFCI outlet will be conducted weekly for four weeks, then monthly for three months. Findings will be reported to monthly QAPI for three months to ensure substantial compliance.	12-10-13 12-11-13 12-11-13 12-24-13 12-10-13