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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 000	INITIAL COMMENTS No deficienceis were cited as a result of the complaints investigation 11/17/16 Event ID# 307L11. IDR 1/13/17 resulted in deletion of F 371.	F 000		
F 278 SS=D	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	F 278		12/9/16

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

Electronically Signed | 12/08/2016

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 by: Based on medical record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses (Resident #58), medication (Resident #83), and dental status (Resident #63) for 3 of 15 sampled residents. The findings included: 1. Resident #58 was admitted to the facility on 6/13/15 and readmitted to the facility on 10/21/16 with multiple diagnoses that included schizophrenia, depression, anxiety, and insomnia. A physician's order dated 10/21/16 indicated Valium (antianxiety medication) 7.5 milligrams (mg) every 8 hours (hrs) as needed (PRN) for anxiety for Resident #58. A review of Resident #58's October 2016 Medication Administration Record (MAR) revealed she was administered Valium for anxiety once on 10/22/16, once on 10/23/16, three times on 10/24/16, three times on 10/25/16, twice on 10/26/16, once on 10/27/16, and once on 10/28/16. The annual Minimum Data Set (MDS) assessment dated 10/28/16 indicated Resident #58 had moderate cognitive impairment. Resident #58 was indicated to have received antianxiety medication on 7 of 7 days during the 10/28/16 MDS review period. Section I, the Active Diagnoses section, was not coded for anxiety (Question I5700). The facility MDS Coordinator was not available for interview as she was on vacation and was unable to be reached by phone.	F 278	Those affected: Director of Nursing/Management Nurse to complete modifications to the Minimum Data Set for residents #58, #83, and #63 by 12/9/16. Those potentially affected: Director of Nursing/Management Nurse to complete audit for section I and section N for accuracy by 12/9/16 for the most recent Minimum Data Set for each resident. There were 23 inaccurate Minimum Data Sets that had modifications made by the Director of Nursing/Management Nurse at the time of the audit. Director of Nursing/Management Nurse to complete audit for section L accuracy by 12/9/16 for the most recent Minimum Data Set for each resident. There were 18 inaccurate Minimum Data Sets that had modifications made by the Director of Nursing/Management Nurse at the time of the audit. Systemic changes: All nursing staff will be in-serviced on accurate coding and completion of the User Data Assessment and Minimum Data Set coding and accuracy by 12/9/16. Two licensed staff on Leave. Both will be in-serviced upon their return. Monitoring and Performance Improvement: Audits will be conducted by Director of Nursing/Management Nurse on 5 Minimum Data Set per week for one month, then bi-weekly for two months, then monthly for three months. Director of Nursing/Management Nurse will bring the	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 An interview was conducted with the Traveling MDS Coordinator on 11/17/16 at 10:10 AM. Section I, the Active Diagnoses section, of the 10/28/16 MDS for Resident #58 was reviewed with the Traveling MDS Coordinator. The physician's order for Valium 7.5mg every 8hrs PRN for anxiety was reviewed with the Traveling MDS Coordinator. The October 2016 MAR for Resident #58 that indicated Valium was administered on 7 of 7 days during the MDS look back period was reviewed with Traveling MDS Coordinator. She reported she was unable to say why anxiety was not indicated to be an active diagnosis on the 10/28/16 MDS for Resident #58. An interview was conducted with the Director of Nursing on 11/17/16 at 10:14 AM. The DON indicated her expectation was for the MDS to be accurate. 2. Resident #83 was admitted to the facility 7/21/16. Cumulative diagnoses included dementia without behavioral disturbance and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated 11/1/16 indicated Resident #83 was severely impaired in cognition. Medications administered during the seven day look back period included the following: antianxiety medication six (6) days. Physician orders for October and November 2016 revealed an order for Lorazepam (antianxiety medication) 0.5 milligrams by mouth every six (6) hours as needed for anxiety. A review of the Medication Administration Record	F 278	results of the audits to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 3 (MAR) for the seven day look-back period 10/26/16-11/1/16 revealed that Resident #83 received antianxiety medication (Lorazepam) on 10/26/16, 10/27/16, 10/28/16, 10/30/16 and 10/31/16-a total of five (5) days. On 11/16/16 at 12:45PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate. On 11/17/16 at 10:53AM, an interview was conducted with the traveling MDS Coordinator who stated she mistook one of the entries as initials and Resident #83 received 5 days of antianxiety medication. 3. Resident # 63 was admitted to the facility on 11/27/13 with multiple diagnoses including vascular dementia. The annual Minimum Data Set (MDS) assessment dated 10/3/16 indicated that Resident #62 had severe cognitive impairment and he was not edentulous. The medical records of Resident #63 were reviewed. The records indicated that Resident #63 was seen by the dentist on 4/6/16. The dental notes indicated that Resident #63 was edentulous. On 11/15/16 at 9:07 AM, Resident #63 was observed. He was observed to be edentulous. On 11/17/16 at 10:15 AM, the facility's traveling MDS Nurse was interviewed. She stated that she expected MDS assessments to be accurate. On 11/17/16 at 10:20 AM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected MDS assessments to be accurate.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 279	Continued From page 4 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 medical record review and staff interview, the facility failed to develop comprehensive plans of care related to the use of antipsychotic medications for 2 of 7 residents reviewed for unnecessary medications (Residents #58 and #117). The findings included: 1. Resident #58 was admitted to the facility on 6/13/15 and readmitted to the facility on 10/21/16 with multiple diagnoses that included schizophrenia, depression, anxiety, and insomnia. Resident #58's comprehensive plan of care included, in part, the focus area of the risk for complications related to the use of psychotropic	F 279	Those affected: Director of Nursing/Management Nurse to complete a modification to the Care Plan for Residents #58 and #117 by 12/9/16 to include diagnosis or the use of antipsychotic medications related to the diagnosis. Those potentially affected: Care Plans for residents receiving antipsychotic medications to be reviewed by Director of Nursing/Management Nurse for accuracy by 12/9/16. There were 83 Care Plans found not addressing the use of psychotropic medications and/or the	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 279	Continued From page 5 drugs for the diagnosis of Depressive Disorder. This focus area was indicated to most recently be updated on 8/5/16. A review of Resident #58's medical record revealed she was hospitalized on 10/12/16 through 10/21/16 for an involuntary behavioral health admission for depression and delusional thoughts. Chief complaints were indicated to be depression, paranoia, and delusional thoughts. The discharge summary, dated 10/21/16, indicated a diagnosis of schizophrenia. The annual Minimum Data Set (MDS) assessment dated 10/28/16 indicated Resident #58 had moderate cognitive impairment and she had delusions during the MDS review period. Resident #58 was indicated to have had no behaviors or rejection of care during the review period. She was additionally indicated to have received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. The Care Area Assessment (CAA) for Resident #58 was triggered for Psychotropic Drug Use. Resident #58 was indicated to have received multiple psychoactive medications that included Latuda (antipsychotic medication), Valium (antianxiety medication), and Cymbalta (antidepressant medication). Resident #58 had a diagnosis of schizophrenia and was indicated to have had frequent delusions. Resident #58's comprehensive plan of care had not addressed Resident #58's diagnosis of schizophrenia or the use of antipsychotic medications related to the diagnosis. An interview was conducted with the Social	F 279	diagnoses related to the psychotropic medications. All were revised by the Director of Nursing/Management Nurse. Systemic changes: All nursing staff will be in-serviced on the need for Care Plan accuracy to include diagnosis or the use of antipsychotic medications related to the diagnosis by 12/9/16. Two licensed staff on Leave. Both will be in-serviced upon their return. Monitoring and Performance Improvement: Audits will be conducted by Director of Nursing/Management Nurse on 5 Care Plans for diagnosis/use of antipsychotic medication related to the diagnosis weekly for one month, then bi-weekly for two months, then monthly for three months. Director of Nursing/Management Nurse will bring the results of the audits to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 279	Continued From page 6	F 279		

Worker (SW) on 11/15/16 at 3:40 PM. She indicated she was familiar with Resident #58. She reported Resident #58 had number of behaviors that included delusions, anxiety, and paranoia. She indicated Resident #58 had a recent mental health hospitalization related to her behaviors and delusions. The SW reported Resident #58 seemed to have had some improvement since the inpatient hospitalization, but she continued with delusions and anxiety.

