STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. BUILDING ______ B. WING ______	C 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/27/23 through 3/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7T1611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/27/23 through 3/2/23. Event ID# 7T1611. The following intakes were investigated: NC00198638, NC00197254, NC00190813, NC00189182, NC00188938, and NC00187999. 10 of the 10 complaint allegations did not result in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		3/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to honor a resident's preference for a shower for 1 of 32 reviewed for choices (Resident #4). Findings included: Resident #4 was admitted to the facility on 7/31/17 with diagnoses that included a stroke. The annual Minimum Data Set (MDS) dated 12/22/22 indicated Resident #4 was cognitively intact. She was totally dependent for bathing. Resident did display behaviors of rejection of care. Resident #4 ' s MDS indicated choosing between a shower and a bed bath was very important to her. Record review of shower logs for Saturday, 2/25/23, indicated Resident #4 "refused a bed bath." During an interview on 2/27/23 at 11:15 AM, Resident #4 indicated she did not receive her scheduled shower over the weekend. She indicated her Saturday Nurse Aide (NA) #1 offered a bed bath but she declined stating she	F 561	F561 Self-Determination Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For Resident # 4: " Resident was offered and provided shower on March 1, 2023, date of notification by surveyor that resident did not receive preference of shower on 2/25/23, by Director of Nursing/Designee.	

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F 561 Continued From page 2

wanted a shower. NA #1 said she was not able to give a shower. Resident #4 was unsure why NA #1 could not give her a shower.

During an interview on 3/1/23 at 10:50 AM, NA #1 indicated she was unable to provide a shower for Resident #4 on Saturday, 2/25/23 due to not having enough nurse aides. NA #1 revealed she switched units mid shift and did not report to the other staff members she was unable to give showers.

During an interview on 3/1/23 at 11:05, the Quality Assurance (QA) Nurse reported she worked as nurse manager on Saturday and was not aware Resident #4 did not get her shower. She indicated if she was aware, she would have provided the shower. The QA nurse reported the facility was not short staffed on Saturday.

During an interview on 3/2/23 at 2:10 PM, the Director of Nursing (DON) indicated she was not aware Resident #4 did not receive a shower over the weekend. She revealed NA #1 did not notify other staff she was not able to get to the shower. The DON indicated if she was aware, Resident #4 would have been offered a shower on evening shift or on Sunday. She believed there was adequate staff working the weekend to provide showers.

During an interview on 3/2/23 at 2:15 PM, the Administrator revealed NA #1 had been educated on asking for assistance if she was not able to provide showers as scheduled. The Administrator revealed there was enough staff working to provide showers.

F 561

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
"   All inhouse residents with BIMS score 12 and above on most recent MDS interviewed by QA Nurse to ensure that preference for a shower over bath has been honored in last 30 days. Any discrepancies found on audit will be addressed thru updating resident careplan on bathing preferences. Audit completed on 03/17/2023.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

"   Director of Nursing developed Inservice Education on 03/06/23 titled Education of Resident Showers over Bed Baths.
"   All direct care staff educated by Director of Nursing/Designee by 03/20/2023.
"   Any Direct care staff not inserviced by this date will be educated on next scheduled shift by Director of Nursing/Designee
"   Any newly hired direct care staff will be inserviced during the orientation/onboarding process by SDC/Designee.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

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F 561	Continued From page 3	F 561	" Director of Nursing on 03/17/2023 to implement monitoring that showers are offered on scheduled days, if desired, before being offered bed bath. Weekly Shower Schedule will be utilized for identification of resident selection for interview based on residents indicated that received bed bath or refused. " Assistant Director of Nursing and Unit Managers inserviced by Director of Nursing on 03/17/23 on Weekly Shower Sheet Audit Tool use. " Unit Managers/Designee of Rehab and LTC units to complete audit tool weekly times 30 days, interviewing 4-5 residents weekly to ensure they were offered shower prior to receiving bed bath, if preference. " `Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		3/28/23

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F 623	Continued From page 4	F 623		

Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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F 623	Continued From page 5	F 623		

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure

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F 623	Continued From page 6	F 623		

to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide written notification to the resident or resident representative of the reason for discharge to the hospital for 2 of 2 sampled residents (Resident #41 and Resident #99) reviewed for hospitalization. This deficient practice had the potential to affect other residents.

The findings included:

1. Resident #41 was admitted to the facility on 08/19/2022.

The resident's quarterly Minimum Data Set (MDS) dated 11/24/2022 revealed the resident's cognition was moderately impaired.

A review of the Resident #41's medical records revealed that the resident had been transferred to the hospital from the facility on 12/04/2022. She was readmitted to the facility on 12/12/2022.

A review of the social service progress notes revealed no documentation that the resident or the responsible party was notified in writing of the date of the transfer and the reason of transfer to the hospital.

On 03/01/2023 at 9:27 AM, the Social Worker (SW) was interviewed. She stated that she was

F623 Notice Requirements Before Transfer/Discharge

Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance.

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

For Residents # 41 and Resident # 99:
" Written notification for reason for discharge on 12/04/22 was mailed to resident #41 and/or resident representative of the reason for the discharge by Social Work/Designee on 03/22/202.
" Written notification for reason for

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F 623	Continued From page 7 new to the facility as a social worker, and she had not notified the resident or the responsible party in writing of the date of the transfer and reason of transfer to the hospital. During an interview on 03/03/2023 at 1:00 PM with the facility Administrator, she stated the Social Worker was new and she was still learning her new role at the facility. The Administrator indicated the facility had not been providing the resident or the resident representative with written notifications of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to resident or resident representative. 2. Resident #99 was admitted to the facility on 2/1/23 with diagnoses that included osteomyelitis. His admission Minimum Data Set (MDS) indicated severe cognitive impairment. A nursing progress note dated 2/20/23 indicated Resident #99 was sent to the hospital. Review of Resident #99's medical record did not reveal his family received written notification of a transfer to the hospital on 2/20/23. During an interview on 3/2/23 at 9:30 AM, the Social Worker revealed had not notified the resident or responsible party the date or reason for the transfer to the hospital in writing. She indicated she was new to the facility. During an interview on 3/2/23 at 2:20 PM, the Director of Nursing (DON) indicated she was not aware of the requirement for written notification of a transfer to the hospital. She indicated the social worker would be completing the transfer notification in the future.	F 623	discharge on 02/20/23 was mailed to resident #99 and /or resident representative of the reason for the discharge by Social Work/Designee on 03/22/2023. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " Audit completed by Director of Nursing on March 17, 2022 of all resident hospital transfers with admission in previous 30 days (February 15-March 17). For any items revealed on audit, Written notification for reason for discharge to be mailed to resident and/or resident representative of the reason for the discharge by Social Work/Designee by 03/22/2023. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " Social Work and Admissions staff inserviced by Director of Nursing on March 17 2023 on required written notification of reason for discharge to hospital with admission to residents and/or representatives. Education included that written notification can be hand delivered, sent by email, if available, or by USPS mailing to address on file. # - 4 Indicate how the facility plans to monitor its performance to make sure that	

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F 623	Continued From page 8 During an interview on 3/2/23 at 2:25 PM, the Administrator revealed the Social Worker was not aware she was supposed to provide written notification of a transfer to the hospital. She indicated the facility had put a plan in place after becoming aware to ensure this will be completed in the future.	F 623	solutions are sustained; " Audit tool developed by Director of Nursing on 03/17/2023. " Director of Nursing/Designee to conduct audit of 100% of resident hospital discharges with admission weekly times 4 weeks to ensure that written notification of reason for discharge was provided to resident and/or representative. " Results of audits will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. ¿	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately for the Preadmission Screening and Resident Review (PASRR) Level II for 2 of 2 residents (Resident #75 and Resident #79) reviewed for PASRR. Findings included: 1. Resident #75 was admitted to the facility on 04/09/2021 with multiple diagnoses that included anxiety, bipolar disorder, and major depression.	F 641	F641 Accuracy of Assessments Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency.	3/28/23

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F 641	Continued From page 9 Review of the PASRR level II referral notification (a determination letter that states if a resident is placed appropriately) dated 07/27/2021 revealed Resident #75 was placed appropriately. Review of the PASRR level I screen dated 7/27/2021 revealed a diagnosis of anxiety, bipolar disorder, and major depression. The annual Minimum Data Set (MDS) dated 04/14/2022 had resident coded as cognitively intact and needed extensive assistance with most Activities of Daily Living (ADLs). The MDS was not coded for PASRR II for Resident #75 An interview with the Social Worker (SW) was conducted on 03/02/2023 at 9:36 AM. The SW stated she has worked at the facility since January 2023 and the MDS nurses handle the MDS. The SW also started she is still training in her new position and may have missed coding the MDS. An interview with the Director of Nursing (DON) and Administrator was conducted on 03/02/23 at 1:58 PM. They stated the SW was new and Section "A" on the MDS should be completed by her. Resident #75 should have been coded as screened for a PASRR level II and the former SW did not orient the SW sufficiently. 2. Record review indicated Resident #79 had a Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 3/22/22. Resident #79 was admitted to the facility on 3/23/22 with multiple diagnoses that included anxiety disorder, bipolar disorder, and dementia.	F 641	This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For resident # 75: " The annual MDS dated 04/14/2022 Passar Level II coding was corrected by MDS Coordinator on 03/01/2023 with a Modification to the coding and was transmitted accepted on 3/7/2023. For resident # 79: " The admission assessment dated 03/29/22 (admission DATE was 03/23/22) Passar Level II coding was corrected by MDS Coordinator on 03/01/2023 with a Modification to the coding and was transmitted and accepted on 03/02/23 # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " Audit of all Admission MDS□s for past 30 days (February 15-March 17) Completed by MDS Coordinator on March 17, 2023 to ensure that coding for A1500 related to the Passar Level II was coded correctly. Any corrections noted on Audit were corrected with Modifications to the Admissions MDS and resubmitted to State. # -3 Address what measures will be put into place or systemic changes made to	

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F 641	Continued From page 10 The admission Minimum Data Set (MDS) assessment dated 3/23/22 was answered "No" to question A1500 which asked if Resident #79 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 3/01/23 at 11:00 AM with the MDS Nurse. The MDS Nurse explained she had been assisting Social Work with updating PASRR and this one did not get updated appropriately. An interview was conducted on 3/01/23 at 3:30 PM with the Administrator. The Administrator explained there had been changes to staff with Social Work and some PASRR had not been entered in the system. The Administrator stated the MDS coding should have been completed for Resident #79 PASRR Level II and she did not know why it was not done.	F 641	ensure that the deficient practice will not recur; " Social Work inserviced by Director of Nursing on March 17, 2023 on RAI Manual for Section A1500 MDS coding of the Level II Passar. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; " Section A1500 MDS Audit Tool developed by Director of Nursing/Designee on March 17, 2023 " Social Work and MDS inserviced by Director of Nursing on March 17, 2023 on use of audit log tool " Audit to be completed for next 60 days (March 17-May 17) jointly by MDS Coordinator and Social Work of all admission assessments completed to verify the Level II Passar has correctly been coded. " Audit tool to be reviewed by Director of Nursing weekly. " Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. ¿	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		3/28/23

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	345349	A. BUILDING ______ B. WING ______	C 03/02/2023

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WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 644 Continued From page 11

A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for 2 of 4 residents reviewed for PASRR (Resident #5 and Resident #49).

Findings included:

1.Resident #5 was originally admitted to the facility on 02/11/2020 with diagnoses that included depressive disorder and anxiety disorder.

Resident #5 medical record revealed on 11/03/2022 she had a new diagnosis of delusional disorder.

Resident #5's annual Minimum Data Set (MDS)

F 644

F644 Coordination of PASSAR and Assessments

Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance.

1 - Address how corrective action will be

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F 644	Continued From page 12 assessment dated 11/18/2022 revealed she was not considered by the state to be a PASARR level II. During an interview on 03/01/2023 at 10:30 AM the Social Worker (SW) stated she was new at the facility, and she had not been aware of the responsibility of referring residents with a new psychiatric diagnosis to PASARR level II evaluation and for the new admission. She indicated moving forward she will make sure the residents who were diagnosed with new psychiatric diagnoses were referred for a PASARR level II evaluation. An interview was conducted with the MDS nurse on 03/01 /2023 at 1:44 PM. She stated that she was not aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission the resident needed to be referred for PASARR level II evaluation. The MDS added that moving forward if a new psychiatric diagnosis was added, she will confirm with the SW if the resident's new diagnoses was referred for a PASARR level II evaluation. An interview was conducted with the Director of Nursing (DON) on 03/02/2023 at 2:00 PM. She stated that she was not very familiar with the regulations related to PASARR level II evaluation, but that she expected the regulations to be followed in reference to completing a PASARR level II evaluation for a newly identified mental illness diagnosis. During an interview on 03/03/2023 at 1:00 PM, the Administrator indicated if a new psychiatric diagnosis required PASARR level II evaluation, then the Social Worker will be responsible for	F 644	accomplished for those residents found to have been affected by the deficient practice; For Resident #5: " Submission of Level II Passar completed by Social Worker on 03/01/2023 with the addition of new diagnosis revealed on 11/03/22 Passar was halted due to Dx of Dementia. For Resident #49: " Submission of Level II Passar complete by Social Worker on 03/01/2023 with the addition of new diagnosis revealed on medical record review on 10/26/21,02/10/22, 04/26/22, 06/07/22, and 11/21/11. Passar was halted due to Dx of Dementia. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " MDS Coordinators and Director of Nursing reviewed all MDS□s in progress or completed in the last 30 days (February 15-March 17) for changes in diagnosis or medications that would indicate need for a Level II PASSAR to be submitted. Audit was completed on 03/17/2023. No other residents were identified as needing Level II Passar submitted. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " Director of Nursing developed Passar	

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F 644	Continued From page 13 PASARR level II referral for an evaluation. She also added the MDS nurse will be following up with SW to confirm that the residents' new diagnoses were referred for PASARR level II evaluation. 2. Resident #49 was admitted to the facility on 10/26/21. Review of Resident #49's annual Minimum Data Set (MDS) dated 08/20/22 indicated Resident #49's current diagnoses included, in part, anxiety disorder and psychotic disorder. Review of the PASRR Level I application dated 07/17/17 revealed no mental health diagnoses. Review of the PASRR Level I Determination Notification letter dated 07/17/17 revealed that "no further PASRR screening is required unless a significant change occurs with the individual's status that suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." Review of Resident #49's medical record revealed diagnoses to include altered mental status - 10/26/21, anxiety disorder - 10/26/21, adjustment disorder with depressed mood - 02/10/22, pseudobulbar affect (a medical condition causing sudden uncontrollable crying and/or laughing that does not match how you feel) - 04/26/22, psychotic disorder with delusions - 06/07/22, and dementia - 11/21/22. An interview on 02/28/23 at 2:30 PM with the Social Worker (SW), she stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASRR. The SW stated she was not in the	F 644	Tracking Log with guidelines for completion for use by MDS and Social Work Department " MDS Coordinators and Social Work were inserviced by Director of Nursing on March 17, 2023 on new facility Passar Tracking Log/Guidelines, with implementation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; " MDS and Social Work to complete Passar Tracking Log for next 60 days and ongoing. " Director of Nursing /Designee to Audit 50% of Passar Tracking Log entries weekly times two weeks and 25 % weekly times 2 weeks and randomly ongoing to ensure Level II Passar review was completed, if applicable, and coded correctly on MDS. " Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. ¿	

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F 644	Continued From page 14 current position when the evaluation should have been completed, and she did not know what had happened or why the evaluation was not done. An interview on 03/01/23 at 12:06 PM, with the Admission Nurse, she stated the resident was admitted with her old PASRR report. She explained there had been a turnover in staff and the information did not get passed. She explained she had entered the data for the update in PASRR and moving forward there would be a system in place to enter PASRR information even when someone leaves their position. An interview on 03/01/23 at 2:00 PM, the Minimum Data Set (MDS) Nurse stated the Social Worker would usually be the one to submit an evaluation for a Level II PASARR change but this slipped their attention since there had been changed in personnel. She confirmed Resident #49's medical record indicated she was admitted to the facility with a Level I PASARR and no Level II PASARR had not been filed. An interview on 3/01/23 at 3:30 PM, the Administrator stated there should have been a new application submitted for a Level II PASARR evaluation. She stated the facility was in the process of completing recommendations from their investigation of Resident #49's PASSAR. The Administrator explained all residents would be reviewed and screened for any needed Level II PASRR assessments when changes occur.	F 644		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing	F 802		3/28/23

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F 802	Continued From page 15 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have sufficient staff to ensure timely meals. This had the potential to affect residents receiving food from the kitchen. Findings included: This tag is cross-referenced to F809. Based on observations, record review, and resident, family, and staff interviews, the facility failed to provide timely meals for 3 of the 3 meals observed. This had the potential to affect all residents receiving food from the kitchen. During observations in the kitchen on 2/27/23 at 10:15 AM and 3/1/23 at 12:00 PM, the Dietary Manager was observed in the cooking area. He revealed the cook was out and he was working long days to cover the open positions.	F 802	Tag F802 Sufficient Dietary Support Personnel Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance # 1 - Address how corrective action will be	

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F 802

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During an interview on 3/2/23 at 11:15 AM, the Dietary Manager revealed trays were served late due to being short staffed in the kitchen. He revealed the afternoon cook and two dietary aides were out the week of survey. The dietary manager revealed corporate had sent a regional chef to assist with short staffing and he had been there around 1 month.

During an interview on 3/2/23 at 2:00 PM, the Administrator revealed that the facility had requested assistance from corporate due to being short staffed. Corporate sent a regional dietary chef to assist. She indicated several new people had been hired to work in the kitchen.

F 802

accomplished for those residents found to have been affected by the deficient practice;

As this had the potential to affect all inhouse residents:
" Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacancies until permanent hires for positions could be obtained to ensure facility has sufficient staff to ensure timely meals.
" Hiring process of Facility- Dietary Services Vendor enhanced, for example with temporary additional signing bonus structure), more frequent updated ads on Indeed, etc, in ongoing attempts to attract additional staff for Dietary Services Department.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
As this had the potential to affect all other residents:
" Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacancies until permanent hires for positions could be obtained to ensure facility has sufficient staff to ensure timely meals.
" Hiring process of Facility Food and Nutrition Vendor enhanced, for example with temporary additional signing bonus structure, more frequent ads updates on Indeed, etc in ongoing attempts to attract additional staff for Dietary Services Department.

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F 802	Continued From page 17	F 802	# -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " Daily Labor Budget Guide developed by Facility Dietary Services Vendor/Administrator on 03/20/2023 to provide guidance on general expected staffing patterns daily to allow for sufficient staff to ensure timely meals. " Food Service Director inserviced by Facility Dietary Services Vendor Regional Director/Administrator on 03/20/2023 on Daily Labor Budget Guide with implementation. " Daily Deployment Schedule developed by Facility Dietary Service Vendor/Administrator on 03/20/2023 to provide daily staffing sheets for Dietary Services Department. " Food Service Director inserviced on Daily Deployment Schedule by Facility Vendor Regional Director/Administrator on 03/20/2023 with implementation on 03/20/2023. " Daily Deployment Schedule to be completed daily by Food Service Director/Designee and updated daily if indicated. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; " Audit Tool was developed by Administrator on 03/20/2023 for auditing process for Daily Deployment Schedule.	

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F 802	Continued From page 18	F 802	" Registered Dietitian inserviced on the Audit Tool by Administrator on 03/20/2023. " Effective week of 03/20/2023 Dietitian/Designee will audit Daily Deployment Schedule 5 times weekly times 2 (two) weeks, then 3 times weekly times 2 (two) weeks, then at least weekly times 4(four) weeks to ensure sufficient staffing provided to ensure timely meals. " Results of Registered Dietitian/Designee audits to be reviewed by Administrator weekly times 4 (four) weeks then every 2 (two) weeks times 4(four). " Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809		3/28/23

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F 809

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§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and resident, family, and staff interviews, the facility failed to provide timely meals for 3 of the 3 meals observed. This had the potential to affect all residents receiving food from the kitchen.

Findings included:

Resident #91 was admitted to the facility on 10/27/22 with diagnoses that included Parkinson's. His quarterly Minimum Data Set (MDS) dated 2/2/23 indicated a moderate cognitive impairment.

During an interview on 2/27/23 at 11:00 AM, Resident #91 indicated that meals were frequently late and always served at different times.

During an interview on 2/27/23 at 1:10 PM, a family member indicated she goes to the facility at lunch time to assist her mother. Lunch trays were often late.

Record review of the facility's meal times indicated that the 400 hall was to receive breakfast at 9:15 AM and lunch at 1:30 PM.

An observation was made on 3/1/23 at 9:50 AM of breakfast trays delivered to 400 hall.

F 809

Tag F809 Frequency of Meals

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1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
As this had the potential to affect all inhouse residents, including resident #91:
" Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacancies until permanent hires for positions could be obtained to ensure facility has sufficient staff to ensure timely meals.

