| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 SS=J | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, physician interviews and record reviews, the facility failed to notify the physician of | F 157 | Woodlands Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance.<br><br>The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Woodlands Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.<br><br>Resident #1 expired in the facility on 04/01/2013.<br>Review of the resident record indicates the resident was his own responsible party and requested that his family not be notified of his change in condition and he declined offers of hospitalization. The record indicated the physician was notified of the resident's change in condition and his desire not to be hospitalized. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth England — TITLE: NHA — (X6) DATE: 4-19-13

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 1<br>continued respiratory distress, that the resident's condition worsened and the resident became unresponsive in 1 of 3 sampled residents with a change in condition (Resident #1).<br><br>Immediate Jeopardy began on 4/1/13 and was identified on 4/5/13 at 1:00 PM. Immediate Jeopardy was removed on 4/5/13 at 6:30 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy).The facility was in the process of full implementation and monitoring their corrective action.<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 3/18/13 with diagnoses of End Stage Chronic Obstructive Pulmonary Disease and Emphysema.<br><br>The admission Minimum Data Set (MDS) dated 3/25/13 indicated that resident #1 had no short term or long term memory problems and no documented behavioral problems. He was coded as cognitively intact and the MDS indicated that he depended extensively on staff for all of his activities of daily living. Resident #1 was not coded as having a prognosis of less than 6 months life expectancy. Resident #1 required continuous oxygen at 4 liters/minute using a nasal cannula.<br><br>A review of resident #1's medical record indicated that he was his own responsible party and signed his admission paperwork to include the Code Status Resuscitation Request/Order form | F 157 | The physician indicated to continue to monitor the resident, although the option of hospitalization was declined by the resident.<br>The Director of Nursing was terminated by the administrator on 04/05/2013.<br><br>The facility has determined that all residents have the potential to be affected but currently, after review of 24 hour shift reports, there is no evidence of any deficient physician or resident representative communication on 04/04/2013.<br><br>All licensed nursing staff have been assigned on-line learning course "Effective Communication" which includes the SBAR tool for communication to the physician, 04/05/2013.<br>All licensed nursing staff will be | 4-5-13<br><br>4-4-13<br><br>4-19-13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 2<br>indicating he would like to be resuscitated in the event of a cardiac or respiratory arrest. This document was dated 3/18/13.<br><br>A review of the Medication Administration Record (MAR) indicated that at 10:00AM on 4/1/13, resident # 1's oxygen saturation was 90% on 4 liters/minute of oxygen using a nasal cannula.<br><br>A review of the medical record indicated that routine vital signs were taken on 4/1/13 at 12:20 PM. Resident #1's vital signs at that time were as follows: blood pressure 132/94, pulse 110, respirations 20.<br><br>A nursing note written by nurse #1 indicated that resident #1 was observed at or around 2:30 PM slumped over in his chair. He was clammy with an oxygen saturation of 81%. The nursing note did not indicate if his oxygen was in use at the time he was found. He was given a breathing treatment and his oxygen saturation increased to 95% on 4 liters/ minutes of oxygen using a nasal cannula. Resident #1's vital signs were as follows: blood pressure 82/60 (low), pulse 78, respiration 48 (elevated) and temperature 97.9 F. The nursing note indicated resident #1 refused to go to hospital for evaluation and he did not want his family notified. The nursing note also indicated that the director of nursing (DON) assessed resident #1 and the physician was notified.<br><br>A review of the Situational Background Assessment Recommendation (SBAR) form dated 4/1/13 indicated nurse #1 reported that resident #1 was cyanotic (blue or purple discoloration of the skin), short of breath and | F 157 | in-serviced by the DON or appropriate designee regarding the following:<br>F Tag 157: Notification of Change Facility policy on Change in Resident Status which includes notification of physician, Validation Checklist for Notification of Changes, and Documentation of Notification, ~~on~~ 04/19/2013<br>Any licensed staff member who has not been trained as of 04/19/2013 will not be allowed to report for duty until training is complete. This information will be included as additional training in licensed nursing orientation and annual re-orientation.<br>All CNAs and Med Aides were in-serviced by the DON or appropriate designee on Notification of change in resident condition 04/19/2013. Any CNA or Med Aide that has not been trained as of 04/19/2013 will not be allowed to report for duty until training is complete. | 4-19-13<br><br>4-19-13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 3<br>anxious. The SBAR form indicated the physician instructed the staff to observe resident #1 and monitor his vital signs. This form indicated the DON was aware of the physician's directive at 2:30 PM.<br><br>The medication administration record (MAR) dated 4/1/13, indicated that at 4:34 PM, resident #1 was not responsive enough to take his medications. The MAR noted that the medication aide (MA) #1 notified nurse #2 of his change of condition.<br><br>A review of resident #1's medical record indicated no ongoing assessment from approximately 2:30 PM until approximately 6:15 PM when emergency medical services (EMS) was notified. There was no evidence of any ongoing assessment of resident #1's respiratory or mental status changes.<br><br>According to the EMS report, on 4/1/13 at approximately 6:15 PM, the call came into the department and they arrived on the scene at 6:27 PM and cardio pulmonary resuscitation (CPR) was in progress by facility staff. Resident #1 was found without a pulse, not breathing and unresponsive. His skin was cold to the touch. Resident #1 was pronounced dead at 6:45 PM.<br><br>In an interview on 4/4/13 at 12:11 PM, nurse #1 stated that on 4/1/13 at approximately 2:30 PM she asked the DON to look at resident #1 because she wanted to send him out but he refused to go to hospital. Nurse #1 stated that the DON stated the hospital could not do anything for resident #1 that the facility could not do. The DON instructed nurse #1 to notify the physician. | F 157 | 24 hour nursing reports will be reviewed by the supervising or charge nurse each shift for identification of proper notification of physician and resident representative as needed and per facility policy. Any discrepancies in notification will be corrected by the supervising or charge nurse reviewing the 24 hour report, 04/05/2013 and ongoing. Validation Checklist will be utilized by the nurse in charge of the resident with a change in condition requiring physician and resident representative for a period of 4 weeks, beginning 04/05/2013.<br>F-157 Notification of Change audits will be conducted by the DON, or appropriate designee weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters, and as needed.<br><br>24 hour reports will be reviewed by the facility administrative team 5 x per week x 4 weeks for compliance with plan as stated above and Validation of Notification forms during Morning | 4-19-13 and ongoing<br><br>4-19-13 and ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 4<br>Nurse #1 stated that she completed a SBAR report with the physician instructions to observe resident #1 and monitor his vital signs and notify him for changes in his respiratory or mental status. Nurse #1 stated that the DON and nurse #2 who was the 3-11 shift nurse, were present at the nursing station when the physician was notified. Nurse #1 stated she also reported to nurse #2 in her shift change report the physician ' s instructions. Nurse #1 stated resident #1 was a full code and she did not feel comfortable with the DON and physician ' s instruction. Nurse #1 could not recall if she specifically stated that resident #1 was cyanotic or a full code but that she thought she did. She stated the SBAR form indicated that resident #1 was found cyanotic and his code status.<br><br>In an interview on 4/4/13 at 1:30 PM, nursing assistant (NA) #1 stated on 4/1/13 at approximately 2:45 PM, she saw resident #1 in the bed. She said he had a mask on his face receiving at breathing treatment. She stated he removed that mask and stated he couldn't breathe. NA #1 told him to keep treatment in place. NA #1 stated she did not go back into resident #1 ' s room because her shift ended at 3:00 PM and she reported off to the NA #2 who was to work with resident #1 on 2nd shift.<br><br>In an interview on 4/4/13 at 2:00 PM, the DON stated that nurse #1 asked her to look at resident #1. She said he was in the bed with a breathing treatment in progress when she entered the room. She said he was in a hospital gown and he was wet with urine and that this was unusual for resident #1. She stated she instructed nurse #1 to check resident #1 for an impaction. She | F 157 | Meeting. Non-compliance will be discussed during this meeting with immediate notifications made as needed and the nurse (s) responsible for any non-compliance re-in-serviced and disciplined by the DON or appropriate designee. The review of the 24 hour report will be continued with a minimum of weekly reviews x 3 weeks, monthly reviews, x 2 months, followed by quarterly x 3 quarters, and as needed, ongoing. Review of the Validation reports will be reviewed 5 days per week by the Facility Administrative Staff during Morning Meeting x 1 week, followed by weekly x 3 weeks, followed by quarterly x 3 quarters, and as needed, ongoing.<br><br>Review of Notification of Change Audits will be reviewed by the facility Administrative Staff during Morning Meeting weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters, and as needed. | 4-19-13 and ongoing<br><br>4-19-13 and ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 5<br>instructed nurse #1 to administer a suppository. The DON stated she ensured resident #1's head of his bed was up and his oxygen was in place. The DON stated nurse #1 called the physician around the time of shift change. The DON stated awareness of resident #1's code status. The DON stated she did not actually assess resident #1 but rather was present during the impaction removal by nurse #1. The DON stated awareness of resident #1's vital signs. She stated she stayed in the room while he was cleaned up and ensured his oxygen was in place and the head of his bed was up. The DON stated she was at the nursing station when nurse #1 notified the physician. She could not recall if nurse #1 made the physician aware of resident #1 full code status. The DON stated she not make contact with floor staff again prior to leaving work that day around 6:00 PM.<br><br>In an interview on 4/4/13 at 3:00 PM, medication aide (MA) #2 stated she went to see resident #1 at the beginning of her shift. She stated resident #1 was thrashing about in the bed and unable to respond to her questions. She stated his oxygen was in place at the time. MA #2 stated she returned to the nursing station and stated she thought resident #1 was dying. MA #2 stated the DON, nurse #1 and nurse #2 were standing at the nursing station and no nurse went to the room with her to see resident #1. MA #2 asked nurse #1 if they were sending him to the hospital. Nurse #1 told her that the DON told her not to send him out. Nurse #1 stated the physician told them to monitor for any further decline in his condition and call him back. MA #2 stated that at 4:34 PM, she tried to give resident #1's his scheduled medication but he was not responsive enough to take his medicine. She stated she told nurse #2 | F 157 | This plan and its outcomes will be reviewed by the QA committee during the monthly QA meeting. Any deviations of the plan will be examined using a RCA approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations, and monitoring will be included in the facility QA meeting minutes. Any changes to the plan above will be documented in the QA meeting minutes, appropriate staff re-in-serviced to changes in the plan. Any changes made to the above plan will require the monitoring of such changes to begin at the initial review schedule of 5 days/week x 1 week; weekly x 3 weeks; monthly x 2 months, quarterly x 3 quarters, and as needed. | 4-19-13 and Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 6 | F 157 | | |

about resident #1's change in condition. MA #2 stated nurse #2 did not go to the room to assess resident #1 to her knowledge. MA #2 stated that around 6:15 PM, she heard a code announced and she responded to resident #1's room to find the MDS nurse initiating CPR.

On 4/5/13 at 11:12 AM, in a telephone interview, NA #2 stated that on 4/1/13 around 3:00 PM, NA #1 told her that resident #1 had not been himself all day and she needed to keep an eye on him. NA #2 stated she was not instructed to get any vital signs or what conditions she was to notify nurse #2. NA #2 stated she was told to "keep an eye on him" by nurse #2. NA #2 stated she went to room to see resident #1 and noted that he appeared to be in distress. She described distress as uncomfortable, moving around in bed, unable able to responds to her questions and gasping for breath. NA #2 stated resident #1's head was off of the pillow and she put his bed back on pillow. NA #2 was unsure if his oxygen was in place. NA #2 left room but she continued to check on resident #1 every 30-40 minutes. NA #2 stated at dinner time, she was passing trays and got to his room and she noted he looked worse. She stated resident #1 was unconscious, was not breathing but still warm. NA #2 stated she went to the doorway and called for a nurse. The MDS nurse and MA #2 came to the room and started CPR. NA #2 got the crash cart. NA #2 stated that nurse # 4 also responded to the room and nurse # 2 called 911.

In a telephone interview on 4/4/13 at 3:20 PM, nurse #2 stated that nurse #1 asked DON to look at resident #1 around shift change so nurse #2 also went into the room to see resident #1 since

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345461 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 7<br>she was going to be caring for him that shift. Nurse #2 said he was gasping for air with his oxygen in place. His eyes were open but he was not responsive. Nurse #2 said she was instructed to monitor resident #1 for worsening in his condition and call the physician for further decline. Nurse #2 stated she was aware that resident #1 was a full code. She stated that she went to the room around 4:15 PM to check the blood sugar of the room mate, and that there was no change in his condition at the time. She stated he was still gasping for air and writhing about in the bed. Nurse 2 said that around 6:00 PM or so, the MDS nurse told her that resident #1 was not looking good. The MDS nurse reported to her that resident #1 was less responsive, pale and breathing sporadically. Nurse #2 said she did not go look at resident #2 but rather called the physician. The physician gave an order to send resident #1 out to the hospital but he apparently he went into respiratory arrest and CPR was started. Nurse #2 stated she did not chart any changes in condition because none occurred until he coded around 6:15 PM.<br><br>In an interview on 4/4/13 at 1:50 PM, the MDS nurse stated that it was around 6:00 PM or so when NA #2 motioned for her to come to room. She stated resident #1 was lying on side gasping breath. His oxygen was in place. She performed a sternal rub without a reaction. Resident #1 had no pulse so she called a code and told NA #2 to get the crash cart. The MDS nurse stated that she felt resident #1 should have been sent him out earlier that day since he was a full code and he was having trouble breathing. She said even though he didn't want to go, she felt resident #1 was not mentally in any condition to make a | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 8<br>rational decision. She stated she did not think anyone was taking his vital signs and was aware the physician told the staff to monitor his condition and call him for any changes.<br><br>In a telephone interview on 4/4/13 at 2:30 PM, the physician recalled getting a phone call on 4/1/13 about resident #1 being in respiratory distress and that he refused to go to the hospital. The physician recalled that nurse #1 stated she administered his ordered breathing treatment when he was found slumped over in the chair because is oxygen saturation rate was 81%. The physician stated awareness that his oxygen saturation rate went up to 95% on 4 liters/minute of oxygen. The physician could not recall if the staff at the facility informed him that resident #1 was a full code but he knew that resident #1 was his on responsible party and that he thought he was a Do Not Resuscitate (DNR). He recalled that resident #1 was already on 4 liters/minutes of oxygen and stated that was as high as he could go. He recalled telling the staff to monitor his vital signs and respiratory status. The physician was unable to recall if he was called again that day about resident #1.<br><br>In a telephone interview on 4/4/13 at 5:00 PM, the physician stated he did not give specific orders but if resident #1 was experiencing respiratory distress, he would have expected the nurses to assess his breathing and respirations, vital signs and called him for any changes in his breathing, respiratory status or changes in his mental status. The physician stated he thought he received a second call that afternoon asking to send him out to the hospital and he told them send him out for evaluation. The physician stated he was unsure | F 157 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 9<br>of time of the second call.<br><br>On 4/5/13 at 10:30 AM, the administrator stated her expectation would have been that when resident #1's respiratory and mental status changed, the physician would be notified and sent to the hospital for evaluation given the seriousness of his condition and vital signs.<br><br>The administrator was notified of the immediate joopardy on 4/5/13 and 1:00 PM.<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>-Resident #1 expired in the facility on 04/01/2013. Review of the resident record indicates the resident was his own responsible party and requested that his family not be notified of his change in condition and he declined offers of hospitalization. The record indicated the physician was notified of the resident ' s change in condition and his desire not to be hospitalized. The physician indicated to continue to monitor the resident although the option of hospitalization was declined by the resident.<br>-The Director of Nursing was terminated by the administrator on 04/05/2013.<br><br>What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice?<br>-The facility has determined that all residents have the potential to be affected but currently, after review of 24 hour shift reports, there is no evidence of any deficient physician or resident representative communication on 04/04/2013.<br>What measures will be put into place or systemic changes will be made to ensure that the deficient | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 10<br>practice will not occur?<br>-All licensed nursing staff have been assigned on-line learning course " Effective Communication " which includes the SBAR tool for communication to the physician, 04/05/2013.<br>-All licensed nursing staff will be in-serviced by the DON or appropriate designee regarding the following and attached. F Tag 157: Notification of Change, Facility policy on Change in Resident Status which includes notification of physician, Validation Checklist for Notification of Changes, and Documentation of Notification on 04/05/2013, ongoing.<br>-Any licensed staff member who has not been trained as of 04/05/2013 will not be allowed to report for duty until training is complete.<br>-This information will be included as additional training in licensed nursing orientation and annual re-orientation.<br>-24 hour nursing reports will be reviewed by the supervising or charge nurse each shift for identification of proper notification of physician and resident representative as needed and per facility policy. Any discrepancies in notification will be corrected by the supervising or charge nurse reviewing the 24 hour report, beginning 04/05/2013 and ongoing.<br>-Validation Checklist will be utilized by the nurse in charge of the resident with a change in condition requiring physician and resident representative for a period of 4 weeks, beginning 04/05/2013.<br>-F-157 Notification of Change audits will be conducted by the DON, or appropriate designee weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters, and as needed.<br>How will performance be monitored and how often? | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 11<br>-24 hour reports will be reviewed by the facility administrative team 5 x per week x 4 weeks for compliance with plan as stated above and Validation of Notification forms during Morning Meeting. Non-compliance will be discussed during this meeting with immediate notifications made as needed and the nurse (s) responsible for any non-compliance re-in-serviced and disciplined by the DON or appropriate designee. The review of the 24 hour report will by continued with a minimum of weekly reviews x 3 weeks, monthly reviews, x 2 months, followed by quarterly x 3 quarters, and as needed, ongoing.<br>-Review of the Validation reports will be reviewed 5 days per week by the Facility Administrative Staff during Morning Meeting x 1 week, followed by weekly x 3 weeks, followed by quarterly x 3 quarters, and as needed, ongoing.<br>-Review of Notification of Change Audits will be reviewed by the facility Administrative Staff during Morning Meeting weekly x 4 weeks, followed by monthly x 2 months, followed by quarterly x 3 quarters, a as needed, ongoing.<br>-This plan and its outcomes will be reviewed by the QA committee during the monthly QA meeting. Any deviations of the plan will be examined using a RCA approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations, and monitoring will be included in the facility QA meeting minutes.<br>Any changes to the plan above will be documented in the QA meeting minutes, appropriate staff re-in-serviced to changes in the plan. Any changes made to the above plan will require the monitoring of such changes to begin at the initial review schedule of 5 days/week x 1 week; weekly x 3 weeks; monthly x 2 months, quarterly x 3 quarters, and as needed. | F 157 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 157 | Continued From page 12<br>On 4/5/13 at 7:30 PM, verification of the credible allegation was evidenced by interviews of direct care nursing staff related to the notification of a change in a residents' status, communication with the physician utilizing the SBAR tool, review of the 24 hour report to identify concerns for the physician to be made aware. The nurses were aware of the validation checklist for all current residents with any noted changes in condition. | F 157 | | |
| F 309 SS=J | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, physician interviews and record review, the facility failed to assess and monitor a resident experiencing a significant change in condition (respiratory distress) and failed to seek medical intervention for a resident in respiratory distress in 1 of 3 residents sampled with a change in condition (Resident #1).<br><br>Immediate Jeopardy began on 4/1/13 and was identified on 4/5/13 at 1:00 PM. Immediate Jeopardy was removed on 4/5/13 at 6:30 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than | F 309 | Resident #1 expired on 04/01/2013<br><br>It is determined that all residents have the potential to be affected.<br><br>Audit of all residents advanced directives was conducted by the social worker to determine the accuracy of such directives as compared to the wishes of the individual resident, as cognitively appropriate on 04/05/2013<br>A review of the 24 hour reports was completed by the DON, or appropriate designee, on 04/04/2013 there is no evidence of any deficient physician or resident representative | 4-5-13<br><br>4-5-13<br><br>4-4-13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 346481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 13<br>minimal harm that is not immediate jeopardy). The facility was in the process of full implementation and monitoring their corrective action.<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 3/18/13 with diagnoses of End Stage Chronic Obstructive Pulmonary Disease (COPD) and Emphysema.<br><br>The admission Minimum Data Set (MDS) dated 3/25/13 indicated that resident #1 had no short term or long term memory problems and no documented behavioral problems. He was coded as cognitively intact and the MDS indicated that he depended extensively on staff for all of his activities of daily living. Resident #1 was not coded as having a prognosis of less than 6 months life expectancy. Resident #1 required continuous oxygen at 4 liters/minute using a nasal cannula.