STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident ' s call light (Resident #42) within reach to allow for the resident to request staff assistance if needed for one of one resident reviewed for accommodation of needs. The findings included: Resident #42 was admitted to the facility on 1/28/16 and most recently readmitted on 10/20/17 with multiple diagnoses that included dementia, muscle weakness, and history of falling. The admission Minimum Data Set (MDS) assessment dated 10/27/17 indicated Resident #42 ' s cognition was moderately impaired. He had no behaviors and no rejection of care. He required the extensive assistance of 2 or more staff with bed mobility, transfers, locomotion on/off unit, toileting, and personal hygiene. The Care Area Assessment (CAA) related to falls for the 10/27/17 MDS indicated Resident #42 required extensive assistance with most Activities of Daily Living (ADLs) and was non-ambulatory except with therapy. He had attempted unassisted standing and ambulation since his admission and had very poor safety awareness. He was at risk for falls.	F 558	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Woodland Hill Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements facts and conclusions that form the basis for the deficiency." Resident #42□s call bell cord was placed within reach when the facility was made aware. It was noted that the resident did not have a clip on his call bell cord and that the CNA had wrapped the cord around the rail to keep the cord from falling to the floor. A facility audit was completed to ensure residents call bell cords were within reach. Several call bell cords were identified as being attached to the bed rail. Those identified concerns were addressed at the time of discovery.	12/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 Resident 42 ' s plan of care, last reviewed 11/29/17, indicated he was at risk for falls related to a history of falls, impaired mobility, and impaired cognition. Interventions included placing his call light within reach. An observation and interview was conducted with Resident #42 on 11/29/17 at 8:50 AM. Resident #42 was lying on his back in bed and the cord to his call light was wrapped around his bed rail. The call light was hanging toward the ground and out of his reach. Resident #42 was alert and interviewable. He indicated he needed staff assistance as he had pain in his stomach, but he was unable to reach his call light. He was observed with a grimace on his face and he appeared to be in pain. An observation was conducted of Resident #42 on 12/1/17 at 8:40 AM. He was observed in his room in bed. Resident #42 ' s call light cord was wrapped around his bed rail and the call light was hanging toward the ground out of his reach. An interview with conducted with Nursing Assistant (NA) #1 on 12/1/17 at 9:45 AM. She indicated she was familiar with Resident #42. She stated Resident #42 was able to use his call light to request staff assistance. She indicated he used the call light frequently. She reported she normally placed Resident #42 ' s call light on his chest so he was able to reach it. An interview was conducted with the interim Director of Nursing (DON) on 12/1/17 at 12:29 PM regarding Resident #42 ' s call light not being placed within his reach. The DON indicated her expectations were for staff to place resident call	F 558	Clips for the call bell cords were ordered and will be installed on the cords upon arrival to the facility so that the resident can reach their call bell with ease. In-service for facility staff to be completed by the Center Nurse Educator and Nurse Practice Educator regarding call bell cords needing to be within reach of the resident and have a call cord clip attached. Education to be completed during orientation for all new hires and annually thereafter. Random audits of 10 resident call bell cords will be complete by the interdisciplinary team ensuring call bell cords are in reach and that the clips are attached. The audits will be completed weekly for four weeks, monthly for three months, quarterly for 3 quarters and annually thereafter. Any identified issues will be addressed at the time of discovery. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Interdisciplinary Team to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2 lights within the resident ' s reach at all times.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a shower as scheduled for 1 of 1 sampled resident reviewed for choices (Resident #37). Findings included:	F 561	Resident # 37 had a shower given to her. The Facility failed to provide a shower/bath per facility schedule and/or resident request.	