- 2 Address how the facility will identify

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F 809	Continued From page 20 An observation was made on 3/1/23 at 1:50 PM of lunch trays delivered to 400 hall. During an interview on 3/2/23 at 11:10 AM, the Dietary Manager indicated the trays were late because they were short staffed in the kitchen. He indicated he was filling in for the cook the day prior. He indicated the trays arriving that late was unacceptable. During an interview on 3/2/23 2:05 PM, the Administrator revealed she was aware of an issue with trays arriving late. She revealed the kitchen usually notifies the floor if trays were late.	F 809	other residents having the potential to be affected by the same deficient practice; As this had the potential to affect all other residents: " Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacancies until permanent hires for positions could be obtained to ensure facility has sufficient staff to ensure timely meals. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " Dietary Services Vendor Management, Facility Nursing Management and Administrator met and reviewed Meal Times Policy on 3/16/23 with revisions made, if applicable " Food Service Director Inserviced on Meal Times Policy by Facility Dietary Services Vendor Regional Director/Administrator on 03/20/2023 " All Facility Dietary Service Vendor staff assigned to this location will be inserviced on Meal Times Policy by Food Service Director/Designee by 03/22/2023. Any staff not inserviced by this date will be inserviced by the start of their next scheduled shift. " All newly hired staff of Facility Dietary Service Vendor assigned to this location after 03/22/2023 will be inserviced on Meal Times Policy during onboarding orientation process by Food Service Director/Designee " Dietary Services Management, Nursing Management and Administrator	

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F 809	Continued From page 21	F 809	met and reviewed Meal Times Delivery schedule on 3/16/23 with revisions made to tray cart arrangement and delivery times if necessary to provide timely meal service. " Food Service Director Inserviced on Meal Times Delivery Schedule by Facility Dietary Services Vendor Regional Director/Administrator on 03/20/2023. " All Facility Dietary Service Vendor staff assigned to this location will be inserviced on Meal Times Delivery Schedule by Food Service Director/Designee by 03/22/2023. Any staff not inserviced by this date will be inserviced by the start of their next schedule shift. " All newly hired staff of Facility Dietary Service Vendor assigned to this location after 03/22/2023 will be inserviced on Meal Times Delivery Schedule during onboarding orientation process by FSD/Designee " Food Cart Delivery Sheet to be completed with each meal service by serving staff, was reviewed/revised by Facility Food Service Director on 03/20/23 with implementation on 03/22/23. " All facility Dietary Service Vendor staff assigned to this location will be inserviced on Food Cart Delivery Sheet by Food Service Director/Designee by 03/22/2023. Any staff not inserviced by this date will be inserviced by the start of their next schedule shift. " All newly hired staff of Facility Dietary Service Vendor assigned to this location after 03/22/2023 will be inserviced on Food Cart Delivery Sheet during	

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F 809	Continued From page 22	F 809	onboarding orientation process by Food Service Director/Designee # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; " Audit Tool Developed by Administrator on 03/20/2023 for auditing of Meal Delivery Times by Dietary Services Staff. " Registered Dietitian inserviced on newly developed Audit Tool by Facility Dietary Services Vendor Regional Director/Administrator on 03/20/2023 , with implementation. " Effective week of 03/20/2023 Registered Dietitian/Designee will conduct random audit of Meal Delivery Times for 50% of meal delivery times weekly times 2 (two) weeks, then 25% of Meal Delivery Times weekly times 2 (two) weeks, then 10% of Meal Delivery Times weekly times 2 (two) weeks, and at least weekly thereafter to ensure timely meal delivery. " Results of Registered Dietitian/Designee audits to be reviewed by Administrator weekly times 4 (four) weeks then every 2 (two) weeks times 4(four). " Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to date and remove leftover food stored for use in one of one kitchen walk-in refrigerator and failed to discard leftover food in 2 of 3 (100 hall and 200 hall) nourishment room refrigerators. Findings included: 1. A tour was conducted on 2/27/23 at 10:00 AM with the Dietary Manager of the kitchen walk-in refrigerator. Observations were made of an opened bag of sliced Swiss cheese with no date and an opened bag of shredded cheese with no date.	F 812	Tag F812 Food Procurement, Store/Prepare/Serve Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/02/2023 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions, and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of	3/28/23

