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WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 12/13/2023 through 12/15/2023. Event ID# VBN511. The following intakes were investigated: NC00210811 and NC00207546. 2 of the 4 complaint allegations resulted in deficiency.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Orthopedic Surgeon interviews the facility failed to perform comprehensive skin assessments, to conduct skin monitoring to the area under an immobilizer and to coordinate care with the resident's orthopedic surgeon to ensure care needs were met when the resident missed her 10/4/23 surgical follow up orthopedic appointment and was not seen by the orthopedist until 11/17/23. At the 11/17/23 orthopedic surgeon visit Resident #1 was identified with a wound on her right knee that appeared necrotic (dead tissue), black in color,	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	1/11/24

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

Electronically Signed | 01/11/2024

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F 686	Continued From page 1 and the skin around it appeared darker like a bruise. This was for 1 of 1 resident reviewed for wound care. The findings included: Resident #1 was admitted to the facility on 8/25/2023. Her diagnoses included right hip prosthetic (previous hip replacement hardware) removal followed by surgical repair of the hip joint (an artificial joint with two bearings replaces damaged joint), chronic kidney disease (CKD) stage 4, and hypertension (high blood pressure). The admission Minimum Data Set (MDS) assessment dated 9/7/2023 revealed Resident #1 was cognitively intact and required extensive assistance of 1 staff member for most activities of daily living (ADL). She was coded as having a surgical wound and no pressure ulcers or venous ulcers. The hospital record for Resident #1 revealed she was admitted to the hospital on 9/18/2023 after a fall in her wheelchair. She was diagnosed with an acute fracture of the right middle portion of the distal femur (thigh bone). Resident #1's right femur was repaired surgically by Orthopedic Surgeon #2 on 9/20/2023. Resident #1's femur fracture was repaired by inserting a metal rod up into the femur bone to stabilize it. The Care Plan for Resident #1 dated 9/19/2023 revealed a plan of care for impaired skin integrity related to immobility/shearing/pressure and surgery defined by surgical incisions. The goal was listed as Resident #1 will experience healing of skin area. As evidenced by no signs and symptoms of infection, granulating tissue in ulcer	F 686	F686 Facility failed to perform comprehensive skin assessments, to conduct skin monitoring to the area under an immobilizer and to coordinate care with the resident orthopedic surgeon to ensure care needs were met when the resident missed her 10/4/23 surgical follow up orthopedic appointment and was not seen by the orthopedist until 11/17/23. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #1 was discharged from facility therefore; no corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/15/23 the Nurse Consultant identified that all current residents have the potential to be impacted. On 12/15/23 the nurse designee / administrative nurse team began completing 100% skin audits on all residents to ensure there were no unidentified wounds to include pressure or non-pressure wounds. This was completed on 12/15/2023. The results included: There were no identified concerns. On 1/8/2024 the Director of Nursing and administrative nurse team completed audits of all new admissions and readmissions for the last 7 days to ensure treatment orders were entered according to the new admission orders per Discharge Summary and or orders were clarified for continued care for residents	

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and wounds, decreased size/depth of ulcers/wounds, no further areas develop through next review. Interventions included:
1. Head to toe skin assessment completed on admission, weekly, and prn (as needed).
2. Keep skin clean and dry.
3. Assess for risk factors associated with skin breakdown.
4. Encourage turning/repositioning frequently.
5. Pressure relief devices; bed/chair.
6. Preventive skin care as indicated.
7. Measure and document wound per facility routine.

The hospital discharge record dated 9/21/2023 for Resident #1 revealed that her right leg was wrapped in ace bandage from her foot to her thigh and an immobilizer was placed on it during surgery on 9/20/2023. Resident #1 was readmitted to the facility on 9/21/2023 with the ace wrap and immobilizer on her right leg. The discharge instructions included to follow-up with Orthopedic Surgeon #2 as outpatient in 2 weeks. Her post operative appointment was scheduled for 10/4/2023. A follow-up appointment for the initial hip surgery (from August 2023) was scheduled with Orthopedic Surgeon #1 on 10/30/2023 at 3:30 PM.

A review of weekly skin assessments revealed no skin assessment was completed from 9/21/23 through 10/4/23.

The record revealed no evidence Resident #1 had attended her outpatient orthopedic surgeon follow up appointment on 10/4/23.