12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 Resident #37 was admitted to the facility on 11/6/16 with multiple diagnoses including cerebro vascular accident with hemiplegia. The annual Minimum Data Set (MDS) assessment dated 10/3/17 indicated that Resident #37 had moderate cognitive impairment. The assessment further indicated that Resident #37 was totally dependent on the staff with bathing and she had not displayed any behavior of rejection to care. The assessment further indicated that it was very important for her to choose between a tub, shower, bed bath or sponge bath. Resident #37's care plan dated 10/3/17 was reviewed. One of the car plan problems was the resident was dependent for toileting and personal hygiene related to recent cerebro vascular accident with left hemiplegia. The goal was the resident will have personal hygiene completed by the staff. The approaches included to complete all toileting, and personal hygiene for the resident. The shower book was reviewed and the shower schedule for Resident #37 was every Wednesday and Saturday. On 11/29/17 at 10:57 AM, Resident #37 was interviewed. She stated that the staff had not offered her a shower. She indicated that when she asked for a shower, she was told the beauty shop would wash her hair. She added that the beauty shop was busy all the time and didn't have time to wash her hair. The September, October and November 2017 shower documentation for Resident #37 were reviewed. On September 2, 6, 9, 16, 20, 23, and October 18, 21, 25, 28 the shower documentation	F 561	This deficient practice has potential to affect all other residents. An audit was completed and found several residents who did not receive a shower on their scheduled day. Any resident identified as not receiving a shower/bath per their schedule was offered one. Education for CNA□s and Licensed Nurses was completed by the Center Nurse Executive and Nurse Practice Educator in regards to the need to offer and provide showers/baths according to the schedule provided, the location of the shower book/schedule and how to access it in Point Click Care and how to accurately code showers and baths for residents including documentation of refusals. Education will also be provided to new hires during orientation and annually thereafter. Random audits of bathing and shower completion and documentation will be done on 10 residents by the Unit Manager(s) weekly for four weeks, monthly for two months, and quarterly for three months and then yearly. Any identified issues will be addressed at the time of discovery. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Unit Manager (s) to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 4 forms were blank, indicating that shower was not provided to Resident #37. The November 2017 shower documentation form revealed that shower was not provided to Resident #37. The form indicated that bed bath was provided by Nurse Aide (NA) # 5 on November 1, 8, 11, 15, 18, 22 and 29. On 11/30/17 at 11:40 AM, Resident #37 was interviewed. She stated that yesterday (Wednesday), she was not offered a shower. On 11/30/17 at 3:40 PM, NA #5 was interviewed. She stated that she didn't remember giving a shower to Resident #37 on 3-11 shift. NA #5 indicated that she followed the shower book in giving showers and she didn't know the shower days for Resident #37. She added that if Resident #37 refused shower it should have been documented. On 12/1/17 at 12:30 PM, the interim Director of Nursing (DON) was interviewed. She expected the NAs to provide shower to residents as scheduled.	F 561	deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units on four of four halls sampled resident rooms. PTAC units had visible dust on the removable air filters in rooms 103, 106, 205, 207, 302, 304, 310, 311, 313, 319, 405	F 584	The facility preventative maintenance schedule was not followed. Action was taken on December 1, 2017 by the Director of Maintenance who reviewed with the Housekeeping Supervisor the manufacturer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 and 408. In addition, the facility failed to maintain bathroom exhaust fans dust free on four of four halls in sampled resident bathrooms. The bathroom vents had visible dust in rooms 103, 104, 109, 216, 304, 305, 307, 401, 403, 405 and 408. The findings included: 1. A review of the instructions regarding Heating Ventilation Air Conditioning (HVAC) (PTAC): Inspect, clean air filter, check drainage; revealed that removable air filters were to be replaced or thoroughly cleaned depending on the type of filter every three months. An observation on 11/28/17 at 11:30 AM revealed visible dust on the removable air filter for the PTAC unit in rooms 302, 304, 310, 311, 313 and 319. An observation on 11/30/17 at 3:00 PM revealed visible dust on the removable air filter for the PTAC unit in rooms 103, 106, 205, 207, 405 and 408. A review of the work history report dated 11/30/17 read the PTAC filters were marked as completed on 10/31/17 by the housekeeping department. A review of the TELS report (a technology-based system for delivering Life Safety, asset management, maintenance, and repair services to building management professionals) the PTAC removeable filters were to be cleaned monthly by maintenance. In an interview on 11/30/17 at 12:15 PM, the Administrator stated she