An interview was conducted with Nurse #3 on 11/15/16 at 4:00 PM. She indicated she was familiar with Resident #58. She reported Resident #58 had frequent delusions and anxiety.

An interview was conducted with the Traveling MDS Coordinator on 11/17/16 at 10:10 AM. The plan of care for Resident #58 as well as the diagnosis of schizophrenia and usage of antipsychotics was reviewed with the Traveling MDS Coordinator. She reported she needed to take a closer look at Resident #58's plan of care.

An interview was conducted with the Director of Nursing on 11/17/16 at 10:14 AM. The DON indicated her expectation was for plans of care to be accurate and updated as needed.

On 11/17/16 at 12:10 PM the Traveling MDS Coordinator provided an updated care plan for Resident #58. The care plan indicated a focus area of: "Disruption in cognition, Schizophrenia. Resident [#58] exhibits delusional thinking at times." This focus area was indicated to have been revised on 11/17/16.

2. Resident #117 was admitted 9/12/16 with

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 279	Continued From page 7	F 279		

cumulative diagnoses of dementia and psychosis. The admission Minimum Data Set (MDS) dated 9/19/16 indicated severe cognitive impairment and extensive assistance with most of his activities of daily living.

A review of the medications ordered on admission included Seroquel (an antipsychotic) 25 milligrams (mg) to be given every evening.

Resident #117 ' s care plan dated 9/21/16 did not include a care plan for the use of an antipsychotic medication to include the monitoring of the potential side effects or monitoring of the targeted behaviors to warrant the continued use of an antipsychotic medication.

In an observation on 11/14/16 at 4:00 PM, Resident #117 was sitting in a wheelchair at the nursing station when he stood and attempted to ambulate unassisted. He was easily redirected.

In an interview on 11/16/16 at 2:45 PM, Nursing Assistant (NA) # 1 stated Resident #117 often resisted care and had been observed disrobed while ambulating in the hall on occasion.

In an interview on 11/16/16 at 2:50 PM, NA #2 stated Resident #117 required close observation especially as the day went on when he seemed to become more confused. NA #2 stated Resident #117 had been observed disrobed but only ambulating inside his room.

In another observation on 11/16/16 at 3:00 PM, Resident #117 was observed sitting in a wheel chair at the nursing station. He appeared cooperative but confused about what he was supposed to do and where he was supposed to

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 279	Continued From page 8 be. In an interview on 11/17/16 at 10:00 AM, the traveling MDS Coordinator stated her expectation that a care plan would have been completed at the time of admission since Resident #117 was actively prescribed Seroquel and would require behavior monitoring, gradual dose reduction evaluation and observation for possible adverse side effects. In an interview on 11/17/16 at 11:27 AM, the Administrator voiced the importance of monitoring resident ' s prescribed antipsychotic medications and that a care plan would have been expected on Resident #117 to ensure behavior monitoring, possible dose reduction and potential adverse side effects related his Seroquel.	F 279		
F 280 SS=E	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	F 280		12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 9 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to revise plans of care related to behavior monitoring for 4 of 7 residents reviewed for unnecessary medications (Residents #58, #63, #67, #83). The findings included: 1. Resident #67 was initially admitted to the facility on 3/11/15 and most recently readmitted on 12/24/15 with diagnoses that included schizophrenia, anxiety, depression, and dementia. Resident #67's comprehensive plan of care included, in part, the focus area of the risk for complications related to the use of psychotropic drugs. This focus area was indicated to most recently be updated on 8/12/16. The goal was for Resident #67 to receive the smallest most effective dose of psychotropic medications without side effects. The interventions included completion of the behavior monitoring flow sheet for Resident #67. The annual Minimum Data Set (MDS) assessment dated 11/5/16 indicated Resident #67's cognition was significantly impaired, she had no delusions, no hallucinations, no behaviors, and no rejection of care. Resident #67 was indicated to have received antipsychotic medication and antidepressant medication on 7 of 7 days during the MDS review period.	F 280	Those affected: Care Plans for residents #67, #58, #63 and #83 will be reviewed and revised by the Director of Nursing/Management Nurse by 12/9/16 to state the Behavior Monitoring Tool will be used to reflect the residents□ behavior. Behavior monitoring tool will be implemented for the affected residents by 12/9/16 by the Director of Nursing/Management Nurse. Those potentially affected: Residents with a behavior care plan will be reviewed by 12/9/16 by the Director of Nursing/Management Nurse. There were 11 care plans that did not address behaviors and the behavior monitoring tool. The Director of Nursing/Management Nurse revised those care plans to include the behaviors and the behavior monitoring tool. Behavior monitoring tool will be implemented for all appropriate residents by 12/9/16 by the Director of Nursing/Management Nurse. Systemic Changes: All nursing staff will be in-serviced on adding the Behavior Monitoring Tool to the Care Plan for residents with behaviors or receiving antipsychotic medications by 12/9/16. Two licensed staff on Leave. Both will be in-serviced upon their return.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 10 A review of the medical record revealed the most recent behavior monitoring flow sheet for resident #67 was completed in May 2016. An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, the nurses had documented behaviors on hard copy behavior flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was unsure when the eMARs were implemented. She suggested speaking to the nursing staff. An interview was conducted with Nurse #2 on 11/15/16 at 3:58 PM. She reported that behaviors were documented in the Electronic Medical Record (E MR). She stated that the nurses used to utilize hard copy behavior monitoring flow sheets, but these were no longer in use. She indicated she thought some residents had behavior monitoring on their eMAR that needed to be completed each shift by the nurse, but she was not sure if every resident had it on their eMAR. She indicated she needed to ask another nurse if the behavior monitoring was included on all residents' eMARs. The interview with Nurse #2 continued and Nurse #3 was included in this portion of the interview on 11/15/16 at 4:00 PM. Nurse #3 indicated that behaviors were documented on nursing progress notes. She reported that the electronic behavior monitoring on the eMAR had not been utilized	F 280	Monitoring and Performance Improvement: Audits will be conducted by the Director of Nursing/Management Nurse on 5 Care Plans that the Behavior Monitoring Tool is addressed on the Care Plan for residents with behaviors or on antipsychotic medications. Audits will be done weekly for one month, then bi-weekly for two months, and then monthly for three months. The Director of Nursing/Management Nurse will bring the results of the Care Plan audits to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 11	F 280		

yet, but it was going to be implemented in the future.

An interview was conducted with the Unit Manager (UM) on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow sheet, but this had been phased out when the facility began eMAR sometime in May of 2016. The UM indicated there were no behavior monitoring flow sheets utilized after the transition to eMAR.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON indicated there was a huge adjustment period when the facility transitioned from hard copy MARs to eMARs. She revealed, "The ball got dropped" and the care plans had not been revised to indicate that the behavior monitoring flow sheets were no longer utilized. She indicated the completion of the behavior monitoring flow sheets should have been removed from the care plans. The DON reported her expectation was for care plans to be accurate and revised as needed.

2. Resident #58 was initially admitted to the facility on 6/13/15 and most recently readmitted to the facility on 10/21/16 with multiple diagnoses that included schizophrenia, depression, anxiety, insomnia.

Resident #58's comprehensive plan of care

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 12	F 280		

included, in part, the focus area of the risk for complications related to the use of psychotropic drugs. This focus area was indicated to most recently be updated on 8/5/16. The goal was for Resident #58 to receive the smallest most effective dose of psychotropic medications without side effects. The interventions included completion of the behavior monitoring flow sheet for Resident #58.

The annual Minimum Data Set (MDS) assessment dated 10/28/16 indicated Resident #58 had moderate cognitive impairment and she had delusions during the MDS review period. Resident #58 was indicated to have had no behaviors or rejection of care during the review period. She was additionally indicated to have received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

A review of the medical record revealed the most recent behavior monitoring flow sheet for Resident #58 was completed in May 2016.

An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, the nurses had documented behaviors on hard copy behavior flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was unsure when the eMARs were implemented. She suggested speaking to the nursing staff.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 13	F 280		

An interview was conducted with Nurse #2 on 11/15/16 at 3:58 PM. She reported that behaviors were documented in the Electronic Medical Record (E MR). She stated that the nurses used to utilize hard copy behavior monitoring flow sheets, but these were no longer in use. She indicated she thought some residents had behavior monitoring on their eMAR that needed to be completed each shift by the nurse, but she was not sure if every resident had it on their eMAR. She indicated she needed to ask another nurse if the behavior monitoring was included on all residents' eMARs.

The interview with Nurse #2 continued and Nurse #3 was included in this portion of the interview on 11/15/16 at 4:00 PM. Nurse #3 indicated that behaviors were documented on nursing progress notes. She reported that the electronic behavior monitoring on the eMAR had not been utilized yet, but it was going to be implemented in the future.

An interview was conducted with the Unit Manager (UM) on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow sheet, but this had been phased out when the facility began eMAR sometime in May of 2016. The UM indicated there were no behavior monitoring flow sheets utilized after the transition to eMAR.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 14	F 280		

out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON indicated there was a huge adjustment period when the facility transitioned from hard copy MARs to eMARs. She revealed, "The ball got dropped" and the care plans had not been revised to indicate that the behavior monitoring flow sheets were no longer utilized. She indicated the completion of the behavior monitoring flow sheets should have been removed from the care plans. The DON reported her expectation was for care plans to be accurate and revised as needed.

3. Resident #63 was admitted to the facility on 11/27/13 with multiple diagnoses including psychosis, anxiety, depression and posttraumatic stress disorder. The annual Minimum Data Set (MDS) assessment dated 10/3/16 indicated that Resident #63 had severe cognitive impairment and had received antipsychotic, antianxiety, and antidepressant for the last 7 days. The assessment also indicated that Resident #63 had not displayed hallucinations, delusions or any behavioral symptoms in the last 7 days.

The care plan of Resident #63 was reviewed. The care plan problems included resident at risk for complications related to the use of psychotropic drugs and resident has delusions, hallucinations and paranoia. The goals were resident should have the smallest most effective dose without side effects and resident will have less incidents of behaviors through next review. The approaches included to complete behavior monitoring flow sheet and to document delusions on the behavior sheets.

The medical records of Resident #63 were

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 15	F 280		

reviewed. The records did not contain any behavior monitoring flow sheets since May 2016.

On 11/17/16 at 10:13 AM, the facility's traveling MDS Nurse was interviewed. She stated that the care plan should have been revised for behavior monitoring when the facility stopped using the behavior monitoring flow sheets.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON indicated there was a huge adjustment period when the facility transitioned from hard copy MARs to eMARs. She revealed, "The ball got dropped" and the care plans had not been revised to indicate that the behavior monitoring flow sheets were no longer utilized. She indicated the completion of the behavior monitoring flow sheets should have been removed from the care plans. The DON reported her expectation was for care plans to be accurate and revised as needed.

4. Resident #83 was admitted to the facility 7/21/16. Cumulative diagnoses included: dementia without behavioral disturbance and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment dated 11/1/16 indicated Resident #83 was severely impaired in cognition. Mood state indicated Resident #83 stated she was tired or had little energy never or one day. No behaviors were indicted during the assessment period. Medications administered during the assessment period included seven (7) days of antipsychotic

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 16	F 280		

medication and six (6) days of antianxiety and antidepressant medication.

A care plan dated 8/1/16 indicated Resident #83 was at risk for complications related to the use of psychotropic drugs. Interventions included to complete behavior monitoring flow sheet.

The medical records for Resident #83 were reviewed. The records did not contain any behavior monitoring flow sheets since resident ' s admission on 7/21/16.

An interview was conducted with the UM on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow sheet, but this had been phased out when the facility began eMAR (electronic medication administration record) sometime in May of 2016. The UM indicated there were no behavior monitoring flow sheets utilized after the transition to eMAR.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON indicated there was a huge adjustment period when the facility transitioned from hard copy MARs to eMARs. She revealed "The ball got dropped" and the care plans had not been revised to indicate that the behavior monitoring flow sheets were no longer utilized. She indicated the completion of the behavior monitoring flow sheets should have been

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 280	Continued From page 17 removed from the care plans. The DON reported her expectation was for care plans to be accurate and revised as needed.	F 280		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to consistently monitor and document behaviors to support a clinical rationale for initiation, continuation, and/or	F 329	Those affected: Behavior Monitoring Tool to be implemented by Director of Nursing/Management Nurse for residents #63, #67, #94 and #117 by 12/9/2016.	12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 18 increase in dosage of psychotropic medication (Residents #63, #67, #94, and #117) and failed to identify a duplicate order for antihistamine medication resulting in a duplication of therapy (Resident #103) for 5 of 7 residents reviewed for unnecessary medications. The findings included: 1. Resident #94 was initially admitted to the facility on 10/25/15 and readmitted on 11/13/15 with multiple diagnoses that included dementia, anxiety, and depression. Resident #94's comprehensive plan of care included, in part, the focus area of the risk for complications related to the use of psychotropic drugs. This focus area was indicated to most recently be updated on 9/13/16. The goal was for Resident #94 to receive the smallest most effective dose of psychotropic medications without side effects. The interventions included Resident #94 being monitored for the continued need of medication and monitored for side effects of medication. Resident #94 had an initial psychiatric evaluation on 5/12/16. The chief complaint/nature of presenting problem was indicated to be "dementia, depression, anxiety". Resident #94 was indicated to be referred for evaluation due to a noted decline in her kidney function and a concern of the Nurse Practitioner (NP) with Resident #94's existing psychotropic medications. The psychiatric evaluation reported Resident #94 stated, "I'm always anxious". Resident #94 denied depression, auditory and visual hallucinations, and distress with side effects from existing psychotropic medications. The Psychiatric Mental Health Nurse Practitioner (PMHNP) indicated Resident #94's presentation	F 329	Those potentially affected: Residents receiving antipsychotic or antianxiety medications will have a Behavior Monitoring Tool put into place by 12/9/16 by the Director of Nursing/Management Nurse. Newly admitted resident□s medications will be reviewed during our clinical meeting by the Director of Nursing/Management Nurse for the need of a Behavior Monitoring Tool. Once the medications are reviewed, the Director of Nursing/Management Nurse will implement the behavior monitoring tool as appropriate. The behavior monitoring tool will be implemented for any resident placed on a medication that requires the behavior monitoring tool by the Director of Nursing/Management Nurse. Those affected: Director of Nursing/Management Nurse to review Resident #103□s medication for duplication by 12/9/16. Resident 103 had 1 duplicate medication order. The attending Physician was notified and clarified the order. Those Potentially Affected: Physician orders were reviewed for accuracy and duplication therapy for all other residents by Director of Nursing/Management Nurse. There were 2 residents had duplication of therapy. Physicians were notified and any changes to the medication orders were completed. Systemic Changes: All nursing staff will be in-serviced by 12/9/16 in regards to the	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 19 suggested more anxiety than depression. The PMHNP indicated her plan was to implement a gradual dose reduction (GDR) of Resident #94's antidepressant and initiate an alternate anxiolytic (antianxiety medication). Resident #94's psychiatric medications at the time of the 5/12/16 psychiatric evaluation were: Ativan (antianxiety medication) 0.5 milligrams (mg) once daily for anxiety, Ativan 0.5mg every 8 hours (hrs) as needed (PRN) for anxiety, Paxil (antidepressant medication) 10mg once daily for depression, and Remeron (antidepressant medication) 7.5mg once daily at night for depression and appetite support. A physician's order dated 5/12/16 indicated the initiation of Buspar (antianxiety medication) 7.5mg twice daily and a discontinuation of Paxil 10mg once daily for Resident #94. The quarterly MDS dated 5/18/16 indicated Resident #94 was cognitively intact, had no delusions, no hallucinations, no behaviors, and no rejection of care. She was indicated to have received antianxiety medication and antidepressant medication on 7 of 7 days during the MDS review period. A nursing progress note dated 6/27/16 indicated Resident #94 had increased anxiety, agitation, and confusion that morning. A physician's order dated 7/14/16 indicated an increase in the frequency of routine Ativan 0.5mg to twice daily (from once daily), a decrease in the frequency of Ativan 0.5mg PRN to every 12 hrs PRN (from every 8 hrs), an increase in Buspar to 15mg twice daily (from 7.5mg) for Resident #94.	F 329	Behavior Monitoring Tool and the documentation of behaviors on the tool. Two licensed staff on Leave. Both will be in-serviced upon their return. All nursing staff will be in-serviced by 12/9/16 in regards to duplication of medication and when receiving orders to review if an order is a duplicate order for a medication and to notify the attending physician of the duplication. Two licensed staff on Leave. Both will be in-serviced upon their return. Monitoring and Performance Improvement: Audits of the Behavior Monitoring Tool will be conducted by the Director of Nursing/Management Nurse weekly for one month, bi-weekly for two months, and then monthly for three month. All new orders will be reviewed weekly for one month and then monthly for three months for duplication of orders. The Director of Nursing/Management Nurse will bring the results of the audits to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 20	F 329		

A physician's order dated 7/18/16 indicated an increase in the frequency of routine Ativan 0.5mg to every 6 hrs (from twice daily), a discontinuation of PRN Ativan, and a decrease in Buspar to 7.5mg twice daily (from 15mg) for Resident #94.

A nursing progress note dated 7/20/16 indicated Resident #94 continued with increased anxiety and repetitive questions.

A follow up psychiatric evaluation was conducted for Resident #94 by the PMHNP on 7/26/16. The note indicated staff had reported Resident #94 had confusion, inconsistent complaints of poor sleep accompanied by sleeping all day, tearful episodes and increased anxiety. Resident #94 reported during the evaluation she had difficulty falling asleep, decreased appetite, decreased energy, and depression. Resident #94 denied anxiety, hallucinations, or distress. The PMHNP indicated Resident #94's denial of anxiety was inconsistent with her presentation. The PMHNP indicated her plan was to increase Resident #94's antianxiety and antidepressant medication. She additionally indicated she was considering a mood stabilizer if needed based on Resident #94's response.

A physician's order dated 7/27/16 indicated an increase in Remeron to 15mg once daily (from 7.5mg once daily), and an increase in Buspar to 15mg twice daily (from 7.5mg twice daily) for Resident #94.

Nursing progress notes dated 8/3/16, 8/4/16, 8/5/16, and 8/6/16 indicated Resident #94 had increased anxiety (8/3, 8/4, 8/5, 8/6), restlessness (8/3, 8/4), and agitation (8/5).

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 21	F 329		

A nursing progress note dated 8/7/16 indicated Resident #94 had decreased anxiety.

A physician's order dated 8/8/16 indicated a decrease in the frequency of routine Ativan 0.5mg to three times daily (from every 6 hrs), the initiation of Risperdal (antipsychotic medication) 0.5mg twice daily, and the initiation of Depakote (mood stabilizer) 125mg once daily for Resident #94.

A physician's order dated 8/12/16 indicated an increase in frequency of Depakote 125mg to twice daily (from once daily) and a decrease in Risperdal to 0.25mg twice daily (from 0.5mg) for Resident #94.

The quarterly MDS dated 8/18/16 indicated Resident #94 was cognitively intact, had no delusions, no hallucinations, no behaviors, and no rejection of care. She was indicated to have received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

A follow up psychiatric evaluation was conducted for Resident #94 by the PMHNP on 8/23/16. The note indicated staff reported Resident #94 had continued confusion, tearful episodes, persistent presentation of anxiety resulting in repetitive calls to family, and a decrease in complaints of poor sleep. Resident #94 reported to PMHNP she had improved sleep, appetite, and fair energy. Resident #94 additionally reported some depression and anxiety in the mornings. Resident #94 denied hallucinations or distress. The PMHNP indicated medications had been adjusted recently and no further medication

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 22	F 329		

adjustments were recommended at that time.

A pharmacy consultation report for Resident #94 dated 8/29/16 indicated the recommendation to decrease the frequency of Risperdal 0.25mg to once daily (from twice daily) with the eventual goal of discontinuation. This recommendation was addressed on 11/1/16 by the PMHNP. She declined the recommendation and indicated Resident #94 struggled with delusions, feeling unsafe, exhibiting behaviors, and distress.

A physician's order dated 9/1/16 indicated a decrease in Remeron to 7.5mg once daily (from 15mg), a decrease in frequency of Depakote 125mg to once daily (from twice daily), and the initiation of Lamictal (mood stabilizer) 25mg once daily for Resident #94.

The quarterly MDS dated 9/7/16 indicated Resident #94 was cognitively intact, had no delusions, no hallucinations, no behaviors, and no rejection of care. She was indicated to have received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

A physician's order dated 10/4/16 indicated the discontinuation of Depakote 125mg once daily for Resident #94.

A nursing progress note dated 10/5/16 indicated Resident #94 had a decrease in anxiety.

A pharmacy consultation report for Resident #94 dated 10/31/16 indicated the repeated recommendation to decrease the frequency of Risperdal 0.25mg to once daily (from twice daily) with the eventual goal of discontinuation. At the

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 23	F 329		

time of this recommendation the previous recommendation for Resident #94, dated 8/29/16, had not been addressed by the physician. This recommendation was addressed on 11/15/16 by the PMHNP. She declined the recommendation for Resident #94 indicating a Risperdal dose reduction was delayed due to efforts initiating an alternate medication to buffer/replace it.

A follow up psychiatric evaluation was conducted for Resident #94 by the PMHNP on 11/1/16. The note indicated staff reported no complaints of behavior or function, noting decreased confusion, somatic complaints, tearful episodes, and anxiety for Resident #94. She reported to the PMHNP she had good sleep, appetite, and fair energy. She additionally reported she had some depression and anxiety that was manageable at that time. Resident #94 indicated she had no hallucinations or distress. The PMHNP indicated Resident #94 was tolerating the mood stabilizer (Lamictal) and had a reduction of mood instability and restlessness. The PMHNP indicated her plan was to increase Lamictal 25mg to twice daily from once daily.

A note included in the physician's orders dated 11/1/16 indicated Resident #94 continued to exhibit mood instability and distress.

A physician's order dated 11/1/16 indicated an increase in the frequency of Lamictal 25mg to twice daily (from once daily) for Resident #94.

The review of the medical record revealed Resident #94 had documented behaviors in the nursing progress notes on 6 distinct days from 5/12/16 through 11/1/16. Resident #94 had a variety of medication changes that included the

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 24	F 329		

initiation of an antianxiety medication (5/12/16), an antipsychotic medication (8/8/16) and two distinct mood stabilizers (8/8/16 and 9/1/16). As of 11/1/16 Resident #94's psychotropic medications included Risperdal, Lamictal, Ativan, Buspar, and Remeron.

An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, nurses had documented behaviors on hard copy behavior monitoring flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was also unsure when the eMARs were implemented. She suggested speaking to the nursing staff.

An interview was conducted with Nurse #2 on 11/15/16 at 3:58 PM. She reported that behaviors were documented in the Electronic Medical Record (E MR). She stated that the nurses used to utilize hard copy behavior monitoring flow sheets, but these were no longer in use. She indicated she thought some residents had behavior monitoring on their eMAR that needed to be completed each shift by the nurse, but she was not sure if every resident had it on their eMAR. She indicated she needed to ask another nurse if the behavior monitoring was included on all residents' eMARs.

The interview with Nurse #2 continued and Nurse #3 was included in this portion of the interview on 11/15/16 at 4:00 PM. Nurse #3 indicated that

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 25	F 329		

behaviors were documented on nursing progress notes. She reported that the electronic behavior monitoring on the eMAR had not been utilized yet, but it was going to be implemented in the future.

An interview was conducted with the Unit Manager (UM) on 11/16/16 at 9:45 AM. The procedure for pharmacy consultation recommendations was reviewed with the UM. She indicated that pharmacy recommendations related to psychotropic medications were reviewed by the PMHNP. She indicated she was responsible for putting the pharmacy consultation recommendation sheets in a folder that was kept at the facility for the PMHNP to review. She reported the PMHNP came to the facility weekly. The UM indicated her expectation was for the pharmacy consultation recommendations to be addressed by the PMHNP in about 3-4 days. The pharmacy consultation recommendation for Resident #94 dated 8/29/16 that was addressed by the PMHNP on 11/1/16 was reviewed with the UM. She indicated there was a period of time when the facility NP and the PMHNP had been in the process of deciding who was going to be responsible for addressing pharmacy consultation recommendations related to psychotropic medications. The UM indicated she thought this recommendation may have come in during the time when a decision had not been made and that may have been why it was not addressed until over two months later (11/1/16).

A second interview was conducted with the UM on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 26	F 329		

sheet, but this had been phased out when the facility began eMAR sometime in May of 2016. The UM indicated there were no hard copy behavior monitoring flow sheets utilized after the transition to eMAR.

The interview with the UM continued. She reported that from her understanding, when a nurse administered a psychotropic medication the electronic system was supposed to automatically trigger questions that required the nurse to indicate if the resident had behaviors and if the resident had any side effects from the psychotropic medication. The UM reported that yesterday afternoon (11/15/16) one of the nurses had asked her about behavior monitoring in the eMAR. She revealed after she was asked this question by nursing staff she looked into the eMARs and discovered these questions had not been automatically triggered. The UM stated she had not been aware of this before yesterday afternoon. She reported she then went through each resident's eMAR who was on a psychotropic medication and she added two questions to the eMAR that were required to be answered every shift by nursing staff. The first question asked if the resident was behavior free and the second question asked if the resident was free from side effects of psychotropic medications. The UM reported that without the behavior monitoring included on the eMAR, the only way for nurses to document behaviors was in the nursing progress notes.

A follow up interview was conducted with the UM on 11/17/16 at 9:36 AM. She revealed she was now aware that the medical records had not contained behavioral documentation that was needed to support the use of psychotropic

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 27	F 329		

medications. She indicated the facility was currently looking into a way to solve this problem.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON revealed she became aware of the lack of behavior monitoring documentation as of 11/15/16. She indicated she was not aware this was a problem previously. She reported her expectation was for nursing staff to document behaviors each time they occurred. She stated that if they occurred multiple times during the day she expected them to be documented at least once daily. The DON indicated she expected behaviors to be documented to support the need for initiation, continuation, and/or increase in the dosage of psychotropic medications.

The interview with the DON continued. She reported the facility was aware their use of psychotropic medications was high and they were working on a plan to reduce the use of psychotropic medications, specifically antipsychotics. She indicated the facility began to focus on this concern around July 2016 with the goal of decreasing their use antipsychotic medications. The DON reported that the facility met with both their Medical Director and the PMHNP to discuss their goal. She revealed she thought that over the past few months there had been a significant decrease in their antipsychotic usage, but she was aware there was still a need to decrease their usage.

2. Resident #67 was initially admitted to the

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 28	F 329		

facility on 3/11/15 and most recently readmitted on 12/24/15 with diagnoses that included schizophrenia, anxiety, depression, and dementia.

Resident #67's comprehensive plan of care included, in part, the focus area of the risk for complications related to the use of psychotropic drugs. This focus area was indicated to most recently be updated on 8/12/16. The goal was for Resident #67 to receive the smallest most effective dose of psychotropic medications without side effects. The interventions included Resident #67 being monitored for the continued need of medication, monitored for side effects of medication, and documentation on the behavior monitoring flow sheet.

Resident #67 had a follow up psychiatric evaluation on 2/18/16 by a psychiatrist. The chief complaint/nature of the presenting problem was indicated to be "depression". Resident #67 was indicated to have no new behavioral issues reported, she had reduced crying spells, and her depressive symptoms were stable. The psychiatrist's evaluation revealed no evidence of mania or psychosis and no evidence of abnormal thought content or process. Her current psychiatric medications were Seroquel (antipsychotic medication) 50 milligrams (mg) in the morning and 100mg at night, Celexa (antidepressant medication) 30mg at night, and Xanax (antianxiety medication) 1mg every 6 hours as needed (PRN). The psychiatrist indicated Resident #67's psychosis was stable and he indicated he would consider a gradual dose reduction (GDR) of Seroquel if further clinical stability was achieved.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 29	F 329		

A physician's order dated 2/22/16 indicated a decrease in Celexa to 20mg at night (from 30mg) for Resident #67.

Resident #67 had a follow up psychiatric evaluation on 3/31/16 by the Psychiatric Mental Health Nurse Practitioner (PMHNP). Staff reported Resident #67 had no complaints of behavior or function. Resident #67 endorsed good sleep, fair appetite and adequate energy, no distress with auditory or visual hallucinations, and she denied mania. Resident #67 had reported some depression and anxiety at times. Her current psychiatric medications were Seroquel 50mg in the morning and 100mg at night, Celexa 20mg at night, and Xanax 1mg every 6 hours PRN. The PMHNP recommended no medication changes.

The quarterly MDS dated 4/1/16 indicated Resident #67 had significant cognitive impairment, had no delusions, no hallucinations, no behaviors, and no rejection of care.

A physician's order dated 4/20/16 indicated a decrease in Celexa to 10mg at night (from 20mg) for 7 days, a discontinuation of Celexa on 4/28/16, and the initiation of Effexor (antidepressant medication) 37.5mg once daily for Resident #67.

The quarterly MDS dated 4/22/16 indicated Resident #67 had significant cognitive impairment, had no delusions, no hallucinations, no behaviors, and no rejection of care.

A physician's order dated 4/28/16 indicated an increase in Effexor to 75mg once daily (from 37.5mg) for Resident #67.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 30	F 329		

Resident #67 had a follow up psychiatric evaluation on 4/28/16 by the PMHNP. Staff reported Resident #67 had no complaints of behavior or function, but there were some periods of crying and depression noted. Resident #67 indicated she had some difficulty falling asleep, had fair appetite and adequate energy, no distress with auditory or visual hallucinations, and she denied mania. Resident #67 had reported some depression and anxiety at times. Her current psychiatric medications were Seroquel 50mg in the morning and 100mg at night, Effexor 75mg once daily, and Xanax 1mg every 6 hours PRN. The PMHNP recommended no medication changes due to the exacerbation of grief with the upcoming anniversary of her spouse ' s death.

The quarterly MDS dated 5/9/16 indicated Resident #67 had significant cognitive impairment, had no delusions, no hallucinations, no behaviors, and no rejection of care.

A pharmacy consultation report dated 5/30/16 indicated the recommendation to decrease Seroquel 100mg to 75mg. This recommendation was addressed on 6/9/16 by the PMHNP. She declined the recommendation indicating Resident #67 was guardedly stable and reported breakthrough delusions/auditory visual hallucinations.

The quarterly MDS dated 8/9/16 indicated Resident #67 had significant cognitive impairment, had no delusions, no hallucinations, no behaviors, and no rejection of care.

Resident #67 had a follow up psychiatric evaluation on 8/23/16 by the PMHNP. Staff

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 31	F 329		

reported Resident #67 had no complaints of behavior or function. Resident #67 endorsed good sleep, fair appetite and adequate energy, denied depression, anxiety, mania, and distress with auditory or visual hallucinations. Resident #67 had reported some depression and anxiety at times. Her current psychiatric medications were Seroquel 50mg in the morning and 100mg at night, Effexor 75mg once daily, and Xanax 1mg every 6 hours PRN. The PMHNP recommended no medication changes as Resident #67 was "guardedly stable at current doses".

The annual MDS dated 11/5/16 indicated Resident #67 had significant cognitive impairment, had no delusions, no hallucinations, no behaviors, and no rejection of care.

A review of the medical record revealed Resident #67 had no behaviors documented in the nursing progress notes from 1/1/16 through 11/1/16. Resident #67's medication included an antipsychotic that had no dosage adjustment in over one year despite a recommendation by the consulting pharmacist (5/30/16).

An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, the nurses had documented behaviors on hard copy behavior flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was unsure when the eMARs were implemented. She suggested speaking to

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 32	F 329		

the nursing staff.

An interview was conducted with Nurse #2 on 11/15/16 at 3:58 PM. She reported that behaviors were documented in the Electronic Medical Record (E MR). She stated that the nurses used to utilize hard copy behavior monitoring flow sheets, but these were no longer in use. She indicated she thought some residents had behavior monitoring on their eMAR that needed to be completed each shift by the nurse, but she was not sure if every resident had it on their eMAR. She indicated she needed to ask another nurse if the behavior monitoring was included on all residents' eMARs.