During an interview with the Facility Transporter on 12/13/2023 at 12:13 PM she indicated she had

such as not limited to: post op surgical site care, Orders for care of orthopedic boots/immobilizers/braces to include skin and wound assessment. This audit was completed by nurse management on 1/8/2024. The results included: There were no identified concerns.
On 1/8/2024 the administrative nurse team reviewed the past 7 days of new Admissions/Re-admissions to include bedside validation assessment to ensure appropriate assessment was completed to include not limited to: Weekly skin assessment (UDA), pressure ulcer assessment (UDA) and / or Non -pressure wound assessment (UDA). This completed on 1/10/2024. The results included: There were 2 residents with missing pressure and non-pressure assessments on admission. On 1/10/2024 the administrative nurse team implemented corrective actions for those residents which includes: Assessments were completed with notification to medical provider and responsible party, treatment orders verified and / or initiated and Consultation to wound provider for 1 of 2 residents.

On 1/11/2024 the administrative nurse team audited all residents to ensure anyone with a splint/brace/immobilizer/orthopedic boot or other supportive device has been identified and there are specific care orders present in the medical record to include not limited to: Frequency of use, How and when Donning and Doffing to occur, Scheduled assessment of skin

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she had taken over as the transporter on 10/1/2023 when the facility was sold to another organization. She further stated that Resident #1 was initially scheduled to see the Orthopedic Surgeon for her initial postoperative visit on 10/4/2023. She stated that she had scheduled the appointment with the non-emergency transport service, because it was on a Wednesday and that was the day, she took the facility's residents on dialysis to their dialysis treatments. The Facility Transporter indicated the non-emergency transport service had not been able to transport Resident #1 on 10/4/2023 and the resident missed the scheduled appointment. She indicated the 10/4/2023 appointment was rescheduled for 10/11/2023 at 10:00 AM.

A review of weekly skin assessments revealed no skin assessment was conducted from 10/4/2023 through 10/7/2023.

A weekly skin assessment was conducted on 10/8/2023 by Agency Nurse #1. The assessment listed the type of new skin condition was a surgical wound. This was the first weekly skin assessment conducted since Resident #1's readmission on 9/21/23.

Agency Nurse #1 was unavailable for interview during the survey. She no longer worked for the facility and the Administrator stated she did not have a phone number for this nurse.

The record revealed no evidence Resident #1 had attended her outpatient orthopedic surgeon follow up appointment on 10/11/23 at 10:00 AM.

In an interview conducted with the Facility Transporter on 12/13/2023 at 12:13 PM, she

integrity underneath the device. This completed on 1/11/2024. The results included: 4 of 12 residents noted with required correction to plan of care. On 1/11/2024 the administrative nurse team implemented corrective action for those residents which includes: correction to care plans and order completed.

On 1/11/2024 the administrative nurse team completed skin assessments to all residents identified to have splint/brace/immobilizer/orthopedic boot or other supportive device to ensure no skin integrity concerns to include not limited to: open wounds, darken skin integrity, circulatory issues or any other concerns. This completed on 1/11/2024. The results included: There were no identified concerns.

On 1/9/2024 the RN Supervisor and Minimal Data Set (MDS) nurse audited all residents with wounds for the presence of a care plan and appropriate interventions. This completed on: 1/11/2024. The results included: 6 residents identified with care plans that needed to be updated and or added. On 1/11/2024 the Minimal Data Set Nurse implemented corrective actions to include updated all care plans to reflect each wound with appropriate interventions.