was aware of	F 584	recommendations and facility preventative maintenance of the resident room Packaged Thermal Air Conditioners (PTACs). PTACs in the facility will be inspected, cleaned and filters replaced or cleaned as needed by the Director of Maintenance, Maintenance staff or Housekeeping Staff. The Director of Maintenance will evaluate and review the preventative schedule pertaining to PTACs and adjust the frequency of filter changes and equipment cleaning per manufacturer□s recommendations as necessary to ensure proper operation of the equipment. The Director of Maintenance provided written procedure for Housekeeping Manager, Maintenance Staff, and Housekeeping Staff to follow when servicing/cleaning a PTAC. The Director of Maintenance/Housekeeping Supervisor will observe Maintenance Staff or Housekeeping Staff members using this procedure to accomplish the assigned preventative maintenance. The Center Executive Director will randomly audit work completed of the current month□s PTAC preventative maintenance schedule, then monthly for two months, quarterly for three months then yearly to ensure it was completed correctly and to establish standards set forth by the user manuals and facility policy & procedure. Identified issues will be addressed at time of discovery. The Center Executive Director will report the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 preventative maintenance concerns. She stated she recommended a part-time maintenance assistant and was awaiting approval. The Administrator stated the facility was thirty years old and required constant repairs that leave little time for the preventative task. In an interview and facility round on 12/1/17 at 9:20 AM, the Maintenance Supervisor stated the Housekeeping Supervisor was responsible for cleaning the PTAC filters. He stated he was unaware of the frequency the PTAC filter were to be cleaned but rather he utilized the TELS system to know when preventative task was due. He stated the Housekeeping Supervisor was in the process of cleaning the PTAC filters 11/30/17 once the facility was made aware of the filter concerns. He stated his time was mostly consumed with immediate concerns and repairs so the Housekeeping Supervisor was assisting with some of the preventative maintenance task. In an interview on 12/01/17 at 9:25 AM, the Housekeeping Supervisor stated she was not aware how often the PTAC filters were to be cleaned. She stated her department had been cleaning the PTAC filters as needed. In an interview on 12/01/17 at 11:24 AM, the Administrator stated it was her expectation the PTAC filters be cleaned as scheduled. 2. A review of the Instructions for Exhaust Fans: Inspect exhaust fans for proper operation and clean if necessary revealed instructions to clean vents using vacuum and air compressor, when needed to remove all dust. An observation on 11/28/17 at 11:30 AM revealed	F 584	results of the random compliance audits to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Resident Bathroom exhaust vents identified during the annual survey were cleaned by the Director of Maintenance and Housekeeping Manager. The remaining resident bathroom exhaust fans were inspected and many were identified as needing a good cleaning and will be cleaned immediately. The Director of Maintenance was educated on following facility policy & procedure regarding preventative maintenance schedules. The Director of Maintenance and Housekeeping Supervisor will work together on a monthly basis to inspect and clean if necessary resident bathroom exhaust fans per the preventative maintenance schedule. The Center Executive Director will inspect resident bathroom exhaust fans monthly for two months, quarterly for three months then yearly. The Center Executive Director will report audit results monthly to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 visible dust on the bathroom exhaust fans in rooms 304, 305 and 307. An observation on 11/30/17 at 3:00 PM revealed visible dust on the bathroom exhaust fans in rooms 103, 104 109, 216, 401, 403, 405 and 408. A review of the TELS report read the exhaust fans were to be inspected monthly and cleaned as needed. In an interview on 11/30/17 at 12:15 PM, the Administrator stated she was aware of preventative maintenance concerns. She stated she recommended a part-time maintenance assistant and was awaiting approval. The Administrator stated the facility was thirty years old and required constant repairs that leave little time for the preventative task. In an interview and facility round on 12/01/17 at 9:20 AM, the Maintenance Supervisor stated he was responsible to ensuring the bathroom exhaust fans were clean and free of dust. He stated he was unaware of the frequency the bathroom exhaust fans were to be cleaned but rather he utilized the TELS system to know when preventative task was due. He stated his time was mostly consumed with immediate concerns and repairs. In an interview on 12/1/17 at 11:24 AM, the Administrator stated it was her expectation the bathroom exhaust fans be cleaned as needed.