<br><br>A review of resident #1's medical record indicated that he was his own responsible party and signed his admission paperwork to include the Code Status Resuscitation Request/Order form indicating he would like to be resuscitated in the event of a cardiac or respiratory arrest. This document was dated 3/18/13.<br><br>A review of the physician orders indicated that resident #1 was to receive a breathing treatment every four hours. There were no medications or breathing treatments ordered that could have been given as needed for shortness of breath. | F 309 | communication or lack of assessment by nursing staff for resident's requiring such interventions<br><br>All licensed nursing staff will be re-in-serviced by the DON, or appropriate designee, as to the standard criteria for monitoring resident's condition as listed below, but not limited to: VS (Temperature, Pulse, Respirations, Blood Pressure, Pulse Ox), Level of Consciousness and Responsiveness, Level of Cognition, 04/19/2013<br>Any licensed nursing staff who has not been in-serviced as of 04/19/2013 will not be allowed to report for duty until training is complete.<br>All licensed nursing staff will be re-in-serviced on Documentation Standards by the DON, or appropriate designee 04/19/2013 | 4-19-13<br><br>4-19-13 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/06/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 14<br>A review of resident #1's bowel record indicated that resident #1 had a stool on 3/31/13 described at medium and soft formed.<br><br>A review of the Medication Administration Record (MAR) indicated that at 10:00AM on 4/1/13, resident #1's oxygen saturation was 90% on 4 liters/minute of oxygen using a nasal cannula.<br><br>A review of the medical record indicated that routine vital signs were taken on 4/1/13 at 12:20 PM. Resident #1's vital signs at that time were as follows: blood pressure 132/94, pulse 110, respirations 20.<br><br>In a nursing note written by nurse #1, she indicated that resident #1 was observed at or around 2:30 PM slumped over in his chair. He was clammy with an oxygen saturation of 81%. The nursing note did not indicate if his oxygen was in use at the time he was found. He was given a breathing treatment and his oxygen saturation increased to 95% on 4 liters/ minutes of oxygen using a nasal cannula. Resident #1's vital signs were as follows: blood pressure 82/60 (low), pulse 78, respiration 48 (elevated) and temperature 97.9 F. The nursing note indicated resident #1 refused to go to hospital for evaluation and he did not want his family notified. The nursing note also indicated that the director of nursing (DON) assessed resident #1 and the physician was notified.<br><br>On 4/1/13 at 2:30 PM, nurse #1 completed a Situational Background Assessment · Recommendation (SBAR) form. This form indicated nurse #1 reported to the physician that resident #1 was cyanotic (blue or purple | F 309 | All licensed nursing staff will be in-serviced by the DON or appropriate designee regarding the following:<br>F Tag 309: Quality of Care, Facility Policy on Change in Resident Status which includes notification of physician, Validation Checklist for Notification of Changes, Practice Guideline for Notification of Changes, Documentation of Notification, 4-19-2013.<br>Any licensed nursing staff who has not been in-serviced as of 04/19/2013 will not be allowed to report for duty until training is complete.<br><br>This information will be included as additional training in licensed nursing orientation and annual re-orientation.<br><br>For applicable residents (those in need of targeted monitoring) 5% chart audit of nursing documentation will be conducted daily x 5 days, | 4-19-13 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 15<br>coloration of the skin), short of breath and anxious. This form indicated that the he physician instructed the staff to observe resident #1 and monitor his vital signs. This form indicated the DON was aware of the physician's directive.<br><br>The medication administration record (MAR) dated 4/1/13, indicated that at 4:34 PM, resident #1 was not responsive enough to take his medications. The MAR noted that the medication aide (MA) #1 notified nurse #2 of his change of condition.<br><br>A review of resident #1's medical record indicated no ongoing assessment from approximately 2:30 PM until approximately 6:15 PM when emergency medical services (EMS) was notified. There was no evidence of any ongoing assessment of resident #1's respiratory or mental status changes.<br><br>According to the EMS report, on 4/1/13 at approximately 6:15 PM, the call came into the department and they arrived on the scene at 6:27 PM and cardio pulmonary resuscitation (CPR) was in progress by facility staff. Resident #1 was found without a pulse, not breathing and unresponsive. His skin was cold to the touch. Resident #1 was pronounced dead at 6:45 PM.<br><br>In an interview on 4/4/13 at 12:11 PM, nurse #1 stated that on 4/1/13 at approximately 2:30 PM, she and MA # 1 assisted resident #1 in getting in the bed. Nurse #1 stated she asked the DON to look at resident #1 because she wanted to send him out but he refused to go to hospital. Nurse #1 stated that the DON stated the hospital could not do anything for resident #1 that the facility could | F 309 | weekly x 3 weeks, monthly x 2 months, quarterly x 3 quarters. Beginning 04/05/2013, and ongoing. This audit will identify the validation through documentation of monitoring applicable resident's condition and related notification of physician and resident representative as appropriate.<br>24 hour reports will be reviewed by the facility administrative team 5 x per week x 4 weeks for compliance with plan and Validation of Notification forms during Morning Meeting. Non-compliance will be discussed during this meeting with immediate notifications made as needed and the nurse(s) responsible for any non-compliance re-in-serviced and disciplined by the DON or appropriate designee. 04/05/2013 and ongoing.<br>The review of the 24 hour report will be continued with a minimum of weekly reviews x 3 weeks, monthly reviews x 2 months, quarterly reviews x 3 quarters, and as needed. | 4-19-13 and ongoing<br>4-19-13 and ongoing<br>4-19-13 and ongoing |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 16<br>not do. Nurse #1 stated the DON instructed her to check resident #1 for an impaction. Nurse #1 stated the DON stated " did you ever think that was his problem? " Nurse #1 stated she checked resident #1 for an impaction and there was noted medium amount of hard stool removed. A suppository was administered after the stool was removed. Nurse #1 stated did not check resident #1's medical record to see if he had a recent bowel movement. She stated she called the physician and completed a SBAR report with the physician instructions to observe resident #1 and monitor his vital signs and to notify him for changes in his respiratory or mental status. Nurse #1 could not recall if she informed the physician of dis-impacting resident #1 and administrating a suppository. Nurse #1 stated that the DON and nurse #2 were present at the nursing station when the physician was notified. Nurse #1 stated she also reported to nurse #2, the 3-11 shift nurse, in her shift change report the physician ' s instructions. Nurse #1 stated resident #1 was a full code and she did not feel comfortable with the DON and physician ' s instruction. Nurse #1 could not recall if she specifically stated that resident #1 was a full code but that she thought she did. She stated his code status was indicated on the SBAR form. Nurse #1 stated she could not recall if nurse #2 went to the room to observe resident #1 prior to her leaving the facility at the end of her shift.<br><br>In an interview on 4/4/13 at 12:20 PM, medication aide #1 (MA) stated she helped assist nurse #1 in getting resident #1 into the bed on 4/1/13 at approximately 2:30 PM. She stated resident #1 refused to go to the hospital so nurse #1 went to talk to the DON. Nursing assistant #1 came to her | F 309 | Review of Advanced Directives Audits, and Notification of Change Audits will be reviewed by the facility Administrative Staff during Morning Meeting weekly x 4 weeks, monthly, x 2 months, quarterly x 3 quarters and as needed, 04/04/2013 and ongoing. This plan and its outcomes will be reviewed by the QA committee during the monthly QA meeting. Any deviations of the plan will be examined using a RCA approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations and monitoring will be included in the facility QA meeting minutes. Any changes to the plan above will be documented in the QA meeting minutes, appropriate staff re-in-serviced to changes in the plan. Any changes made to the above plan will require the monitoring of such changes to begin at the initial review schedule of 5 days/week x 1 week, weekly x 3 weeks, monthly x 2 months, quarterly x 3 quarters, and as needed. | 4-19-13 and ongoing<br>4-19-13 and ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 17<br>in resident #1 ' s room and told her anothor resident requested a pain medication. MA #1 asked NA #1 to stay with resident #1. MA #1 stated sometime shortly after she returned to her medication cart, the DON approached her and requested a Ducolax suppository for resident #1.<br><br>In an interview on 4/4/13 at 130 PM, NA #1 stated on 4/1/13 at approximately 2:45 PM, she saw resident #1 already in the bed. NA #1 stated MA # 1 asked her to stay with resident #1 until nurse #1 returned. NA #1 stated resident #1 had a mask on his face receiving at breathing treatment. She stated he removed that mask and stated he couldn ' t breathe. NA #1 told him to keep treatment in place. NA #1 stated that once nurse #1 and the DON were in the room, she left to complete her rounds and report off to NA #2.<br><br>In an interview on 4/4/13 at 2:00 PM, the DON stated that nurse #1 asked her to look at resident #1. She said he was in the bed with a breathing treatment in progress when she entered the room. She said he was in a hospital gown and he was wet with urine and that this was unusual for resident #1. She stated she instructed nurse #1 to check resident #1 for an impaction. She instructed nurse #1 to administer a suppository. The DON stated she did not check the medical record to see when resident #1 last had a bowel movement.<br>The DON stated she ensured resident #1's head of his bed was up and his oxygen was in place. The DON stated nurse #1 called the physician around the time of shift change. The DON stated awareness of resident #1's code status. The DON stated she did not actually assess resident #1 but rather was present during the impaction removal | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 18<br>by nurse #1. The DON stated awareness of resident #1's vital signs. She stated she stayed in the room while he was cleaned up and ensured his oxygen was in place and the head of his bed was up. The DON stated she was at the nursing station when nurse #1 notified the physician. She could not recall if nurse #1 made the physician aware of resident #1 full code status. The DON asked nurse #1 if she had checked resident #1 for an impaction because she wanted to be sure that resident #1 was not being sent out to the hospital unnecessarily. The DON stated she felt overwhelmed because of the acuity of the residents being admitted to the facility and stated she had to be sure a trip to the emergency room was warranted. The DON stated she did not think it was an emergency at the time and felt that the stool evacuation would be effective in easing resident #1's distress. The DON stated she was aware that nurse #1 was not satisfied with her directive. The DON stated that could have impacted her decision not to return to the floor to reassess the condition of resident #1. The DON stated she did not make contact with floor staff again prior to leaving work that day around 6:00 PM.<br><br>In an interview on 4/4/13 at 3:00 PM, MA #2 stated she went to see resident #1 at the beginning of her shift. She stated when she saw him, he was thrashing about in the bed and unable to respond to her questions. She stated his oxygen was in place at the time. MA #2 stated she returned to the nursing station and stated she thought resident #1 was dying. MA #2 stated the DON, nurse #1 and nurse #2 were standing at the nursing station and no nurse went to the room with her to see resident #1. MA #2 | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 19<br>asked nurse #1 if they were sending him to the hospital. Nurse #1 told her that the DON told her not to send him out. Nurse #1 stated the physician told them to monitor for any further decline in his condition and call him back. MA #2 stated that she was not aware if nurse #2 went to the room to see resident #1. MA #2 stated that at 4:34 PM, she tried to give resident #1 ' s his scheduled medication but he was not responsive enough to take his medicine. She stated she told nurse #2 about resident #1's change in condition. MA #2 stated nurse #2 did not go to the room to assess resident #1 to her knowledge. MA #2 stated that around 6:15 PM, she heard a code announced and she responded to resident #1's room to find the MDS nurse initiating CPR.<br><br>In a telephone interview on 4/5/13 at 11:12 AM, NA #2 stated that on 4/1/13 around 3:00 PM, NA #1 told her that resident #1 had not been himself all day and she needed to keep an eye on him. NA #2 stated she was not instructed to get any vital signs or what conditions she was to notify nurse #2. NA #2 stated she was told to " keep an eye on him " by nurse #2. NA #2 stated she went to room to see resident #1 and noted that he appeared to be in distress. She described distress as uncomfortable, moving around in bed, unable able to responds to her questions and gasping for breath. NA #2 stated resident #1's head was off of the pillow and she put his bed back on pillow. NA #2 was unsure if his oxygen was in place. NA #2 left the room but she continued to check on resident #1 every 30-40 minutes. NA #2 stated at dinner time, she was passing trays and got to his room and she noted he looked worse. She stated resident #1 was unconscious, was not breathing but still warm. NA | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 20<br>#2 stated she went to the doorway and called for a nurse. The MDS nurse and MA #2 came to the room and started CPR. NA #2 got the crash cart. NA #2 stated that nurse # 4 also responded to the room and nurse # 2 called 911.<br><br>In a telephone interview on 4/4/13 at 3:20 PM, nurse #2 stated that nurse #1 asked DON to look at resident #1 around shift change so nurse #2 also went into the room to see resident #1 since she was going to be caring for him that shift. Nurse #2 said he was gasping for air with his oxygen in place. His eyes were open but he was not responsive. Nurse #2 said she was instructed to monitor resident #1 for worsening in his condition and call the physician for further decline. Nurse #2 stated she was aware that resident #1 was a full code. She stated that she went to the room around 4:15 PM to check the blood sugar of the room mate, and that there was no change in his condition at the time. She stated he was still gasping for air and writhing about in the bed. Nurse 2 said that around 6:00 PM or so, the MDS nurse told her that resident #1 was not looking good. The MDS nurse reported to her that resident #1 was less responsive, pale and breathing sporadically. Nurse #2 said she did not go look at resident #2 but rather called the physician. The physician gave an order to send resident #1 out to the hospital but he apparently he went into respiratory arrest and CPR was started. Nurse #2 stated she did not note any changes in condition from approximately 4:15 PM when she checked the room mate blood glucose level and until he coded around 6:15 PM. Nurse #2 stated she did not go and observe resident #1 after MA #2 told her he was not able to take his 4:30 PM medication. Nurse #2 stated she did not | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 21<br>recall if MA #2 reported that resident #1 was not responsive. Nurse #2 indicated resident #1 was ordered a breathing treatment every hour hours and his next one was due at 6:00 PM and she planned to administer the breathing treatment but resident #1 coded before she got to administer it.<br><br>In an interview on 4/4/13 at 1:50 PM, the MDS nurse stated that it was around 6:00 PM or so when NA #2 motioned for her to come to room. She stated resident #1 was lying on side gasping breath. His oxygen was in place. She performed a sternal rub without a reaction. Resident #1 had no pulse so she called a code and told NA #2 to get the crash cart. The MDS nurse stated that she felt resident #1 should have been sent him out earlier that day since he was a full code and he was having trouble breathing. She said even though he didn't want to go, she felt resident #1 he was not mentally in any condition to make a rational decision. She stated she did not think anyone was taking his vital signs and was aware the physician told the staff to monitor his condition and call him for any changes.<br><br>In an interview on 4/5/13 at 3:30 PM, nurse #3 stated around 6:00 PM or so on 4/1/13, a code was announced on the overhead system. She responded to the room and the MDS nurse and MA #2 were performing CPR. Once EMS arrived, they took over the code and pronounced resident #1 dead at 645 PM.<br><br>In a telephone interview on 4/4/13 at 2:30 PM, the physician recalled getting a phone call on 4/1/13 about resident #1 being in respiratory distress and that he refused to go to the hospital. The physician recalled that nurse #1 stated she | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 22<br>administered his ordered breathing treatment when he was found slumped over in the chair because is oxygen saturation rate was 81%. The physician stated awareness that his oxygen saturation rate went up to 95% on 4 liters/minute of oxygen. The physician stated that because his oxygen saturation rate improved after the breathing treatment, he felt observation was an adequate intervention at the time. The physician could not recall if the staff at the facility informed him that resident #1 was a full code but he knew that resident #1 was his own responsible party and that he thought he was a Do Not Resuscitate (DNR). He recalled that resident #1 was already on 4 liters/minutes of oxygen and stated that was as high as he could go. He recalled telling the staff to monitor his vital signs and respiratory status. The physician was unable to recall if he was called again that day about resident #1.