STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 05/15/23 through 05/18/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BF5411.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted from 05/15/23 through 05/18/23. Event ID # BF5411. The following intakes were investigated: NC00201845, NC00201707, and NC00199468. 7 of the 7 complaint allegations resulted in no deficiencies.	F 000		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		6/5/23

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

Electronically Signed | 06/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 1 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to provide the resident or resident's representative with the bed hold policy upon transfer to the hospital 4 of 4 residents (Resident #15, Resident #48, Resident #69, and Resident #7) reviewed for hospitalizations. Findings included: 1. Resident #15 was admitted to the facility on 1/12/21. Resident #15's 12/28/22 Significant Change Minimum Data Set (MDS) assessment revealed resident was cognitively intact. A nursing progress note on 1/7/23 indicated Resident #15 was discharged to the hospital. Interview on 5/18/23 at 9:55 AM with Resident #15 revealed she did not recall being informed of or provided with the bed hold policy when she was sent to the hospital. Interview on 5/18/23 at 9:37 AM with Nurse #2 revealed she didn't send bed hold policy with the resident or provide it to the resident representative when a resident was transferred to the hospital.	F 625	State Non-Compliance Facility failed to provide the resident or residents representative with the bed hold policy upon transfer to the hospital. Corrective Action Education began immediately by facility educator and managers on bed hold policy. Folders for each unit were made to include the bed hold policy with transfer packets. 100% of nursing staff were educated on or before 5/27/23. The admission liaison and social worker were educated on 5/23/23 regarding all new admissions to include resident and resident representative receiving a bed hold policy upon admission and documentation to validate. Audit was created (Verge - Accreditation Software Program) to monitor new admissions as well as transferred patients to the hospital. Daily chart audits for new admissions and hospital transfers began 6/5/23 and will continue for a minimum of 90 days with goal being >90%. Staff Responsible Educator/Managers Sustainability of Compliance Will continue to monitor for sustainability compliance of 90 days at >90% compliance to follow with monthly chart of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 2 Interview on 5/17/23 at 1:25 PM with the Admissions Director revealed she didn't discuss the bed hold policy with the resident or representative when a resident was transferred to the hospital. The Admission's Director stated she thought the Social Worker was responsible for the bed hold policy. Interview on 5/17/23 at 1:18 PM with the Social Worker (SW) revealed she had been in the position at the facility for 2.5 years. The SW stated she didn't know anything about sending the bed hold policy with the resident when they were discharged to the hospital or providing the family with the written bed hold policy. The SW stated maybe the Business Office Manager handled this. Interview on 5/17/23 at 1:22 PM with the Business Office Manager (BOM) revealed the facility did not send the bed hold policy with the resident when they were discharged to the hospital. BOM stated there used to be a form and a policy, but the facility had not been doing it for a long time. Interview on 5/18/23 at 2:27 PM with the Director of Nursing (DON) revealed the bed hold policy was supposed to be sent with the resident when a resident was sent out to the hospital, but the facility had not been doing this for a while. The DON stated the facility would start providing the written bed hold policy to the resident or resident representative of the bed hold policy upon discharge to the hospital. 2. Resident #48 was admitted to the facility on 4/13/22.	F 625	5 random charts to be reported in our regulatory meetings as requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 3	F 625		

The Minimim Data Set (MDS) discharge assessment revealed Resident #48 was discharged on 1/25/23. The MDS entry tracking record revealed Resident #48 was readmitted to the facility on 2/02/23.

A nursing note on 1/25/23 revealed Resident #48 was discharged to the hospital. There was no evidence a bed hold policy was provided to the resident or resident representative was included.

The MDS discharge assessment revealed Resident #48 was discharged on 2/22/23. The MDS entry tracking record revealed Resident #48 was readmitted to the facility on 2/24/23.

A nursing note on 2/22/23 revealed Resident #48 was discharged to the hospital. There was no evidence a bed hold policy was provided to the resident or resident representative was included.

Interview on 5/18/23 at 9:37 AM with Nurse #2 revealed she didn't send bed hold policy with the resident or provide it to the resident representative when a resident was transferred to the hospital.

Interview on 5/17/23 at 1:25 PM with the Admissions Director revealed she didn't discuss the bed hold policy with the resident or representative when a resident was transferred to the hospital. The Admission's Director stated she thought the Social Worker was responsible for the bed hold policy.

Interview on 5/17/23 at 1:18 PM with the Social Worker (SW) revealed she had been in the position at the facility for 2.5 years. The SW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 4	F 625		

stated she didn't know anything about sending the bed hold policy with the resident when they were discharged to the hospital or providing the family with the written bed hold policy. The SW stated maybe the Business Office Manager handled this.

Interview on 5/17/23 at 1:22 PM with the Business Office Manager (BOM) revealed the facility did not send the bed hold policy with the resident when they were discharged to the hospital. BOM stated there used to be a form and a policy, but the facility had not been doing it for a long time.

Interview on 5/18/23 at 2:27 PM with the Director of Nursing (DON) revealed the bed hold policy was supposed to be sent with the resident when a resident was sent out to the hospital, but the facility had not been doing this for a while. The DON stated the facility would start providing the written bed hold policy to the resident or resident representative of the bed hold policy upon discharge to the hospital.

3. Resident #69 was readmitted to the facility on 12/13/22.

The Minimim Data Set (MDS) discharge assessment revealed Resident #69 was discharged on 02/10/23. The MDS entry tracking record revealed Resident #69 was readmitted to the facility on 02/13/23.

Resident #69's nursing progress notes for 2/10/23 revealed the resident was sent to the emergency room for evaluation. There was no evidence a bed hold policy was provided to the resident or resident representative was included.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 5	F 625		

Resident #69's Minimum Data Set (MDS) assessments indicated the resident was discharged with return anticipated on 2/10/23.

Interview on 5/18/23 at 9:37 AM with Nurse #2 revealed she didn't send bed hold policy with the resident or provide it to the resident representative when a resident was transferred to the hospital.

Interview on 5/17/23 at 1:25 PM with the Admissions Director revealed she didn't discuss the bed hold policy with the resident or representative when a resident was transferred to the hospital. The Admission's Director stated she thought the Social Worker was responsible for the bed hold policy.

Interview on 5/17/23 at 1:18 PM with the Social Worker (SW) revealed she had been in the position at the facility for 2.5 years. The SW stated she didn't know anything about sending the bed hold policy with the resident when they were discharged to the hospital or providing the family with the written bed hold policy. The SW stated maybe the Business Office Manager handled this.

Interview on 5/17/23 at 1:22 PM with the Business Office Manager (BOM) revealed the facility did not send the bed hold policy with the resident when they were discharged to the hospital. BOM stated there used to be a form and a policy, but the facility had not been doing it for a long time.

Interview on 5/18/23 at 2:27 PM with the Director of Nursing (DON) revealed the bed hold policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 6	F 625		

was supposed to be sent with the resident when a resident was sent out to the hospital, but the facility had not been doing this for a while. The DON stated the facility would start providing the written bed hold policy to the resident or resident representative of the bed hold policy upon discharge to the hospital.

4. Resident #7 was admitted to the facility on 06/04/20.

Resident #7's 02/28/23 Quarterly Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairments.

The MDS discharge assessment revealed Resident #7 was discharged on 03/22/23. The MDS entry tracking record revealed Resident #7 was readmitted to the facility on 03/27/23.

Review of nursing progress note on 03/22/23 at 8:57 AM indicated the nurse observed Resident #7's had swollen left upper arm and elbow. Nurse #2 note indicated Resident #7 was discharged to the hospital with no statement regarding bed hold policy being provided to the resident or the resident representative.

Interview on 5/18/23 at 9:37 AM with Nurse #2 revealed she didn't send bed hold policy with the resident or provide it to the resident representative when a resident was transferred to the hospital.

Interview on 5/17/23 at 1:25 PM with the Admissions Director revealed she didn't discuss the bed hold policy with the resident or representative when a resident was transferred to the hospital. The Admission's Director stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 625	Continued From page 7 thought the Social Worker was responsible for the bed hold policy. Interview on 5/17/23 at 1:18 PM with the Social Worker (SW) revealed she had been in the position at the facility for 2.5 years. The SW stated she didn't know anything about sending the bed hold policy with the resident when they were discharged to the hospital or providing the family with the written bed hold policy. The SW stated maybe the Business Office Manager handled this. Interview on 5/17/23 at 1:22 PM with the Business Office Manager (BOM) revealed the facility did not send the bed hold policy with the resident when they were discharged to the hospital. BOM stated there used to be a form and a policy, but the facility had not been doing it for a long time. Interview on 5/18/23 at 2:27 PM with the Director of Nursing (DON) revealed the bed hold policy was supposed to be sent with the resident when a resident was sent out to the hospital, but the facility had not been doing this for a while. The DON stated the facility would start providing the written bed hold policy to the resident or resident representative of the bed hold policy upon discharge to the hospital.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		5/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 637	Continued From page 8 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to complete a significant change assessment on 1 of 1 residents (Resident #18) reviewed for significant change. Findings included: Resident #18 was admitted to the facility on 6/30/2017 and was readmitted from the hospital on 12/2/21 with diagnoses of Alzheimer's disease, anxiety disorder, restlessness, chronic pain syndrome, and a history of falling. Review of the quarterly Minimum Data Set (MDS) dated 12/31/22 revealed Resident #18 had clear speech, sometimes understood, sometimes understands, had no signs or symptoms of delirium, had no behavior symptoms or mood indicators, required extensive assistance with transfers and eating, supervision with locomotion on and off the unit, had no impairments to upper or lower extremities, and had no falls. Review of the quarterly MDS dated 3/1/23 revealed Resident #18 had unclear speech, had signs and symptoms of delirium including inattention behavior and disorganized thinking both were continuously present and did not	F 637	State Non-Compliance Facility (MDS) failed to complete a significant change assessment on a patient with a documented significant change. Corrective Action Education completed immediately regarding the importance of MDS capture of significant change(s) with residents. Resident #18 chart reviewed with immediate modification. Audit was created (Verge - Accreditation Software Program) to monitor residents with identified significant changes. Daily chart audits for new significant changes will begin 6/5/23 and will continue for a minimum of 90 days with goal being 100%. Staff Responsible MDS Nurse/Director of Nursing Sustainability of Compliance Will continue to monitor for sustainability compliance of 90 days at 100% to follow with monthly chart auditing of 5 random charts to be reported in our regulatory meetings as requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 637	Continued From page 9 fluctuate, altered level of consciousness behavior was present and fluctuated. Resident #18's mood indicators included poor appetite for several days, had a behavior of wandering which occurred 1 to 3 days, required total dependence with bed mobility and eating, locomotion on and off unit did not occur, had impairment to a lower extremity on one side, and had one fall. A review of Resident #18's MDS assessments revealed a Significant Change in Status Assessment had not been completed after the noted new symptoms of delirium, mood indicators, behavior, decline in activity of daily living in bed mobility and eating, new impairment to lower extremity range of motion, and fall. An interview on 5/17/23 at 1:30 PM the MDS Nurse #1 stated that a Significant Change in Status Assessment should be done whenever there is a change in two or more areas of improvement or decline. MDS Nurse #1 further revealed that a Significant Change in Assessment should have been completed on 3/1/23. An interview on 5/17/23 at 2:00 PM with the Director of Nursing revealed that a Significant Change in Assessment should be completed of noted areas of decline or improvement is noted when completing the MDS.	F 637		
F 641 SS=B	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:	F 641		5/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 641	Continued From page 10 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Assessment (MDS) for 1 of 1 residents (Resident #28) who received dialysis treatments. Findings included: Resident #28 was admitted to the facility on 01/31/16. Diagnoses included, in part, end stage renal disease (ESRD) with hemodialysis. Review of a physician order dated 09/22/22 revealed an order for dialysis treatments on Monday, Wednesday, and Friday for Resident #28. The MDS quarterly assessment dated 04/05/23 revealed Resident #28 was cognitively intact and was not coded as receiving dialysis. Review of Resident #28's care plan updated on 04/05/23 revealed a plan of care for ESRD hemodialysis on Monday/Wednesday/Friday with a goal that resident would not exhibit signs or symptoms of infection and or clotting at access site through next review. Interventions included monitoring and recording weight, monitor intake and output as ordered, monitor lab work and report abnormalities to provider. Monitor and report signs of infection, do not take blood pressure or draw blood from shunt arm, palpate for thrill over bruit site daily and notify provider if absent, and communicate with dialysis center. An interview was conducted with the MDS Nurse on 05/18/23 at 1:17 PM. The MDS Nurse confirmed Resident #28 was receiving dialysis treatments three times per week. The MDS nurse stated she did not know how she missed	F 641	State Non-Compliance Facility (MDS) failed to accurately code resident receiving dialysis. Corrective Action 100% of all dialysis patients (3) were reviewed for accurate MDS coding. Resident #28 was coded and modification made with MDS on 5/19/23. Audit was created (Verge - Accreditation Software Program) to monitor residents on dialysis. MDS monthly assessment calendar along with audit tool (Verge) will be utilized for auditing dialysis patients for 90 days (New dialysis patients, quarterly/annual assessments) with goal being 100%. Staff Responsible MDS Nurse/Director of Nursing Sustainability of Compliance Will continue to monitor for sustainability compliance of 90 days at 100% compliance to follow with monthly chart auditing of 2 random charts to be reported in our regulatory meetings as requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 641	Continued From page 11 coding the assessment accurately. An interview was conducted with Director of Nursing on 05/18/223 at 2:45 PM. The DON stated Resident #28 has been on dialysis for years and the MDS should have been coded accurately to reflect the resident's care.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 657	Continued From page 12 by: Based on record review and staff interviews, the facility failed to invite a cognitively intact resident (Resident #2) to an interdisciplinary care plan meeting for 1 of 18 residents reviewed. Resident # 2 was admitted to the facility on 10/5/22 with medical diagnoses of debility, heart failure, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. A review of Resident #2's quarterly MDS dated 3/27/23 indicated the resident was cognitively intact and had no signs of delirium or behaviors. Resident #2's care plan was last reviewed on 4/4/23 by MDS Nurse #1. Resident #2's care plan meeting minutes last reviewed on 4/4/23 did not include if Resident #2 was invited to attend. An interview conducted with Resident #2 on 5/15/23 at 4:01 PM revealed that Resident #2 had not been invited or attended any care plan meetings since Resident #2's admission. Resident #2 stated that she would like to go to her care plan meetings so she understood what she needed to do to go home. On 5/17/23 at 8:56 AM MDS Nurse #1 stated families were invited to care plan meetings by mail and residents who were alert and oriented were verbally invited. The verbal invitation was not documented in the resident's chart and no record of the invitation was documented in the MDS office. MDS Nurse #1 stated records should have been kept of when residents were verbally informed of care plan meetings. MDS Nurse #1	F 657	State Non-Compliance Facility (MDS) failed to invite cognitively intact resident to an interdisciplinary care plan meeting. Corrective Action Education was provided immediately to MDS nurse regarding all residents who are alert and oriented to be invited to all care plan meetings and documentation reflective of the invitation. June care plan meeting calendar reviewed with all alert and oriented patients being invited along with resident family/representative to include documentation reflective of the invite on 5/31/23. Audit was created (Verge - Accreditation Software Program) to monitor care plans. Daily chart audits for care plans inclusive of alert and oriented patient invites for 90 days with goal being 100%. Staff Responsible MDS Nurse/Director of Nursing Sustainability of Compliance Will continue to monitor for sustainability compliance of 90 days at 100% compliance to follow with monthly chart auditing of 5 random charts to be reported in our regulatory meetings as requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 657	Continued From page 13 stated she could not recall if she had invited Resident #2 specifically to the care plan meeting however it was normal practice for MDS Nurse #1 to do so the day before or the day of the care plan meeting. An interview with the Director of Nursing on 5/17/23 at 10:11 AM revealed alert and oriented residents should be provided with the same invitation as their family and if the resident does not want to attend it should be included in the care plan meeting minutes.	F 657		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance	F 867		5/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 867	Continued From page 14	F 867		

indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 867	Continued From page 15 §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 867	Continued From page 16 (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a recertification and complaint investigation on 01/24/22. This was for one deficiency that was originally cited in the area of comprehensive assessments after significant change and was subsequently recited on the current recertification and complaint survey on 05/19/23. The continued failure during 2 survey of records shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F637: Based on medical record review and staff interviews, the facility failed to complete a significant change assessment for 1 of 1 resident (Resident 18) reviewed for significant change. During the annual recertification and complaint survey on 01/24/22, the facility failed to complete 2 significant change Minimum Data Set (MDS) assessments within 14 days.	F 867	State Non-Compliance Facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place and inability to sustain an effective Quality Assurance Program. Corrective Action Education provided Immediately to IDT (Interdisciplinary Team) regarding implemented procedures/interventions, significant changes, and the importance of communication with reflective documentation. Audit was created (Verge - Accreditation Software Program) to track and trend data inclusive of significant changes with implemented procedures/interventions to follow up for validity. Daily audits for implemented interventions and effectiveness for 90 days with goal being >90%. Information to be discussed daily in IDT and captured in the monthly QAPI minutes and report. Staff Responsible MDS/Director of Nursing Sustainability of Compliance Will continue to monitor for sustainability compliance of 90 days at >90%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 867	Continued From page 17 An interview was conducted with the Director of Nursing (DON) on 05/19/23 at 3:00 PM. The DON reported the interdisciplinary team discussed the MDS assessments as part of their meeting every morning, and she did not know why the QAPI plan was ineffective for significant change assessments.	F 867	compliance to follow with monthly chart auditing of 5 random charts to be reported in our regulatory meetings as requested.	