3. Systemic changes
Beginning on 12/15/23 the Nurse Consultant began education to Nurse management team on the Quality

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F 686	Continued From page 4 stated that the orthopedic appointment scheduled for 10/11/2023 at 10:00 AM was cancelled by the non-emergency transport service again. A weekly skin assessment was completed on 10/15/2023 by Nurse #2 and listed no new skin area concerns. An interview was conducted with Nurse #2 on 12/14/2023 at 4:03 PM. Nurse #2 stated that when she had performed the weekly skin assessments on Resident #1, she had not removed the dressing on the right leg or the immobilizer. She further stated that she had never seen the surgical incisions, or the leg without the padding or the brace to protect it. She explained that she had checked the right popliteal pulse (behind the knee) and observed capillary refill in the toes (quick test to check for adequate blood flow by pushing on the nailbed of the of the fingers or toes and observing how long it takes for the nail to turn pink again) and movement of the toes during the skin assessment. Nurse #2 indicated there were no physician's orders to change the dressing or to do anything to it. She could not explain why no one had called the Orthopedic Surgeons office for further instructions after Resident #1 missed her initial post operative appointments. A progress note written by the Nurse Practitioner (NP) on 10/30/2023 read in part that Resident #1 had tested positive for COVID that day. In an interview with the Facility Transporter on 12/13/2023 at 12:13 PM, she stated that she had cancelled Resident #1's orthopedic appointment that was scheduled on 10/30/2023 at 3:30 PM. The Facility Transporter further stated that when	F 686	Assurance process for Admission/Readmissions. Beginning on 12/15/2023, the Director of Nursing and the Staff Development Coordinator (SDC) began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) including agency staff on: " Admission Order Process " Wound/Skin Assessment and documentation Process. Beginning on 12/15/23, the Director of Nursing and the Staff Development Coordinator (SDC) began education on all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), Medication Aides, Nurse Aides including agency staff on: " Splint/Brace/Immobilizer Education Process. The above in-services were incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 1/11 /2024 any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Quality Assurance monitoring	

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F 686	Continued From page 5 she called the orthopedic office to reschedule the appointment, they had told her she needed to wait at least 10 days because the resident had COVID. She indicated the appointment was rescheduled for 11/17/2023 at 8:15 AM. The record indicated there were no skin assessments after 10/8/23 until 11/2/23. A weekly skin assessment was conducted by Nurse #3 on 11/2/2023 and no new skin area concerns were listed as the current skin condition. A Wound Round assessment was completed on 11/8/2023 by Nurse #3 and revealed the following: a. right thigh (front)-surgical incision healing with no signs and symptoms of infection noted. Clean and dry with 3 staples intact. b. Right knee (front)-left side of right knee are 3 small incisions that have 2-3 staples that are all clean dry and intact. c. Right knee (front)-top of knee staples clean dry and intact. Bruising around top of knee and staples. Foam dressing applied. d. Right heel-unstable 1.5x 2-centimeter (cm) foam dressing applied. e. other-top of right foot with 3 small circular spots. Removed ace wrap and skin dry and scaly, lotion applied. There were no signs and symptoms of infection noted and no signs of pain noted. Narrative notes read, "cleaned with NS [normal saline] and patted dry, foam dressing applied to knee and heel. Ace wrap applied to leg and stops at ankle. No signs and symptoms of infection noted. Resident tolerated dressing change with no signs or symptoms of pain.	F 686	procedure. The DON or Designee will monitor compliance utilizing the F686 Quality Assurance Tools weekly x 2 weeks then monthly x 3 months or until resolved for compliance with the wound/immobilizer process. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: _1/11/2024_____	

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An interview was conducted with Nurse #3 (interim Wound Nurse) on 12/14/2023 at 1:08 PM. Nurse #3 stated that she worked at the facility one day a week to help wherever she was needed. She explained that she was currently filling in for the facility Wound Nurse, who had been off since 12/8/2023. Nurse #3 stated that she was the nurse who performed the weekly skin assessments for Resident #1 on 11/2/2023 and 11/8/2023. She further stated that she had not removed the surgical dressing or the immobilizer on 11/2/2023, because there was not a physician's order to remove them. Nurse #3 explained that on 11/8/2023, someone had asked her to complete the wound round assessment for Resident #1 and document what she saw. She further explained that she could not remember who asked her to do it. Nurse #3 stated that there were staples in Resident #1's right knee and the skin around it had appeared "discolored looking". She further stated that she had replaced the foam dressing on the knee and right heel and rewrapped the leg from the ankle to mid-thigh with the same gauze padding and ace wrap. She indicated that she did not wrap the foot because there were some dark spots that looked like they could have been caused by wrinkles in the ace wrap.

A subsequent interview with Nurse #3 was conducted on 12/14/2023 at 3:15 PM. Nurse #3 (interim Wound Nurse) stated that when she changed Resident #1's right leg dressing on 11/8/2023, she knew it was the original dressing because the hospital used brown foam dressing pads and that was what was on her leg. She further stated that she had applied the facility's pink foam pad to the incision and wrapped the leg

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back in the original padding and ace wrap bandage. Nurse #3 indicated that she assumed the dark areas on the top of the foot were caused by the wrinkles in the ace wrap, and that is why she had rewrapped it from the ankle up to the thigh. She further stated that the wound had appeared clean and dry at that time. The interim Wound Nurse stated that she did not know why anyone didn't call the Orthopedic Surgeon's office for wound treatment orders.

A weekly skin assessment was conducted by Nurse #2 on 11/15/2023 with no new skin area concerns.

During interview with Nurse #2 on 12/14/2023 at 4:03 PM she reported when she performed the weekly skin assessments on Resident #1, she had not removed the dressing on the right leg or the immobilizer.

A physician's progress note written by Orthopedic Surgeon #1 on 11/17/2023 during a Resident #1's post-operative visit, read in part, "Patient status post Right bipolar hip replacement on 8/22/2023. She underwent open reduction and internal fixation of comminuted [bone is broken in more than 2 pieces] distal third femur fracture on 9/20/2023. Staples removed from Right knee incision site. Area over right patella [knee] dark secondary to pressure from immobilizer." Recommendations were to discontinue the immobilizer, remain non-weight bearing on right lower extremity. Daily dressing changes to right patella with xeroform (is a fine mesh gauze occlusive dressing used to cover and protect wounds) and apply dry dressing.

A telephone interview was conducted with

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Orthopedic Surgeon #1 on 12/14/2023 at 1:31 PM. Orthopedic Surgeon #1 stated that he was the surgeon that had performed Resident #1's right hip repair surgery on 8/22/2023. He further stated that Resident #1 was discharged to the nursing facility, and she subsequently fell and fractured her right femur on 9/18/2023. Orthopedic Surgeon #1 stated that he had been shocked to see her in his office that day (11/17/2023) for her initial post-op visit. Orthopedic Surgeon #1 indicated that she should have had the follow up appointment with Orthopedic Surgeon #2 as scheduled on 10/4/2023 because he had performed the femur repair surgery. He stated that when Resident #1 had surgery on 9/20/2023 an ace wrap and immobilizer had been applied and it was still on her leg when she came to the office on 11/17/2023. He further stated that he had checked the femur fracture site because it had been almost 2 months since her surgery on 9/20/2023. Orthopedic Surgeon #1 stated that when he had removed the dressing there was an open area just below the surgical site on the right knee that appeared necrotic (dead) and black and the skin around it was darker like a bruise. He further stated that he had recommended the wound doctor see her for her wounds. He indicated that the initial post op visit for femur surgery was usually in 2-4 weeks after surgery, and the surgical dressing and ace wrap would be removed at that time. He further indicated that the immobilizer was usually worn on the leg for 6 weeks and depending on the x-rays, a hinge brace would have been applied to allow for flexion of the knee. Orthopedic Surgeon #1 stated that the ace wrap and immobilizer being on that long did not help the situation because of the constant pressure being exerted on the leg. Orthopedic

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Surgeon #1 stated that Resident #1, because of her age and comorbidities such as underlying vascular disease would set her up for more complications post operatively. He indicated that Resident #1 should have been seen more frequently, so they could have monitored her more closely. Orthopedic Surgeon #1 stated that because they had been unable to observe the leg or monitor the skin for almost 2 months, the changes had already occurred. He further stated that regardless, the dressing would have been changed and the site would have been examined on the first post op visit, which should have occurred in the first 2-3 weeks after surgery, not 2 months after surgery.

Orthopedic Surgeon #2 was on vacation and unable to be interviewed during the investigation.

A physician's progress note written by the Nurse Practitioner (NP) on 11/20/2023 indicated Resident #1's right lower extremity was assessed and the knee area (the area described by Orthopedic Surgeon #1 as necrotic on his assessment on 11/17/23) was noted with discoloration. Recommendations included right lower extremity Doppler venous studies (used to check the circulation in the legs) and a wound consult.

An interview was conducted with the Nurse Practitioner (NP) on 12/15/2023 at 10:57 AM. The NP stated she was new to the facility and just started in October 2023. She further stated that she had observed Resident #1 in what appeared to her to be a soft cast and an ace wrap on her right lower extremity on 10/30/2023, when she saw her for COVID. The NP explained that she did not remember if Resident #1 had an

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immobilizer on her leg or not. She indicated that she did not become involved with Resident #1's wound until after her orthopedic appointment on 11/17/2023.

The Focused Wound Exam by the Wound Doctor dated 11/30/2023 revealed Resident #1's advancing peripheral arterial disease/gangrene significantly increases their susceptibility to complications and poor prognosis. Refer to vascular surgery. The assessment of the knee area was described as follows:
Non-pressure wound of the right, anterior knee full thickness measuring 3.0 x 4.4 x depth not measurable due to presence of nonviable tissue and necrosis. There was no drainage and consisted of thick adhered black necrotic tissue (eschar) 80% and skin 20%. The reason for no sharp debridement was listed as a chronic stable wound with insignificant amount of necrotic tissue and no signs of infection. Monitor closely for now. Debridement not indicated secondary to severe peripheral arterial disease. The dressing/treatment plan was to apply betadine daily and cover with gauze roll for 22 days.

An interview was conducted with the Wound Doctor on 12/14/2023 at 2:42 PM. The Wound Doctor stated that he first saw Resident #1's right leg wounds by telehealth on 11/22/2023, and they appeared to be "bad". He did not give an explanation of what "bad" meant, but instead provided the following information. Resident #1 had other wounds on her feet and legs in addition to the area on her knee (identified on 11/17/23 by Orthopedic Surgeon #1). The Wound Doctor indicated that the calf, dorsal foot, and heel all appeared to be arterial vascular wounds (these wounds developed after 11/17/23 when the

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WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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F 686	Continued From page 11	F 686		

immobilizer was removed) due to poor circulation and the knee wound was close to the surgical site. The Wound Doctor further stated that even though Resident #1's leg was in an immobilizer the wounds did not appear to be pressure related areas. He indicated that a delay of 2 months for an initial post op visit could cause a problem because a lot of things could have been going on under the dressing. The Wound Doctor stated that Resident #1's vascular doppler studies showed that she had some moderate to severe vascular problems. He further stated that the facility should have at least been conducting weekly skin checks, and that the immobilizer and dressing should not have been left on for 7 weeks.

An interview was conducted with the Director of Rehabilitation at the facility on 12/13/2023 at 2:51 PM. He stated that Resident #1 had been making progress in therapy and was about ready to go home, when she fell and fractured her femur. He stated that Resident #1's right leg was completely wrapped from top to bottom with an ace bandage and was fitted with an immobilizer that kept her leg straight. He further stated that he had asked the nursing staff about getting orders several times to see if the immobilizer could be removed when she was supine (on her back) in bed. The Director of Rehab stated that the response from the nursing staff was that the surgeon had to check it, before it could be removed. He did not say which staff members he had asked. He stated that the immobilizer could be repositioned if it moved, but it was designed to fit snug and to prevent any lateral movement of the knee.

An interview was conducted with the Director of Nursing (DON) on 12/15/2023 at 12:01 PM. The

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F 686	Continued From page 12 DON indicated that residents should be seen by their physician/surgeon for their initial post-op visit in a timely manner. She stated that generally if a resident does not have an order to remove the dressing post-op, you don't remove it. The DON further stated that one of the nursing staff should have reached out to the orthopedic surgeon's office for wound orders after the initial post-op visit was cancelled. An interview was conducted with the interim Administrator and the Administrator in Training (AIT) on 12/15/2023 at 12:14 PM. The Administrator indicated that looking back at the situation, someone from the facility should have reached out to the orthopedic surgeon's office for follow up instructions since she did have to wait almost 2 months to be seen after surgery.	F 686		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, non-emergency transportation services Manager, Orthopedic Surgeon, and orthopedic surgeon's Office Manager interviews, the facility failed to ensure a resident had transportation arrangements for initial post-operative appointment with the Orthopedic Surgeon on 10/4/2023, resulting in the resident not being seen by the Orthopedic Surgeon until 11/17/2023. At the 11/17/23 orthopedic surgeon visit Resident #1 was identified with a wound on her right knee	F 745	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be	1/11/24