<br><br>In a telephone interview on 4/4/13 at 5:00 PM, the physician stated he did not give specific orders but if resident #1 was experiencing respiratory distress, he would have expected the nurses to assess his breathing and respirations, vital signs and called him for any changes in his breathing, respiratory status or changes in his mental status. The physician stated he thought he received a second call that afternoon asking to send him out to the hospital and he told them send him out for evaluation. The physician stated he was unsure of time of the second call.<br><br>In an interview on 4/5/13 at 10:30 AM, the administrator stated her expectation would have been that when resident #1's respiratory and mental status changed, the physician would be notified and sent to the hospital for evaluation | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 23<br>given the seriousness of his condition and vital signs.<br><br>The administrator was notified of the immediate jeopardy on 4/5/13 and 1:00 PM.<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>-Resident #1 expired on 04/01/2013<br>What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice?<br>-It is determined that all residents have the potential to be affected.<br>-Audit of all residents advanced directives was conducted by the social worker to determine the accuracy of such directives as compared to the wishes of the individual resident, as cognitively appropriate on 04/05/2013<br>-A review of the 24 hour reports was completed by the DON, or appropriate designee, on 04/04/2013 there is no evidence of any deficient physician or resident representative communication or lack of assessment by nursing staff for resident ' s requiring such interventions<br><br>What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not occur?<br>-All licensed nursing staff will be re-in-serviced by the DON, or appropriate designee, as to the standard criteria for monitoring resident ' s condition as listed below, but not limited to: VS (Temperature, Pulse, Respirations, Blood Pressure, Pulse Ox), Level of Consciousness and Responsiveness, Level of Cognition on 04/05/2013 and ongoing.<br>Any licensed nursing staff who has not been | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 24<br>in-serviced as of 04/05/2013 will not be allowed to report for duty until training is complete.<br>-All licensed nursing staff will be re-in-serviced on Documentation Standards by the DON, or appropriate designee (see attached) on 04/05/2013 and ongoing.<br>-All licensed nursing staff will be in-serviced by the DON or appropriate designee regarding the following and attached: F Tag 309: Quality of Care, Facility Policy on Change in Resident Status which includes notification of physician, Validation Checklist for Notification of Changes, Practice Guideline for Notification of Changes, Documentation of Notification, on 4-5-2013.<br>Any licensed nursing staff who has not been in-serviced as of 04/05/2013 will not be allowed to report for duty until training is complete.<br>This information will be included as additional training in licensed nursing orientation and annual re-orientation.<br>For applicable residents (those in need of targeted monitoring) 5% chart audit of nursing documentation will be conducted daily x 5 days, followed by weekly x 3 weeks, followed by monthly x 2 months, followed by quarterly x 3 quarters. Beginning 04/05/2013, and ongoing.<br>This audit will identify the validation through documentation of monitoring applicable resident ' s condition and related notification of physician and resident representative as appropriate.<br>How will performance be monitored and how often?<br>-24 hour reports will be reviewed by the facility administrative team 5 x per week x 4 weeks for compliance with plan and Validation of Notification forms during Morning Meeting. Non-compliance will be discussed during this meeting with immediate notifications made as | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345461 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 25<br>needed and the nurse(s) responsible for any non-compliance re-in-serviced and disciplined by the DON or appropriate designee. 04/05/2013 and ongoing.<br>The review of the 24 hour report will be continued with a minimum of weekly reviews x 3 weeks, monthly reviews x 2 months, followed by quarterly x 3 quarters, and as needed.<br>Review of Advanced Directives Audits, and Notification of Change Audits will be reviewed by the facility Administrative Staff during Morning Meeting weekly x 4 weeks, followed by monthly, x 2 months, followed by quarterly x 3 quarters and as needed, 04/04/2013 and ongoing.<br>This plan and its outcomes will be reviewed by the QA committee during the monthly QA meeting. Any deviations of the plan will be examined using a RCA approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations and monitoring will be included in the facility QA meeting minutes.<br>Any changes to the plan above will be documented in the QA meeting minutes, appropriate staff re-in-serviced to changes in the plan. Ongoing<br>Any changes made to the above plan will require the monitoring of such changes to begin at the initial review schedule of 5 days/week x 1 week, weekly x 3 weeks, monthly x 2 months, quarterly x 3 quarters, and as needed. Ongoing<br><br>On 4/5/13 at 7:30 PM, verification of the credible allegation was evidenced by interviews of direct care nursing staff related to the notification of a change in a residents' status, communication with the physician utilizing the SBAR tool, review of the 24 hours report to identify concerns for the physician to be made aware. The nurses were | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345481 | A. BUILDING _____ B. WING _____ | C 04/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLANDS NURSING & REHABILITATION CENTER | 400 PELT DRIVE FAYETTEVILLE, NC 28301 |

| (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 309 | Continued From page 26<br>aware of the validation checklist for all current residents with any noted changes in condition. | F 309 | | |