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 _____	10/28/2016

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 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and residents the facility failed to provide a homelike dining experience by serving residents in the dining rooms on service trays and leaving discarded paper items and lids on the tables while residents were eating during 4 of 5 dining observations. The findings included: During an observation on 10/24/16 at 6:06 PM 14 residents seated in the main dining room for the dinner meal were served by staff members. The food items were not removed from the serving trays for 10 of the 14 residents. The done lids containing discarded paper items were placed in the middle of the tables where the residents were eating. An observation of the dinner meal in the 200 hall dining room on 10/24/16 at 5:45 PM revealed all 6 residents' meals were left on the serving trays and 4 of the dome lids were left on the table with discarded paper items inside the lids. On 10/27/15 at 8:03 AM Nursing Assistant (NA) #3 was observed to provide trays of food to each of 13 residents seated in the dining room. All of the food items were left on the serving tray when placed in front of each resident. The dome lids were removed from the main plate and were all placed in the center of each of the tables where the residents were seated. The dome lids	F 252	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 10/28/16 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 *For All In-House Residents: " Facility policy Assistance with Meals reviewed and revised by Nursing Home Administrator/Director of Nursing Services on 11/9/16 to include "removing meal items from service tray, and upon completion of meal setup for resident, will place service tray and ancillary service items in designated location away from dining table" to promote a homelike dining experience.	11/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2016

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F 252	Continued From page 1 contained discarded paper and lids from opening the resident's food items. NA #3 was the only staff member in the dining room serving the residents. During an interview with NA #3 on 10/27/16 at 10:40 AM he stated he placed the dome lids in the middle of the tables because he was afraid if he took the time to place the dome lids somewhere else the food items would get cold. On 10/27/16 at 10:10 AM the Food Service Manager stated the staff working with the residents in the other unit's dining room served the residents by removing the food items from the tray and placing them on the table so he was unsure why the residents in this unit's dining room were served on their trays. Unit Manager #2 was interviewed on 10/27/16 at 10:35 AM. She stated she was assisting with the tray delivery in the dining room on 10/24/16 during the dinner meal and observed most of the residents were served with their food items still on the tray and the dome lids stacked in the middle of the tables. She stated the residents who had their food items removed from the trays were served by a staff member who usually worked on another unit. She added she felt the food should be served in a more homelike fashion. The Director of Nursing (DON) was interviewed on 10/27/16 at 10:40 AM. He stated the dining experience needed to be more homelike and it would be better if the residents were served more like they were at his previous place of employment where the residents were served individually by the staff. On 19/28/16 at 8:03 AM the residents who were eating in the dining room did not have their food items on the serving trays. An interview with 3 of the residents who were present and had been present during the previous dining observations	F 252	" In-service of all direct care staff and any other staff trained as feeding assistants on revised facility policy Assistance with Meals by Staff Development Coordinator/Designee. Any staff not in serviced on new procedure by 11/16/16 will be in serviced on next scheduled shift by Staff Development Coordinator/Designee. " Newly hired Direct care staff and any other newly hired staff trained as feeding assistants will be in-serviced on facility policy Assistance with Meals during the new employee orientation process by Staff Development Coordinator/Designee. " Dining Room Audit Tool developed by Director of Nursing Services/Designee on 11/10/16 related to dining room observations of utilization by direct care staff and any trained feeding assistants of facility policy Assistance with Meals, to include observation of removing meal items from service tray, and upon completion of meal setup for resident, placement of service tray and ancillary service items in designated location away from dining table to promote a homelike dining experience. Any areas of concern noted during audit tool usage will be address at time of observation. " Nursing Supervisors/Charge Nurses/Designee in serviced by Director of Nursing Services/Designee on newly developed dining room audit tool by 11/10/16 with implementation.	

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F 252	Continued From page 2 revealed they preferred to have the food items removed from the serving trays.	F 252	" Audits will be performed by Nursing Supervisors/Charge Nurses/Designee 14 times weekly x 2 weeks, then 7 times weekly x 2 weeks and weekly thereafter. Director of Nursing Services will review results of audits weekly times 4 weeks and random selection ongoing. " Results of Dining Room Audits to be reviewed in next scheduled Quality Assurance Committee Meeting and again the following quarter to determine ongoing monitoring and frequency needed based on audit results. *Completion Date: 11/16/16	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews and record review, the facility failed to investigate to determine the root cause of a fracture for 1 of 1 residents (Resident #167) reviewed for accidents. Findings included: Resident #167 was admitted to the facility on	F 323	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 10/28/16 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	11/16/16

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F 323	Continued From page 3 9/15/16 with diagnoses that included rheumatoid arthritis and a recent stroke with right sided weakness. An interim Resident Care Plan, initiated on 9/22/16 indicated Resident #167 was at risk for falls. A goal of not experiencing any falls was to be achieved by orienting the resident to the environment and assessing her ability to use the call light and bed controls, making changes to the environment that contributed to falls, keeping the call light in reach at all times, maintaining the bed in low position, using non-skid shoes and/or socks, therapy as indicted and involving the resident in supervised activities. Review of the 9/22/16 Body Assessment did not reveal any bruising to the right toes or foot. Nurse's notes for 9/25/16 at 6:10 PM revealed Resident #167 moved around the unit and to the dining room independently in her wheelchair. The 9/29/16 Admission Minimum Data Set (MDS) for Resident #167 indicated she was severely cognitively impaired. No behaviors or rejection of care was identified. The resident was identified as requiring extensive assistance for bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene. Functional limitation in range of motion was identified on one side of the resident's upper extremity. Per the MDS the resident had no functional limitation in range of motion of the lower extremities. The MDS indicated the resident's fall history prior to admission was unable to be determined, but she had had no falls since admission to the facility. On 10/3/16 a change in medical condition form	F 323	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 For Resident #167: " Walking boot placed by Orthopedist on 10/19/16 for 24hr/day which prevented right foot/leg from falling from foot pedal of wheel chair. " Update to Care Plan by MDS on 10/26/16 to include walking boot and transfers. " Incident report for 10/3/16 reporting of bruising of right foot completed on 10/27/16 by LPN. " Investigation of incident initiated on 10/27/16 and completed on 10/28/16 by Director of Nursing Services/Assistant Director of Nursing to determine root cause of reported injury from 10/3/16. " New orders received on 11/9/16 from Orthopedist related to walking boot application. Therapy referral order received 11/9/16 to evaluate and treat for interventions for prevention of right foot/leg from falling from foot pedal of wheel chair related to 11/9/16 order from orthopedist for walking boot application changes. " Care Plan updated on 11/9/16 by	

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F 323	Continued From page 4 indicated Resident #167's right foot and toes were observed to be bruised with a small open area to the small toe. The small toe was noted to be tender to touch with redness and slightly swollen. The nursing intervention included making sure the resident's feet were clear of the wheelchair wheels and other obstacles due to right sided weakness. The 10/3/16 nurse practitioner (NP) progress note indicated Resident #167 had a lot of bruising and redness to her right foot. An abrasion was also seen to the right 5th toe. The NP documented all the toes of the right foot were bruised and swollen and redness extended from the 5th toe up to the ankle. The NP documented the resident was unsure how she had injured her foot. X-rays were ordered with results indicating an acute fracture of the 5th metatarsal toe. A review of nurse's notes prior to the 10/3/16 right toe fracture identified the resident's right sided weakness. However, there was no documentation identifying her foot slipping off the wheelchair foot rest and no interventions documented to prevent injury secondary to her foot slipping off the pedals. Review of incident reports and investigations for Resident #167 revealed investigations had been completed for falls that occurred on 10/7/16 and 10/10/16. The investigations included staff statements, root cause of the falls identified with appropriate interventions placed. There was no investigation provided for Resident #167's right toe fracture that had occurred on 10/3/16. Resident #167's care plan with an onset date of 10/8/16 identified the resident's risk for falls,	F 323	MDS. For Resident # 167 and all other in-house residents: " Facility Policy Accidents and Incidents - Investigation and Reporting reviewed and revised by Director of Nursing Services on 11/08/2016 " Facility policy Change in a Resident's Condition or Status reviewed and revised by Director of Nursing Services on 11/08/2016 " All licensed nursing staff will be in serviced on facility policy Accidents and Incidents - Investigation and Reporting and Change in a Resident's Condition or Status by Director of Nursing/Designee by 11/16/16. Any licensed nursing staff not in serviced by 11/16/16 will be in serviced on next scheduled shift by Director of Nursing Services/Designee. " Newly hired Licensed nursing staff will be in-serviced on facility policy Accidents and Incidents - Investigating and Reporting and Change in a Resident's Condition or Status during the new employee orientation process by Staff Development Coordinator/Designee. " Assistant Director of Nursing Services counseled and in serviced on facility policy Accidents and Incidents - Investigation and Reporting by Director of Nursing Services on 11/2/2016.	

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F 323	Continued From page 5 identified measurable goals and documented interventions to prevent falls. In the problem list, the resident's right toe fracture was identified. However, the care plan goals or interventions did not address the resident's foot slipping off the foot pedals of the wheelchair and did not place interventions to prevent foot slippage and possible injury in the future. On 10/19/16, an orthopedic consult revealed Resident #167 had a right 5th metatarsal fracture and needed a short boot for protection. The physician ordered the boot be worn 24 hours per day. During a family interview on 10/25/16 at 3:40 PM, the Responsible Party (RP) stated Resident #167 had sustained a fracture since admission to the facility. The RP stated due to the resident's right sided weakness, at times, the resident's right foot slipped off the wheelchair foot pedals and would get caught under the wheels of the wheelchair. The RP was unaware of any interventions that had been placed to keep the resident's feet from injury. The RP added since the fracture, the resident wore a boot on her right foot, which was present at this time. The RP added the boot prevented the resident from placing her feet under the foot rest of the wheelchair. Nurse #1 was interviewed on 10/27/16 at 9:55 AM. The nurse stated when a resident sustained an injury, nurses were expected to complete a change in condition report, complete an incident report and treat any injuries using the facility's wound care protocols. The nurse added if staff were unsure of how the incident occurred, the supervisor was notified. Nurse #1 stated while she was not on duty when Resident #167 injured	F 323	" All in-house residents medical records will be audited by Director of Nursing/Designee for most recent 60 days to identify any Change in Medical Condition forms with content that indicate Accident and Incident investigation needed to ensure completion of Report of Incident/Accident Form (Incident Report) and that investigation to determine root cause has been completed. Any inconsistencies found on audit will be address at that time by Director of Nursing/Designee. " Audit Tool developed by Director of Nursing Services on 11/10/16 to monitor Change in Medical Condition forms with content that indicate Accident and Incident investigation needed to ensure completion of Report of Incident/Accident Form (Incident Report) and that investigation to determine root cause has been completed. " Assistant Director of Nursing/Nursing Supervisors in-serviced by Director of Nursing on 11/10/16 on newly developed audit tool with implementation. " Audit to be completed of 25% of in-house residents medical records weekly times 4 weeks then 10% of in-house residents weekly thereafter by Director of Nursing Services/Assistant Director of Nursing/Nursing Supervisors to review Change in Medical Condition forms with content that indicate Accident and Incident investigation needed to ensure completion of Report of Incident/Accident	

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her foot, she was aware of the fracture. Prior to the injury, she had last worked with the resident during the 3:00 PM to 11:00 PM shift on 10/2/16. During her shift, Resident #167 had no complaints of pain and she had not received any reports from staff the resident's foot was bruised. Nurse #1 described Resident #167 as fidgety and acknowledged she had seen the resident place her feet between the raised foot rests on the chair. She added Resident #167 was able to push herself backwards in the chair. Nurse #1 added she was unaware of interventions placed to keep the resident's feet from being injured.

An observation was made of the resident on 10/27/16 on 10:09 AM. Resident #167 was in her room sitting in the wheelchair. A specialized boot was seen on the resident's right foot and a pressure reducing boot was observed on Resident #167's left foot. Both feet were placed on the wheelchair footrests. The resident had activated the call bell which was answered promptly by staff.

On 10/27/16 at 10:11 AM, Nurse #2 was interviewed. The nurse stated when a resident sustained an injury or incident, a change in condition report was completed that described the incident. An investigation was then completed by the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) to determine what happened. Nurse #1 stated the bruises on Resident #167's right foot had been reported to her by Nursing Assistant (NA) #1 on 10/3/16 during the 7:00 AM to 3:00 PM shift. Since the NP was in the facility, she assessed the resident and ordered an X-ray. The result of the X-ray identified a right little toe fracture, but it was not determined how the fracture occurred. The nurse

Form (Incident Report) and that investigation to determine root cause has been completed. Results of audits to be reviewed weekly by Director of Nursing Services and Administrator.

" Results of Audits to be reviewed in next scheduled Quality Assurance Committee Meeting and again the following quarter to determine ongoing monitoring and frequency needed based on audit results.

Completion Date: 11/16/16

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stated she made Unit Manager (UM) #1 aware of the fracture. The nurse stated in a follow up interview that the therapy department had tried a device across the foot pedals of the wheelchair for one day, but Resident #167 was unable to tolerate the device. Nurse #2 was unaware of any other interventions that had been used to protect Resident #167's feet from injury.

Review of therapy notes failed to reveal documentation about the resident's inability to maintain her feet on the foot pedals of the wheelchair and failed to document any interventions to keep the resident from injuring her feet.

UM #1 was interviewed on 10/27/16 at 10:36 AM. The UM stated when an incident or injury occurred to a resident, nurses were expected to complete an incident report. An investigation was held involving staff and the involved resident in order to determine what happened. The UM stated she did not know how Resident #167's right toe fracture occurred. She added Nurse #2 notified her about the X-ray results and the right toe fracture. The UM added she notified the DON. The nurse stated she had spoken with the RP and the resident trying to determine the cause of the fracture, but a cause had not been determined. The UM was unable to disclose any interventions that had been placed to keep the resident's feet safe from injury.

NA #1 was interviewed on 10/27/16 at 10:57 AM. The NA acknowledged she had reported Resident #167's right foot bruising to Nurse #2 on 10/3/16 during the 7:00 AM to 3:00 PM shift. The NA stated the resident's foot was not swollen, but was bruised and added 10/3/16 was the first time

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she noticed the bruised foot. NA #1 stated Resident #167 had difficulty with transfers even with 2 staff members assisting and the use of a gait belt. She added this was due to the stroke and the resident's lack of control over her right leg. NA #1 described Resident #167's right leg as flopping around during transfers that resulted in her hitting surrounding items. Additionally, the NA stated Resident #167 pushed herself in the wheelchair around her room and she had observed the resident's foot under the wheelchair wheel. NA #1 stated at one point, a board had been put across the foot pedals to keep the resident's feet from dropping off. She added she thought the resident had broken her toe during times her foot dropped off the wheelchair foot pedal and her foot was positioned under the wheel.

The ADON was interviewed on 10/27/16 at 11:07 AM. The ADON stated she found out about Resident #167's broken toe around the first part of October when UM #1 reported the fracture in the morning clinical meeting. Typically, she stated an investigation was conducted that included reviewing previous skin assessments and obtaining statements from staff that had worked with the resident. The ADON acknowledged staff statements were not completed for Resident #167's incident that resulted in her fractured toes. She stated she dropped the ball on this incident by not completing the investigation and determining the cause of the fractured toes.

On 10/27/16 at 11:32 AM, the DON was interviewed. He stated he had been unaware of Resident #167's broken toe until today. The DON acknowledged an investigation had not been

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done to determine the root cause of the fracture and added an investigation should have been completed.

The DON reported on 10/27/16 at 2:06 PM, that he had reviewed the clinical notes and spoken with staff. He added Resident #167 had the bruising to her right foot and was unable to recall what happened. He added it was reasonable the injury occurred during her therapy. He added due to the location of the injury it was not suspect and was not a reportable condition. The DON acknowledged again there had been no investigation to determine the root cause of Resident #167's right foot bruising and small toe fracture.

NA #2 was interviewed on 10/27/16 at 3:13 PM. The NA stated he had worked with Resident #167 on the 11:00 PM to 7:00 AM shift that began on 10/2/16. He added the resident's movements were sporadic and she would throw her arms out and hit things. He stated during his shift, the resident had no complaints of pain, but acknowledged he had not observed her feet during his shift, so he was unaware if Resident #167's right foot bruising was present during his shift.