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F 745	Continued From page 13 that appeared necrotic (dead tissue), black in color, and the skin around it appeared darker like a bruise.This occurred for 1 of 1 resident reviewed for medically related social services (Resident #1). The Findings included: Resident #1 was admitted to the facility on 8/25/2023 with diagnoses to include right hip replacement, chronic kidney disease and hypertension. Resident #1 was discharged to the hospital on 9/18/2023 and she was diagnosed with a right femur fracture. Resident #1 was readmitted to the facility on 9/21/2023 following a surgical stabilization of the distal third right femur fracture on 9/20/2023. She was discharged home on 12/4/2023. The admission Minimum Data Set (MDS) dated 09/07/2023 revealed Resident #1 was cognitively intact and required extensive assistance of 1 staff member for most activities of daily living (ADL). Review of the hospital discharge packet for Resident #1 dated 9/21/2023 revealed she was scheduled for a follow-up appointment with Orthopedic Surgeon #2 on 10/4/2023 at 3:30PM. She was also scheduled for her second post-op visit for her right hip surgery with Orthopedic Surgeon #1 on 10/30/2023 at 3:30 PM. An interview with Resident #1's Granddaughter occurred on 12/13/2023 at 11:27 AM. The Granddaughter stated that the facility had called and asked her if she could transport her grandmother to her orthopedic appointment on 10/11/2023, because the non-emergency transport service had cancelled. She further	F 745	corrected by the dates indicated. F745 " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 discharged home on 12/4/2023. Prior to discharge, and two cancelled appointments due to transportation being cancelled by contract transport services, Resident #1 was taken by the facility Transport Coordinator to a previously scheduled orthopedic appointment on 11/17/2023. No other residents were identified as being affected by the alleged deficient process. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with missed appointments have the potential to be affected by the alleged deficient practice. On 1/11/23, the administrator and transportation coordinator completed a review identify any transportation cancellations in the last 30 days, 12/11/23 □ 1/10/23 resulting in a cancelled doctor□s appointment. 4 of 66 resident scheduled appointments were identified to have a missed scheduled appointment. Residents with missed appointments were reviewed by the Director of Nursing or Unit manager to ensure there were no identified concerns	

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stated that she had told the facility she was unable to provide transportation for her grandmother to the orthopedic surgeon's office on 10/11/2023.

An interview with the Facility Transporter occurred on 12/13/2023 at 12:13 PM. The Facility Transporter stated that Resident #1 did have an appointment scheduled on 10/4/2023 with the orthopedic surgeon, and she had arranged for the non-emergent transport service (NETS) to take her to the appointment. She further stated that NETS had cancelled because they didn't have a truck, so she had called and rescheduled the appointment for the next week on 10/11/2023. The Facility Transporter stated that NETS cancelled again on 10/11/2023, because they did not have enough trucks. The Facility Transporter explained that she was unable to transport Resident #1 to her orthopedic appointments on 10/4/2023 and on 10/11/2023, because the appointments were on Wednesday. She further explained that on Wednesday's she transported the facility's 3 residents that were on dialysis to their appointments and picked them up. The Transporter stated she had called Resident #1's granddaughter to see if she could transport her to her appointment on 10/11/2023, but she was not available. The Facility Transporter indicated that the granddaughter had said she would reschedule the appointment and would call her back. The Facility Transporter stated that after she was unable to get back with the granddaughter about the appointment, and Resident #1 already had an orthopedic appointment scheduled on 10/30/2023, so she would just take her on that day. She indicated that Resident #1 tested positive for COVID-19 on 10/30/2023 prior to her appointment, and it had to

or need for clarification in orders to ensure optimal care received during that time to include not limited to: surgical site care, care needs of splints/immobilizer or other devices, or other skin and wound care. This was completed on 1/11/2024. The results included: 3 appointments were rescheduled and1 resident refused to go to the appointment and did not want it rescheduled. The review showed that 2 missed appointments were rescheduled within a short time frame; an annual appointment was scheduled later in 2023 as there were no immediate issues. In one case the doctor gave us new orders to follow which were acted upon.

The Transportation Coordinator will bring any missed appointment to the attention of the Administrator and Director of Nursing on the day the appointment is missed. In addition, appointments will be discussed during the Monday □ Friday inter-disciplinary stand-up meeting including missed appointments, reason, and reschedule date to identify any residents that may have the potential to be affected by a missed appointment.

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

On 12/14/23, the SDC began in-servicing all interdisciplinary team administration staff and licensed nurses on the Transportation/Appointment process. This training will include all current staff

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F 745	Continued From page 15 be rescheduled. The Facility Transporter stated that when she had called to reschedule the 10/30/2023 appointment she had been told by the orthopedic office staff to wait at least 10 days to reschedule, and the appointment was scheduled for 11/17/2023. She further stated that she had transported Resident #1 to her orthopedic appointment on 11/17/2023 at 8:15 AM by wheelchair in the facility transportation bus, in between transporting the residents on dialysis. An interview occurred with the Manager of NETS on 12/13/2023 at 1:12 PM. The Manager stated that they had to cancel transport service for Resident #1 on 10/4/2023, because they did not have enough staff. He further stated that when the Facility Transporter had called back to reschedule for 10/11/2023, he realized he was overbooked so he had handed the call over to the hospital non-emergent transport services. The Manager stated he didn't know why the hospital had cancelled the transport. The Manager stated that because transport was cancelled on 10/4/2023 for Resident #1, she should have been a priority the next week. He indicated that he just didn't have enough staff to operate all the trucks. He further indicated that this was a big problem all over the state and not just in Robeson County. The Manager stated that he was already running short and if a truck broke down or staff called in sick there was no way he could transport patients. He further stated that the County required him to keep three trucks available every day for transporting the 23 patients on dialysis to their appointments. An interview was conducted with Supervisor for the Hospital non emergent transport service on 12/14/2023 at 10:13 AM. The Supervisor	F 745	including agency. This training included: " Appointment Procedure " Transportation aide duties and responsibilities " Rescheduled and Missed Appointments process " Notifications The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 1/11/24 will not be allowed to work until the training is completed. Should a resident miss a doctor□s appointment the Transportation Coordinator will immediately notify the Administrator and the Director of Nursing, and reschedule for the next available appointment explaining the reason (i.e. follow-up, initial, post-operative, etc.) for the missed appointment to the physician office scheduler. The Unit Manager will also follow-up with the physician□s office for any further orders until the rescheduled appointment date; and communicate the rescheduled appointment to the facility medical director and resident/family. This follow-up will be documented and any new orders will be communicated and followed. The Unit Manager will be a resource for the Transportation Coordinator in re-scheduling appointments. Doctor□s appointments are discussed during the Monday □ Friday inter-disciplinary stand-up meeting	

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F 745	Continued From page 16 explained that when the Manager of NETS had assigned the transport of Resident #1 to them on 10/11/2023, they were already booked up. She stated that they only had so many trucks and they were just unable to complete the transport on 10/11/2023. An interview was conducted with the Administrator in Training (AIT) on 12/14/2023 at 9:10 AM. The AIT explained that she was the Director of Nursing (DON) for the facility up until 10/1/2023. She stated that the facility used to have two transporters that drove the vans and scheduled the appointments. The AIT further stated that they had been owned by the hospital until 10/1/2023, and their non-emergent transport service had provided backup transportation if they were needed. She indicated that since the facility was bought by an outside corporation, the hospital no longer provided those routine services for them. The AIT further indicated that NETS was now the facility's alternate choice for transport services. She stated that now they just have one person, the Facility Transporter, in charge of scheduling and transporting residents to their appointments. An interview was conducted with the DON on 12/14/2023 at 9:32 AM. The DON stated that the Unit Managers were responsible for putting in the orders upon admission to the facility, and they made the Facility Transporter aware of any appointments for the residents. She further stated that the Facility Transporter was responsible for making all the transport arrangements. The DON explained that she was aware that the orthopedic appointments that were scheduled for Resident #1 on 10/4/2023 and 10/11/2023 were cancelled by NETS, and the 10/30/2023 appointment had to be rescheduled because she had COVID. She	F 745	including missed appointments, reason, and reschedule date to identify any residents that may have the potential to be affected by a missed appointment. The facility signed a new contract with BARTs Transportation and Buies Care Transport enabling us to lessen our reliance on Robeson County□s transportation services (NETS) for stretcher and wheelchair transportation services. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Administrator and/or designee will monitor tag F745 for appointments and transportation cancellations weekly for 3 weeks and monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. " Date of Compliance January 11, 2024	

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stated that if the Facility Transporter was having difficulty scheduling an appointment, she usually would go to one of the Unit Managers for help.
A telephone interview was conducted with Orthopedic Surgeon #1 on 12/14/2023 at 1:31 PM. Orthopedic Surgeon #1 stated that he was the surgeon that had performed Resident #1's right hip repair surgery on 8/22/2023. He further stated that Resident #1 was discharged to the nursing facility, and she subsequently fell and fractured her right femur on 9/18/2023. Orthopedic Surgeon #1 stated that he had been shocked to see her in his office that day (11/17/2023) for her initial post-op visit. Orthopedic Surgeon #1 indicated that she should have had the follow up appointment with Orthopedic Surgeon #2 as scheduled on 10/4/2023 because he had performed the femur repair surgery. He stated that when Resident #1 had surgery on 9/20/2023 and an ace wrap and immobilizer had been applied and it was still on her leg when she came to the office on 11/17/2023. He further stated that he had checked the femur fracture site because it had been almost 2 months since her surgery on 9/20/2023. Orthopedic Surgeon #1 stated that when he had removed the dressing there was an open area just below the surgical site on the right knee that appeared necrotic (dead tissue) and black and the skin around it was darker like a bruise. He further stated that he had recommended the wound doctor see her for her wounds. He indicated that the initial post op visit for femur surgery was usually 2-4 weeks after surgery, and the surgical dressing and ace wrap would be removed at that time. He further indicated that the immobilizer was usually worn on the leg for 6 weeks and depending on the x-rays, a hinge brace would have been applied to

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allow for flexion of the knee. Orthopedic Surgeon #1 stated that the ace wrap and immobilizer being on that long did not help the situation because of the constant pressure being exerted on the leg. Orthopedic Surgeon #1 stated that Resident #1, because of her age and comorbidities such as underlying vascular disease would set her up for more complications post operatively. He indicated that Resident #1 should have been seen more frequently, so they could have monitored her more closely. Orthopedic Surgeon #1 stated that because they had been unable to observe the leg or monitor the skin for almost 2 months, the changes had already occurred. He further stated that regardless, the dressing would have been changed and the site would have been examined on the first post op visit, which should have occurred in the first 2-3 weeks after surgery, not 2 months after surgery.

An interview with the Orthopedic Office Practice Manager occurred on 12/14/2023 at 1:40 PM. The Orthopedic Office Practice Manager stated the office had different codes for initial post operative visits and subsequent visits. She explained that initial post operative visits were a priority, and the longest Resident #1 should have had to wait for a follow-up visit was 2 weeks and 3 weeks at the most. The Orthopedic Office Practice Manager stated the 10/4/2023 appointment was cancelled and rescheduled for 10/11/2023, and it was also cancelled. She further stated that the appointment on 10/30/2023 was coded as a follow up from her 9/6/2023 initial post operative visit for her hip surgery, with Orthopedic Surgeon #1. She stated the facility had stated they wanted to reschedule the 10/30/2023 appointment when Resident #1 had to cancel due to testing positive for COVID. The Orthopedic

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Office Practice Manager explained that because the 10/30/2023 was coded as a follow up appointment for the hip, it did not trigger a priority for initial post-operative visit. She stated that even though Resident #1had tested positive for COVID, if the office had known that this was her initial post-operative femur surgery appointment, they would have been able to see her after 5 days and not had to wait until 11/17/2023. The Orthopedic Office Practice Manager further stated that Resident #1 should never have had to wait 2 months for a post-operative visit.

An interview was conducted with the Director of Nursing (DON) on 12/15/2023 at 12:01 PM. The DON stated that the facility does everything it can to provide transportation for the residents to their outside appointments. She further stated that they call family and ask if they can take them, and they make the doctor aware if they are unable to provide transportation for some reason. The DON indicated that residents should be seen by their physician/surgeon for their initial post-op visit in a timely manner, not 2 months later.

An interview was conducted with the interim Administrator and the Administrator in Training (AIT) on 12/15/2023 at 12:14 PM. The Administrator stated that the facility was very sorry that the transportation was cancelled on 10/4/2023 and 10/11/2023 for Resident #1's post op orthopedic surgeons' appointments. She further stated that they felt like the facility had done everything they could do to get her to those appointments, and that outside transport had cancelled them. The Administrator explained that the appointment on 10/30/2023 was cancelled because Resident #1 had tested positive for COVID, and that was not the facility's fault. The

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F 745	Continued From page 20 Administrator indicated that looking back at the situation, someone from the facility should have reached out to the orthopedic surgeon's office for follow up instructions since she did have to wait almost 2 months to be seen after surgery.	F 745		