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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	06/23/2011

JUL 15 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE 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 GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to address the needs of 1 of 1 residents receiving dialysis (#111). The findings include: Resident #111 was admitted t the facility on 06/17/11 with diagnoses that included Hypoglycemia, Diabetes Mellitus, Reflux disease, ESRD (end stage renal disease) and requiring Hemodialysis. According to the Nursing Admission Assessment	F 279	Woodlands Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Woodlands Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. A care plan was developed to address the needs of resident #111 receiving dialysis. The admission care plan was revised to include dialysis as a problem with appropriate interventions. All nurses have been in-serviced on the revised admission care plan. All new admission and re-admission charts of residents requiring dialysis will be reviewed by the care plan team or designee within 24 hours to ensure compliance.	6-22-11 6/29/11 7/12/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth England	Administrator	7-12-11

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.

W.C
M.P
D.U S.W.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 1 dated 06/17/11, the resident had no memory problems and was independent in the decision making process. In addition, under the section " Additional Concerns ", " Dialysis " is checked. A review of the residents medical record did not reveal a care plan to address the resident ' s needs related to his receiving dialysis." During an interview with nurse #1 on 06/22/11 at 10:30 AM it was revealed " we do all the admission assessments within the first 24 hours. An interim care plan is developed using that information. The resident ' s needs related to dialysis should be included in the care plan. " Nurse #1 indicated that she would look at the care plan. " During an interview with the Director of Nursing (DON) on 06/22/11 at 11:115 AM it was revealed " I would expect that there would be something on the interim care plan about checking the site for bleeding or infection and checking the bruit or thrill. " During an interview with nurse #1 on 06/22/11 at 11:45 AM it was revealed " I did not see any thing in the care plan related to dialysis. We usually review all new admissions at the morning meeting the next day after admission to be sure that everything has been completed. (Name of resident) was admitted on a Friday so we would have reviewed him on Monday morning. The only thing I can think of is that we did not complete our meeting on Monday because of the survey team arrival. "	F 279	The Director of Nursing or Designee will audit new admission/re-admission care plans of residents needing dialysis monthly x 3 months ,then quarterly thereafter, to ensure compliance. The QA committee will review the results of the care plan audits monthly x 3 months, then quarterly x 3 quarters.	

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OMB NO. 0938-0391

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	345481	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	JUL 28 2011 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The smoke wall located in the attic space in the 300 hall has holes and penetrations that were not sealed in order to maintain the required rating of the wall. 42 CFR 483.70(a)	K 025	Woodlands Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Woodlands Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. K 025 Penetrations and holes in smoke wall located in attic space on the 300 hall will be sealed. The Maintenance Director or designee will audit all attic space for holes/penetrations in the smoke walls throughout facility and will make repairs as necessary The Maintenance Director or designee will audit smoke walls quarterly and after any contracted services in attic for compliance of K 025. The Maintenance Director or designee will report all findings from smoke wall audit to the Quality Assurance Committee quarterly.	Scheduled 8/15/11
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.6.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Englund | TITLE: Administrator | (X6) DATE: 7-25-11

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	345481	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The oxygen storage room located at the 300/400 hall nurse station was not equipped with a self closing device. 2) The clean and soiled room corridor doors did not close latch and seal. 3) The door to the dry storage room in the kitchen did not close latch and seal. 42 CFR 483.70(a)	K 029	K 029 A self-closing device was installed on the oxygen storage room door at the 300/400 hall nurses' station. A new strike plate was installed to both the clean and soiled linen room doors. The dry storage door will be repaired to insure a smoke tight seal. The Maintenance Director or designee will audit all doors throughout the facility to ensure proper closure. The Maintenance Director or designee will report all findings from door audits and staff training to the Quality Assurance Committee quarterly.	7/18/11 7/15/11 8/26/11
K 038 SS=F	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 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The sidewalk at the 400 Hall exit was did not consist of a hard and unobstructed path to the public way. Part of the sidewalk was missing and there was vehicles and material blocking the path. 2) The gate in the courtyard sidewalk that leads to the public way was equipped with a padlock. 3) The exit door at the end of 100 Hall required	K 038	K 038 Vehicles and materials were removed from pathway on 07/14/11. The sidewalk at the 400 Hall exit will be repaired to insure a hard and unobstructed path to the public way. The padlock was removed from the gate in the courtyard 7/22/11. A latching system will be added to the gate. The frame of the exit door at the end of 100 Hall was sanded and cleaned to reduce the force required to open same. The Maintenance Director or designee will audit public pathways in construction area to assure an	8/26/11 7/15/11

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K 038	Continued From page 2 greater that 15 lbs of force to open. 42 CFR 483.70(a)	K 038	unobstructed path is maintained to comply with K 038. (Communication with contractors was initiated on 07/14/11 to repair damage sidewalk.)	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The audible component for the fire alarm notification devices located in 300 and 400 hall were not operating correctly when tested.	K 051	The Maintenance Director or designee will audit all exit doors quarterly to insure proper opening of same with minimal force to comply with K 038. The Maintenance Director or designee will report findings of audits of public pathways, exit doors, and gate alarm to the Quality Assurance Committee quarterly. K 051 The enunciator (horn strobe) for the fire alarm notification devices located in 300 and 400 hall will be replaced. An audit of all audible components for the fire alarm notification will be conducted throughout the facility. The Maintenance Director or designee will conduct monthly audits to insure all fire alarm notification systems to include the audible alarm components are functioning properly in accordance to K 051. The Maintenance Director or designee will report audit findings regarding the audible fire alarm components to the Quality Assurance Committee quarterly.	8/26/11

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K 051	Continued From page 3 42 CFR 483.70(a)	K 051	K 056 New shower curtains with an 18 inches mesh top were ordered on 07/18/11 to replace current curtains in residents shower room.	
K 056 SS=F	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 observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The shower curtains in the the shower rooms are not equipped with the 18 inch mesh top that will allow for proper coverage of the room. 2) There are sprinkler heads in the facility rated for Green (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). 3) Upon review of the sprinkler inspection report it was noted that a 5 year inspection was due and that the gauges needed to be replaced. The facility at the time of the inspection did not have documentation that these items were addressed. 42 CFR 483.70(a)	K 056	Sprinkler heads with green glass bulbs (200 degrees F) will be replaced with red glass bulbs (155 degrees F). 8/26/11 A 5 year sprinkler inspection will be obtained and gauges will be replaced by to comply with K 056. 7/28/11 The Maintenance Director or designee will inspect/audit the installation of the new shower curtains and red glass bulbs in Sprinkler heads to comply with K 056. The Maintenance Director or designee will report the audits of the shower curtains, bulbs in sprinkler heads, and the results of the 5 year sprinkler inspection to the Quality Assurance Committee.	
K 061	NFPA 101 LIFE SAFETY CODE STANDARD	K 061		

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K 061 SS=D	Continued From page 4 Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The automatic sprinkler system was observed as non-compliant, specific findings include the accelerator line to the dry side of the sprinkler riser has a valve that when closed will affect the operation of the system is not equipped with an electronically supervised tamper alarm. 42 CFR 483.70(a)	K 061	K 061 A tamper alarm will be added to the accelerator line on the dry side of the sprinkler riser to electronically monitor the riser valve.. The Maintenance Director or designee will audit the new riser valve monthly for 3 months and then quarterly for 3 quarters thereafter to comply with K 061. The Maintenance Director or Designee will report quarterly audits to the Quality Assurance Committee.	8/26/11
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) The hood makeup air system in the kitchen did not appear to be operational. The Kitchen was operating under a sever negative air balance in place of a neutral air balance. 42 CFR 483.70(a)	K 069	K 069 The hood makeup air system in the kitchen shall be returned to operational status to insure a neutral air balance. The Maintenance Director or designee will audit the makeup air system to insure a neutral air balance in the kitchen for 3 months and then quarterly thereafter to comply with K 069. The Maintenance Director or Designee will report quarterly audits to the Quality Assurance Committee.	8/26/11
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072	Continued From page 5 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: Based on observation on Thursday 7/14/2011 between 11:00 AM and 3:00 PM the following was noted: 1) Through-out the facility there was storage on the exit corridors. (hoyer lifts, gerri chairs, wheelchairs, transfer chairs, and linen carts .) 42 CFR 483.70(a)	K 072	K 072 The hoyer lifts, gerichairs, wheelchairs, transfer chairs, and linen carts were removed from corridors throughout the facility on 07/14/11. CNA, LPN, and administrative staff were in-serviced in maintaining the corridors free from storage/obstructive items as identified above. Administrative staff will monitor corridors during daily rounds and remove all obstructions immediately if found. Staff will be in-serviced as needed to insure compliance with K 072. Administrative round sheets will be reviewed monthly by the Quality Assurance Committee and the quarterly x 3 quarters.	

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
345481	Woodlands Nursing and Rehabilitation Center	7/14/11
K1		* K4

K6 DATE OF PLAN APPROVAL: 2/27/1997

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 01

NUMBER OF THIS BUILDING: 0101

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

*K7 [ ] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE)

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)
A2. ☒ (ACCEPTABLE POC)
A3. ☐ (WAIVERS)
A4. ☐ (FSES)
A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☒ FULLY SPRINKLERED (All required areas are sprinklered)
B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
C. ☐ NONE (No sprinkler system)

* MANDATORY