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F 812	Continued From page 24 During an interview on 2/27/23 at 10:05 AM, the Dietary Manager indicated he was told he did not have to label cheese in the walk in. During an interview on 3/1/23 at 11:40 AM, the regional Dietary Manager revealed opened cheese should be dated and thrown away by the discard date. During an interview on 3/1/23 at 3:40 PM, the Administrator revealed the Dietary Manager was responsible for monitoring the kitchen walk-in cooler. 2. Posted signage on the nourishment room refrigerator provided instruction for all items placed in the refrigerator to be labeled with the resident ' s name, room number, and will be discarded in 72 hours. A tour was conducted on 2/27/23 at 4:20 PM with the Dietary Manager of the facility ' s nourishment rooms. The 100-hall refrigerator revealed an open bag of granola with no date. The 200-hall refrigerator revealed a plastic container of birthday cake dated 2/21/23, an opened container of cottage cheese dated 2/23/23, and a plastic container of cheesecake dated 2/23/23. During an interview on 2/27/23 at 4:25 PM, the Dietary Manager revealed his staff monitored the refrigerators and discarded expired foods. He was not sure how the foods could have been left in the refrigerator. During an interview on 3/1/23 at 3:40 PM, the Administrator revealed that the unit managers round on the nourishment room refrigerators daily and the Dietary Manager monitors weekly. She	F 812	compliance. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " On 2/27/23 observed items stored without a date in kitchen walk-in refrigerator were discarded by Dietary Manager " On 2/27/23, observed opened items and containers of food in Long Term Care (100 Hall) nourishment room refrigerator and Rehab (200 Hall) nourishment room refrigerator that were not properly labeled, dated or were expired to include any labeled items beyond 72 hours (3 days) were discarded by Dietary Manager. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " On 2/27/23 audit completed, and any other items stored without a date in kitchen walk-in refrigerator were discarded by Dietary Manager " On 2/27/23, audit completed of all nourishment room refrigerators and any opened items and containers of food that were not properly labeled, dated or were expired to include any labeled items beyond 72 hours (3 days) were discarded by Dietary Manager. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 812	Continued From page 25 was unsure how the foods could have been left in the nourishment room refrigerators past 3 days.	F 812	" Food Service Director verbally Inserviced on proper food storage/labeling by Facility Dietary Services Vendor Regional Director/Administrator on 02/27/2023 . " Food Service Director Inserviced on Labeling and Prescribed Snack and Nourishment Policies, to include Labeling, Dating, Storage, Discarding of food items in Kitchen and Nourishment Room refrigerators, by Facility Dietary Services Vendor Regional Director/Administrator on 03/20/2023 " All facility Dietary Service Vendor staff assigned to this location will be inserviced on Labeling and Prescribed Snack and Nourishment Policies, to include Labeling, Dating, Storage, Discarding of food items in Kitchen and Nourishment Room refrigerators, by Food Service Director/Designee by 03/22/2023. Any staff not inserviced by this date will be inserviced by the start of their next schedule shift. " All newly hired staff of Facility Dietary Service Vendor assigned to this location after 03/22/2023 will be inserviced on Labeling and Prescribed Snack and Nourishment Policies, to include Labeling, Dating, Storage, Discarding of food items in Kitchen and Nourishment Room refrigerators, during onboarding orientation process by Food Service Director/Designee. " All nursing staff will be inserviced on Labeling, Dating, Storage, Discarding of food items in Nourishment Room refrigerators by SDC/Designee by 03/22/2023. Any staff not inserviced by	

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F 812	Continued From page 26	F 812	this date will be inserviced by the start of their next schedule shift. " All newly hired staff after 03/22/2023 will be inserviced on Labeling, Dating, Storage, Discarding of food items in Nourishment Room refrigerators during onboarding orientation process by Food Service Director/Designee. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. " Audit Tool Developed by Administrator on 03/22/2023 for auditing of proper food storage in kitchen and nourishment room refrigerators. " Registered Dietitian inserviced on newly developed Audit Tool by Facility Dietary Services Vendor Regional Director/Administrator on 03/22/2023 , with implementation. " Effective week of 03/22/2023 Registered Dietitian/Designee will conduct audit of all Kitchen and Nourishment Room refrigerators 4 times weekly times 2 (two) weeks, then 3 times weekly times 2 (two) weeks and weekly thereafter. " Results of Registered Dietitian/Designee audits to be reviewed by Administrator weekly times 4 (four) weeks then every 2 (two) weeks times 4(four). " Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to	

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F 812	Continued From page 27	F 812	ensure continued compliance.	