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 9	F 636		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 10 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to completely assess residents in the areas of cognition and mood (Resident #76) and pain (Resident #125) for two of eighteen sampled residents. The findings included: 1. a. Resident #76 was admitted to the facility on 3/11/17. Cumulative diagnoses included Alzheimer ' s disease and vascular dementia. A Quarterly Minimum Data Set (MDS) dated 6/18/17 indicated "yes" to question C0600 which asked if a staff assessment for mental status should be conducted. Question C0700, C0800, C0900, C1000 and C1310 indicated "not assessed/ no information". The Social Worker who was responsible for	F 636	Resident # 76 and #125□s Minimum Data Set (MDS) was accurately coded, their interviews were not completed prior to the ARD (Assessment Reference Date) by the Social Worker or Licensed Nursing Staff. The Center Reimbursement Coordinator will verify that Cognition Section C, Mood Section D and Pain Interviews Section J are complete prior to the ARD (Assessment Reference Date). The Clinical Reimbursement Manager will educate the Social Worker, Center Nurse Executive and Center Reimbursement Coordinator on the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) for Sections C, D and J.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 11 completion of sections for cognition and mood was no longer employed at the facility. On 12/01/17 at 12:07 PM, an interview was conducted with the MDS Coordinator. She reviewed the documentation and stated the Social Worker did not complete her section of the MDS (sections C and D) until after the Assessment Reference Date (ARD) so the information was not transferred over the MDS assessment. The MDS Coordinator said the areas should have been completed by the ARD date of 6/18/17. On 12/01/17 at 12:35 PM, an interview was conducted with the interim Director of Nursing who stated she expected the MDS assessments to be accurate and complete. 1. b. Resident #76 was admitted to the facility on 3/11/17. Cumulative diagnoses included Alzheimer ' s disease and vascular dementia. A Quarterly MDS dated 6/18/17 was reviewed and section D for Mood revealed D0100, D0200, D0300, D0500 and D0600 was not assessed by Resident Mood interview or Staff Assessment of Resident Mood. The Social Worker who was responsible for completion of sections for cognition and mood was no longer employed at the facility. On 12/01/17 at 12:07 PM, an interview was conducted with the MDS Coordinator. She reviewed the documentation and stated the Social Worker did not complete her section of the MDS (sections C and D) until after the Assessment Reference Date (ARD) so the	F 636	Audits to be conducted randomly by the Center Reimbursement Manager (Regional MDS Nurse) or Center Nurse Executive weekly for four weeks, monthly for two months, quarterly for three months and then annually for Sections C, D, and J for accuracy/completion prior to transmission to determine compliance. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Center Reimbursement Manager or Center Nurse Executive to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 12 information was not transferred over the MDS assessment. The MDS Coordinator said the areas should have been completed by the ARD date of 6/18/17. On 12/01/17 at 12:35 PM, an interview was conducted with the interim Director of Nursing who stated she expected the MDS assessments to be accurate and complete. 2. Resident #125 was admitted to the facility on 8/25/127 with multiple diagnoses including Congestive Heart Failure. The admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated that Resident #125 had moderate cognitive impairment. The assessment also indicated that pain interview should be conducted. The pain assessment interview sections indicated "not assessed". On 12/1/17 at 12:10 PM, the MDS Nurse was interviewed. The MDS Nurse reviewed the nursing assessments for Resident #125 and stated that nursing staff did not complete the pain assessment and therefore the pain interview on the MDS indicated "not assessed". The MDS Nurse further indicated that nursing staff was responsible for the pain assessment and the nursing assessment was auto populated to the MDS. She stated that she expected the nursing staff to complete the pain assessment in order for the MDS to be complete. On 12/1/17 at 12:35 PM, the interim Director of Nursing (DON) was interviewed. She stated that her expectation was for the MDS to be complete and accurate.	F 636		
F 641	Accuracy of Assessments	F 641		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641 SS=D	Continued From page 13 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level II Preadmission Screening and Resident Review (Resident #67), hospice (Resident #125), and dental (Resident #68) for 3 of 18 residents reviewed. The findings included: 1. