STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, family and staff interview, the facility failed to accurately assess 3 (Residents # 78, #150 & #32) of 10 sampled residents in the areas of accident and dental. The findings include:	F 278	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Woodland Hill Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." 7/22/11 **F-278** 1) Resident #78's Minimum Data Set assessment was modified on July 13,2011 by the MDS Coordinator to reflect the resident's current condition, and including the Care Area Assessment summary and care-plan. Resident #150 Minimum Data Set assessment was modified on July 13,2011 by the MDS Coordinator to reflect the resident's current condition, and including the Care Area Assessment summary and care-plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William B. [illegible]	ADMINISTRATOR	7/22/2011

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 278	Continued From page 1 1. Resident #78 was admitted to the facility on 09/18/08. The annual Minimum Data Set (MDS) assessment dated 05/18/11 indicated that the resident was not edentulous. On 07/13/11 at 09/25 AM, Resident #78 was observed to have no bottom/upper teeth. He stated that he had all his teeth extracted and that he would love to have dentures. On 07/13/11 at 3:40 PM, the MDS Nurse was interviewed. The MDS Nurse acknowledged that the resident was edentulous and that the MDS assessment for dental was not accurate. 2. Resident #150 was admitted to the facility on 04/19/11. The admission MDS assessment dated 04/26/11 indicated that the resident had no falls anytime in the past 2-6 months prior to admission. On 07/13/11 at 10:40 AM, the resident's family member was interviewed. He stated that the resident had been falling at home and at the other nursing home. On 07/13/11 at 3:40 PM, the MDS Nurse was interviewed. The MDS Nurse acknowledged that the resident had falls prior to admission and that the MDS assessment for accident was not accurate. 3. Resident #32 was admitted on 01/18/11 with diagnoses of dysphagia, stroke, muscle weakness, high blood pressure and constipation. The Minimum Data Set (MDS) dated for 04/22/11 indicated Resident #32 had moderate cognitive	F 278	Resident #32 Minimum Data Set assessment was modified on July 13,2011 by the MDS Coordinator to reflect the resident's current condition, and including the Care Area Assessment summary and care-plan. 2. On July 15, 2011, the Minimum Data Set Department audited residents to determine dental status (edentulous) to ensure the current resident's condition was reflect on the most recent comprehensive assessments with modifications made as needed On July 15, 2011, the Minimum Data Set Department audited all residents to determine fall risk to ensure the current resident's condition was reflected on the most recent comprehensive assessments with modifications made as needed 3) The Minimum Data Set Coordinators have completed the AIS Minimum Data Set 3.0 and Rug IV Re-Training Modules on July 14, 2011. On July 15, 2011, the Clinical Reimbursement Manager re-educated the MDS Department related to falls and dental coding in the MDS.	7/22/11

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
	345277	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 278	Continued From page 2 impairment. The MDS indicated to have no difficulties with chewing or swallowing and that he was not edentulous. There was no care plan for Resident #32 dental status. A record review of the Nursing Admission Assessment dated 1/18/11 indicated Resident #32 had chewing difficulties and was without dentures. The April 2011 Quarterly Nursing Assessment indicated he remained edentulous. The nutritional assessments dated 01/24/11 and 04/22/11 indicated Resident #32 to be edentulous. An Interview with Resident #32 on 07/12/11 at 3:24pm confirmed that he did not have any teeth or dentures when he was admitted.	F 278	4) The Director of Nursing Services or designee will randomly audit four charts weekly for 1 month and monthly for 2 months to assure Minimum Data Set coding reflects current conditions. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Administrator and Director of Nursing Services are responsible for overall compliance. Date of compliance July 22, 2011 7/22/11 **F-281**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to administer the medications via gastrostomy tube by gravity for 1 (Resident #47) of 1 sampled resident. The finding includes: The facility's policy on administering medications by enteral tube (undated) was reviewed. The policy read in part " Remove bulb or plunger of syringe, reinsert syringe into the enteric tube. Administer first dose of dissolved medication by	F 281	1. Resident #47 was assessed by the Unit Manager on July 22, 2011 with no change in condition noted. On July 13, 2011, Nurse #1 was immediately re-educated on required technique related to administration of medication via Gastrostomy-Tube. On July 14, 2011 the Unit Manager gave Nurse #1 a competency test and had Nurse #1 do a return demonstration of required technique on administration of medication via a Gastrostomy-Tube. 2. On July 15, 2011 an audit of residents was completed, with three residents identified to have Gastrostomy-Tubes. Resident #47 was the only resident receiving medication through Gastrostomy-Tube.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 281	Continued From page 3 pouring into syringe. If water or medication does not flow freely, raise the height of the syringe to increase the rate of flow or try having the patient change position slightly because the end of the feeding tube may be against the gastric mucosa. If these measures do not improve the flow, a gentle push with bulb of syringe or plunger of the syringe may facility flow of fluid " . Resident #47 was admitted to the facility on 12/03/09. The quarterly MDS assessment dated 05/07/11 indicated that the resident had memory and decision making problems and was on enteral feeding. On 07/13/11 at 8:36 AM, Nurse #1 was observed during medication pass. Nurse #1 was observed to prepare the resident's medications, crushed them and dissolved them in 50 ml (milliliter) of water. After checking the placement, the nurse was observed to fill the syringe with 50 ml of water and pushed it into the tube, followed with 50 ml of dissolved medications and 50 ml of water. The nurse was not observed to try to administer the water and the medications using the syringe by gravity. On 07/13/11 at 8:41 AM, Nurse #1 was interviewed. She stated that she normally administers the enteral medications and water flush by pushing it with the syringe and not by gravity. On 07/13/11 at 3:50 PM, administrative staff #1 was interviewed. She stated that the expectation was that enteral medications are administered by gravity.	F 281	3. Nurses were re-educated by the Staff Development Coordinator and the Unit Managers on or before July 20, 2011 related to medication administration via Gastrostomy tube, as well as completing the Gastrostomy-tube Competency Skills Test. New nurses will complete the Gastrostomy-tube Competency Skills Test and return demonstration during new hire orientation. 7/22/11 4. The Pharmacy Nurse Consultant or designee will observe the administration of medications via Gastrostomy-Tube, weekly for 1 month and then monthly for 2 months. A report will be submitted to the Performance Improvement Committee monthly x 3 months for review. The Administrator and Director of Nursing Services are responsible for overall compliance. Date of compliance July 22, 2011	

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

PRINTED: 07/27/2011
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
	345277	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/27/2011 the emergency power system was tested. During this test the emergency power system did failed to transfer power during the testing of the system. NOTE: The generator was manually started and had the ability to manually transferred to the emergency power system of the facility. CFR#: 42 CFR 483.70 (a)	K 147	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Woodland Hill Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **K-147** 1. On July 27, 2011 corrective action was immediately taken. Cummins Atlantic was notified of the generator malfunction during the onsite testing. A technician was dispatched to the facility to evaluate and repair the problem. After the repair was made, the generator was tested and it automatically transferred emergency power to the facility as required. 2. The generator was tested under full load on Thursday July 28, 2011, and again on Monday August 1, 2011, by the Maintenance Director and meeting emergency generator requirements.	8/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William B Kee	ADMINISTRATOR	8/10/11

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: 07/27/2011
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
	345277	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CARE AND REHABILITATION	400 VISION DRIVE ASHEBORO, NC 27203

(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 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/27/2011 the emergency power system was tested. During this test the emergency power system did failed to transfer power during the testing of the system. NOTE: The generator was manually started and had the ability to manually transferred to the emergency power system of the facility. CFR#: 42 CFR 483.70 (a)	K 147	3. The Maintenance Director was re-educated on generator testing by the Administrator on 08/10/11 related to the requirements of the emergency generator. 4. The Maintenance Director or designee will test the generator on full load 2 x weekly x 1 month, then return to normal Life Safety testing requirements of 1 x weekly for 30 minutes. A report will be submitted to the Performance Improvement Committee monthly x 3 months for review. The Administrator and the Maintenance Director are responsible for overall compliance. Date of compliance: August 11, 2011	

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

William Bost | Administrator | 8/10/11

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.