The interview with Nurse #2 continued and Nurse #3 was included in this portion of the interview on 11/15/16 at 4:00 PM. Nurse #3 indicated that behaviors were documented on nursing progress notes. She reported that the electronic behavior monitoring on the eMAR had not been utilized yet, but it was going to be implemented in the future.

An interview was conducted with the Unit Manager (UM) on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow sheet, but this had been phased out when the facility began eMAR sometime in May of 2016. The UM indicated there were no hard copy behavior monitoring flow sheets utilized after the transition to eMAR.

The interview with the UM continued. She reported that from her understanding, when a nurse administered a psychotropic medication the

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 33	F 329		

electronic system was supposed to automatically trigger questions that required the nurse to indicate if the resident had behaviors and if the resident had any side effects from the psychotropic medication. The UM reported that yesterday afternoon (11/15/16) one of the nurses had asked her about behavior monitoring in the eMAR. She revealed after she was asked this question by nursing staff she looked into the eMARs and discovered these questions had not been automatically triggered. The UM stated she had not been aware of this before yesterday afternoon. She reported she then went through each resident's eMAR who was on a psychotropic medication and she added two questions to the eMAR that were required to be answered every shift by nursing staff. The first question asked if the resident was behavior free and the second question asked if the resident was free from side effects of psychotropic medications. The UM reported that without the behavior monitoring included on the eMAR, the only way for nurses to document behaviors was in the nursing progress notes.

A follow up interview was conducted with the UM on 11/17/16 at 9:36 AM. She revealed she was now aware that the medical records had not contained behavioral documentation that was needed to support the use of psychotropic medications. She indicated the facility was currently looking into a way to solve this problem.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 34	F 329		

revealed she became aware of the lack of behavior monitoring documentation as of 11/15/16. She indicated she was not aware this was a problem previously. She reported her expectation was for nursing staff to document behaviors each time they occurred. She stated that if they occurred multiple times during the day she expected them to be documented at least once daily. The DON indicated she expected behaviors to be documented to support the need for initiation, continuation, and/or increase in the dosage of psychotropic medications.

The interview with the DON continued. She reported the facility was aware their use of psychotropic medications was high and they were working on a plan to reduce the use of psychotropic medications, specifically antipsychotics. She indicated the facility began to focus on this concern around July 2016 with the goal of decreasing their use antipsychotic medications. The DON reported that the facility met with both their Medical Director and the PMHNP to discuss their goal. She revealed she thought that over the past few months there had been a significant decrease in their antipsychotic usage, but she was aware there was still a need to decrease their usage.

3. Resident #103 was admitted to the facility on 8/31/16 with multiple diagnoses including Allergy.
The admission Minimum Data Set (MDS) assessment dated 9/7/16 indicated that Resident #103 had severe cognitive impairment.
The admission physician's orders for Resident #103 dated 8/31/16 were reviewed. The orders included Claritin (antihistamine) 10 milligram (mgs.) by mouth in the afternoon for Allergy.
On 10/25/16, there was an order for Claritin 10 mgs 1 tablet by mouth daily for Allergy.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 35	F 329		

The October and November 2016 Medication Administration Records (MARs) of Resident #103 were reviewed. The MARs indicated that the resident had received Claritin 10 mgs. twice a day from October 25 through November 15, 2016.
On 11/15/16 at 4:30 PM, Nurse #5 was interviewed. She stated that she would call the physician to discontinue one of the orders for Claritin due to duplicate order.
On 11/16/16 at 3:10 PM, Nurse #6 was interviewed. She stated that she was the nurse who wrote the order for Claritin on 10/25/16. Nurse #6 indicated that she didn't realize that Resident #103 was already on Claritin.

On 11/17/16 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the medication nurse, nurse receiving the order and the pharmacist to check for duplicate medication orders.

4. Resident #63 was originally admitted to the facility on 10/29/13 with multiple diagnoses including psychosis, anxiety, depression and posttraumatic stress disorder. The annual Minimum Data Set (MDS) assessment dated 10/3/16 indicated that Resident #63 had severe cognitive impairment and had received antipsychotic, antianxiety and antidepressant in the last 7 days. The assessment further indicated that the resident did not exhibit hallucination, delusion or any behavioral symptoms.
The care plan of Resident #63 dated 10/10/16 was reviewed. One of the problems was resident is at risk for complications related to the use of psychotropic drugs. The goal was resident should have the smallest most effective dose without side effects through next review. One of

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 36	F 329		

the approaches was to complete behavior monitoring flow sheets.
The medical records of Resident #63 were reviewed. The May 2016 behavior monitoring flow sheets were blank indicating that the resident had no behaviors.
There were no June, July, August, September, October or November 2016 behavior monitoring flow sheets found in the records for Resident #63.
Resident #63 was receiving psychiatric services for behavior and medication management.
The physician's orders of Resident #63 were reviewed. The orders revealed that Resident #63 was on Elavil (antidepressant drug), Zoloft (antidepressant drug), Xanax (antianxiety drug), Buspar (antianxiety drug) and Seroquel (antipsychotic drug).
The electronic nursing progress notes were reviewed. There were no daily behavior documentation found to support the continued need of the psychotropic medications.
The orders revealed that Resident #63 was on Elavil 50 milligrams (mgs) at bedtime since 4/8/15. On 5/25/16, there was a doctor's order to increase the Elavil to 100 mgs at bedtime. There was no behavior documentation found in the nurse's notes to support the increase in dosage.
On 2/19/16, there was a doctor's order to increase Xanax to 0.5 mgs every 6 hours from every 8 hours. There was no behavior documentation in the nurse's notes to support the increase in dosage.
On 6/29/16, there was a doctor's order to increase Seroquel to 150 mgs twice a day from 100 mgs in AM and 150 mgs at bedtime. There was no behavior documentation in the nurse's notes to support the increase in dosage.
The monthly drug regimen was reviewed. On 5/31/16, the pharmacist had requested for

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 37	F 329		

gradual dose reduction for Elavil but the request was declined.
On 8/29/16, the pharmacist had requested for gradual dose reduction for Xanax but the request was declined.
An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, nurses had documented behaviors on hard copy behavior monitoring flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was also unsure when the eMARs were implemented. She suggested speaking to the nursing staff.

An interview was conducted with Nurse #2 on 11/15/16 at 3:58 PM. She reported that behaviors were documented in the Electronic Medical Record (E MR). She stated that the nurses used to utilize hard copy behavior monitoring flow sheets, but these were no longer in use. She indicated she thought some residents had behavior monitoring on their eMAR that needed to be completed each shift by the nurse, but she was not sure if every resident had it on their eMAR. She indicated she needed to ask another nurse if the behavior monitoring was included on all residents' eMARs.

The interview with Nurse #2 continued and Nurse #3 was included this portion of the interview on 11/15/16 at 4:00 PM. Nurse #3 indicated that behaviors were documented on nursing progress notes. She reported that the electronic behavior

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 38	F 329		

monitoring on the eMAR had not been utilized yet, but it was going to be implemented in the future.

A second interview was conducted with the UM on 11/16/16 at 11:44 AM. She indicated that behaviors were documented in nursing progress notes. She reported the facility had previously utilized a hard copy behavior monitoring flow sheet, but this had been phased out when the facility began eMAR sometime in May of 2016. The UM indicated there were no hard copy behavior monitoring flow sheets utilized after the transition to eMAR.

A follow up interview was conducted with the UM on 11/17/16 at 9:36 AM. She revealed she was now aware that the medical records had not contained behavioral documentation that was needed to support the use of psychotropic medications. She indicated the facility was currently looking into a way to solve this problem.

An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 10:14 AM. The DON reported that eMAR was implemented on May 23, 2016. She stated that the facility phased out the hard copy behavior monitoring flow sheets when eMAR was implemented. The DON revealed she became aware of the lack of behavior monitoring documentation as of 11/15/16. She indicated she was not aware this was a problem previously. She reported her expectation was for nursing staff to document behaviors each time they occurred. She stated that if they occurred multiple times during the day she expected them to be documented at least once daily. The DON indicated she expected behaviors to be documented to support the need

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 39	F 329		

for initiation, continuation, and/or increase in the dosage of psychotropic medications. The DON added that the family member of Resident #63 did not want changes to the resident's medications.

The interview with the DON continued. She reported the facility was aware their use of psychotropic medications was high and they were working on a plan to reduce the use of psychotropic medications, specifically antipsychotics. She indicated the facility began to focus on this concern around July 2016 with the goal of decreasing their use antipsychotic medications. The DON reported that the facility met with both their Medical Director and the psychiatric services to discuss their goal. She revealed she thought that over the past few months there had been a significant decrease in their antipsychotic usage, but she was aware there was still a need to decrease their usage.

5. Resident #117 was admitted 9/12/16 with cumulative diagnoses of dementia and psychosis. The admission Minimum Data Set (MDS) dated 9/19/16 indicated severe cognitive impairment and coded with no behaviors.

A review of the medications ordered on admission included Seroquel (an antipsychotic) 25 milligrams (mg) to be given every evening.

A review of the medical record only included behavior monitoring in a nursing note dated 10/3/16 at 5:34 PM, 10/4/16 at 1:34 PM, 10/5/16 at 11:41 AM and on 10/6/16 at 1:58 PM. In all of these nursing notes, it was documented that Resident #117 demonstrated on-going wandering in and out of rooms looking for his parents.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 329	Continued From page 40 In an interview on 11/16/16 at 2:00 PM the Director of Nursing (DON) and the Unit Manager (UM) stated it was their policy to only document behaviors by exception. A copy of a policy titled " Behaviors: Management of Challenging " dated as revised 3/15/16 indicated behavior monitoring was indicated for psychotherapeutic medication. The DON stated prior to starting to use the electronic Medication Administration Record (MAR), the nurses were charting behaviors on written behaviors monitoring sheet. Last Spring, the behaviors monitoring was added to the electronic MAR. The DON and UM stated for reasons unknown and previously unnoticed, the behavior monitoring had dropped on the electronic MAR ' s. In an interview on 11/16/16 at 3:10 PM, Nurse #1 stated she was not aware of the need to chart behaviors on Resident #117 since he was on an antipsychotic medication. She stated she was not aware of what behaviors she was supposed to look for in Resident #117. In an interview on 11/17/16 at 10:45 AM, the DON stated she would expect the staff to document any behaviors to support the continued need for an antipsychotic medication for Resident #117.	F 329		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of	F 385		12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 385	Continued From page 41 each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, pharmacist and physician interview, the facility failed to maintain physician services to meet the needs of a resident who required a prescription for an antianxiety medication resulting in delayed obtainment of the medication and the omission of the medication for seven doses for 1 of 5 residents (Resident #83). The findings included: Resident #83 was admitted to the facility 7/21/16. Cumulative diagnoses included: dementia without behavioral disturbance and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated 11/1/16 indicated Resident #83 was severely impaired in cognition. Medications administered during the assessment period included antipsychotic, antianxiety and antidepressant medication. Physician orders were reviewed and revealed an order dated 8/1/16 for clonazepam (medication used to treat anxiety) 0.5 milligrams (mg) by mouth at bedtime for anxiety. A review of the September Medication Administration Record (MAR) revealed the following: 9/26/16 9:02PM clonazepam 0.5 mg by mouth at bedtime for anxiety disorder, med not in facility.	F 385	Those Affected: Director of Nursing/Management Nurse audited controlled medications requiring a written prescription on 11/17/16 for resident #83, and ensured that adequate supply was available. Those Potentially Affected: Audit to be completed by Director of Nursing/Management Nurse by 12/9/16 for controlled medications requiring a written prescription for all residents, and to ensure adequate supply was available. Systemic Changes: All nursing staff will be in-serviced by 12/9/16 regarding the process of obtaining a written prescription for controlled medications. Two licensed staff on Leave. Both will be in-serviced upon their return. The Administrator/Director of Nursing met with Physicians and Physician Extenders regarding the need for prompt action when notified of written prescriptions needed. If there is any delay in receipt of written prescription, the Director of Nursing will be notified. The Director of Nursing will then contact the Medical Director of the need for written prescription.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 385	Continued From page 42 9/27/16 8:22PM clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. 9/28/16 8:34PM clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. 9/29/16 8:38 PM clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. A review of the November MAR revealed the following: 11/1/16 7:09 clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility 11/2/16 (time not noted) clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Did not have any in narcotic box. 11/3/16 8:58 clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Resident had none in facility. On 11/16/16 at 318PM, an interview was conducted with Nurse #8. She stated she did not administer the clonazepam on 11/2/16 and 11/3/16 because the medication had not arrived from the pharmacy and they were waiting for a hard script (written prescription) from the pharmacy. She stated she did not notify the physician. On 11/16/2016 at 4:09PM, an interview was conducted via phone with Resident #83 ' s physician. He stated he expected nursing staff to administer medications as ordered. He said he was available for staff to notify him if they needed a hard script for the medication. Resident #83 ' s physician stated the hard script was sent to the facility on 9/28/16 and on 11/2/16. The physician said the only explanation for the lateness of	F 385	Monitoring and Performance Improvement: The Director of Nursing/Management Nurse will audit controlled medications weekly for one month and then monthly for 3 months, and notify the Physicians of written prescriptions needed as appropriate. The Director of Nursing/Management Nurse will bring the results of each audit to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 385	Continued From page 43 sending the hard script was that he had a new nurse practitioner. He stated she was on vacation this week. He had reviewed her charts and had noted that she might have been a little behind on things and she might have delayed in writing the scripts. On 11/16/2016 at 5:38PM, an interview was conducted with Nurse #9. She said the clonazepam was not in the facility on 9/26/16, 9/27/16, 9/28/16, 9/29/16 and 11/1/16. She stated she usually called the pharmacy first if a control medication (clonazepam) was not in the medication cart and would also notify the next nursing shift that a hard script was needed for the medication. If the medication was still not available the next night, she said she would notify the physician and leave a voice mail and report to the next shift that the medication was needed. Nurse #9 stated she did now why the medication was not available on the days she documented it was not in the facility. A telephone interview was conducted with the pharmacist on 11/17/16 at 9:28AM. He stated if the facility sent a reorder for the clonazepam on a sheet of paper, it would indicate that the script had expired, needed a hard script and the pharmacy would automatically fax the physician for a hard script. He reviewed the pharmacy records and said he could not tell when the medication was sent to the facility in September but the clonazepam was last sent on November 4th.	F 385		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 425	Continued From page 44 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview, the facility failed to ensure medications were available as ordered by the physician for two of seven residents reviewed for unnecessary medications (Resident #83 and #117). The findings included: 1. Resident #83 was admitted to the facility 7/21/16. Cumulative diagnoses included: dementia without behavioral disturbance and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated 11/1/16 indicated Resident #83 was severely impaired in cognition. Medications administered during the assessment period included	F 425	Those Affected: Director of Nursing/Management Nurse will audit medications for sufficient supply for residents #83 and #117 by 12/9/16 to ensure that adequate supply was available. Those Potentially Affected: Director of Nursing/Management Nurse to complete audit by 12/9/16 for all residents to ensure adequate supply of medication. Systemic Changes: All nursing staff will be in-serviced by 12/9/16 regarding the process of obtaining medications if unavailable. Two licensed staff on Leave.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 425	Continued From page 45 antipsychotic, antianxiety and antidepressant medication. Physician orders were reviewed and revealed an order dated 8/1/16 for clonazepam (medication used to treat anxiety) 0.5 milligrams (mg) by mouth at bedtime for anxiety. A review of the September Medication Administration Record (MAR) revealed the following: 9/26/16 9:02PM clonazepam 0.5 mg by mouth at bedtime for anxiety disorder, med not in facility. 9/27/16 8:22PM clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. 9/28/16 8:34PM clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. 9/29/16 8:38 PM clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility. A review of the November MAR revealed the following: 11/1/16 7:09 clonazepam 0.5 mg give 0.5 mg by mouth at bedtime for anxiety disorder. Med not in facility 11/2/16 (time not noted) clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Did not have any in narcotic box. 11/3/16 8:58 clonazepam 0.5 mg by mouth at bedtime for anxiety disorder. Resident had none in facility. On 11/16/16 at 11:15AM, an interview was conducted with the Director of Nursing who stated the pharmacy had the potential for 4 deliveries per day. She said the delivery times were approximately 3:00PM-5:00 PM in the afternoon,	F 425	Both will be in-serviced upon their return. If there is any delay in receipt of written prescription, the Director of Nursing will be notified. The Director of Nursing will then contact the Medical Director of the need for written prescription. Monitoring and Performance Improvement: Director of Nursing/Management Nurse will audit medications for sufficient supply weekly for one month, then monthly for three months. Director of Nursing/Management Nurse will bring results of each audit to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 425	Continued From page 46	F 425		

8:00PM-10:00PM in the evening, 2:00AM--3:00AM in the morning and between 5:00AM-7:00AM. The Director of Nursing stated, for re-ordering medication, nursing staff removed the bar code from the bottom of the medication, placed the bar code on a piece of paper and faxed the re-order to the pharmacy. The Director of Nursing stated her expectation was for the medication to be delivered at the facility within 24 hours. If the medication was not delivered to the facility in 24 hours, she expected the nurse to call the pharmacy and refax the order to the pharmacy.

On 11/16/16 at 318PM, an interview was conducted with Nurse #8. She stated she did not administer the clonazepam on 11/2/16 and 11/3/16 because the medication had not arrived from the pharmacy and they were waiting for a hard script (written prescription) from the pharmacy. She stated she did not notify the physician.

On 11/16/2016 at 4:09PM, an interview was conducted via phone with Resident #83 ' s physician. He stated he expected nursing staff to administer medications as ordered. He said he was available for staff to notify him if they needed a hard script for the medication. Resident #83 ' s physician stated the hard script was sent to the facility on 9/28/16 and on 11/2/16. The physician said the only explanation for the lateness of sending the hard script was that he had a new nurse practitioner. He stated she was on vacation this week. He had reviewed her charts and had noted that she might have been a little behind on things and she might have delayed in writing the scripts.

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 425	Continued From page 47	F 425		

On 11/16/2016 at 5:38PM, an interview was conducted with Nurse #9. She said the clonazepam was not in the facility on 9/26/16, 9/27/16, 9/28/16, 9/29/16 and 11/1/16. She stated she usually called the pharmacy first if a control medication (clonazepam) was not in the medication cart and would also notify the next nursing shift that a hard script was needed for the medication. If the medication was still not available the next night, she said she would notify the physician and leave a voice mail and report to the next shift that the medication was needed. Nurse #9 stated she did now why the medication was not available on the days she documented it was not in the facility.

2. Resident #117 was admitted 9/12/16 with cumulative diagnoses of dementia and psychosis. The admission Minimum Data Set (MDS) dated 9/19/16 indicated severe cognitive impairment and extensive assistance with most of his activities of daily living.

A review of the November 2016 medications ordered included Seroquel (an antipsychotic) 25 milligrams (mg) to be given every evening. A review of the November 2016 Medication Administration Record (MAR) indicated on the evening of 11/2/16 and 11/3/16, Resident #117 did not receive his prescribed Seroquel. The nursing note dated 11/2/16 at 9:29 PM indicated the medication was unavailable. In another nursing note dated 11/3/16 at 8:51 PM, indicated the medication was again unavailable.

In an interview on 11/16/16 at 3:10 PM, Nurse #1

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 425	Continued From page 48 stated she did not give Resident #117 his prescribed Seroquel on the evening of 11/2/16 or the evening of 11/3/16 because it was not available with his other prescribed medications. Nurse #1 stated she was not aware she should have called the pharmacy and had it sent by the backup pharmacy. The Unit Manager (UM) stated that was her expectation. The UM stated that as a nurse, if any prescribed medication was not available, the physician should be notified or pharmacy be notified in order to have the medication sent using the backup pharmacy In a telephone interview on 11/16/16 at 4:07 PM, the Medical Director stated he would have expected the facility to have called the backup pharmacy and obtained the Seroquel as ordered for Resident #117.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		12/9/16

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 431	Continued From page 49 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and failed to date multi dose medications when opened on 3 (100/300/400) medication carts) of 4 medication carts observed. Findings included: The facility's policy on medication storage dated September 29, 2016 was reviewed. The policy indicated that multiple dose vials for injection should be dated when opened and should be discarded 28 days after opening. The policy also indicated that Humalog insulin (used to treat Diabetes Mellitus) should be discarded 28 days after opening and Humulin R (used to treat Diabetes Mellitus) insulin should be discarded 31 days after opening. The policy further indicated that Pulmicort (used to treat Asthma) inhalation should be discarded 2 weeks after opening the foil envelope.	F 431	Those Affected: Director of Nursing/Management Nurse to complete audit of affected 100, 300, 400 hall medication carts by 12/9/16. The result of the audit showed that no medications were expired or opened and undated for the affected medication carts. Those Potentially Affected: Director of Nursing/Management Nurse to complete audit of all medication carts by 12/9/16. The result of the audit showed that no medications were expired or opened and undated for the affected medication carts. Systemic Changes: All nursing staff will be in-serviced by 12/9/16 regarding the process of dating medications when opened, checking the expiration dates prior to administration, and proper	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 431	Continued From page 50 The manufacturer's instruction on the package of Budesonide (Pulmicort) indicated " once the foil/envelope was opened to use the vial/ampule within 2 weeks. " 1. On 11/16/16 at 3:35 PM, the medication cart #1 on 300/400 hall was observed. The following were observed: One opened vial of Novolin R with an opened date of 10/4/16 One opened vial of Humalog with an opened date of 9/3/16 Two opened vials of Humalog with no date of opening Two opened bottles of Lidocaine (local anesthesia) 1% (200 milligrams (mgs) per 20 milliliter (ml) with no date of opening Three ampules of Budesonide (Pulmicort) inhalation (25 mgs/2 ml) not kept inside the foil envelope and was undated On 11/16/16 at 3:45 PM, Nurse # 2 was interviewed. She stated that insulin vials, Lidocaine vials and Budesonide should be dated when opened. Nurse #2 indicated that multi dose vials were good for 28 days after opening. She also indicated that the night shift nurse was responsible in checking the medication carts for expired and undated medications. On 11/17/16 at 10:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to date the medications when opened and to check the expiration date of the medication before administration. The DON further indicated that the pharmacy also had checked medication carts regularly.	F 431	disposal. Two licensed staff on Leave. Both will be in-serviced upon their return. Monitoring and Performance Improvement: Director of Nursing/Management Nurse will audit medication carts monthly for one year to ensure all opened medications are dated, and that expired medications are disposed of. Director of Nursing/Management Nurse will bring results of each audit to the Performance Improvement meetings.	

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	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 431	Continued From page 51	F 431		

2. On 11/16/16 at 3:50 PM, medication cart #2 (300/400) was observed. There were 4 ampules of Budesonide kept inside an opened envelope with no date of opening.

On 11/16/16 at 3:54 PM, Nurse #4 was interviewed. She stated that Budesonide should be dated when opened. Nurse 4 observed the opened envelope and acknowledged that the envelope was not dated when opened.

On 11/17/16 at 10:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to date the medications when opened and to check the expiration date of the medication before administration. The DON further indicated that the pharmacy also had checked the medication carts regularly.

3. On 11/16/16 at 3:35PM, an observation of the medication cart for 100 hall revealed 2 vials of ipratropium albuterol lying in the medication box. The vials had been removed from the foil pouch and were not dated.

Manufacturer's instructions on medication box indicated the vials should be kept in the foil pouch.

On 11/16/16 at 3:35PM, an interview with Nurse #7 who stated the vials should have been in a foil pouch. The nurse then took both vials and discarded them.

On 11/17/16 at 10:15AM, an interview was conducted with the Director of Nursing who stated pharmacy checked the medication carts when they come to the facility. She said she also

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 _____	C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	**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 431	Continued From page 52 expected nursing staff to check the medications prior to administration, date medications when opened and keep the ipratropium in the foil pouch.	F 431		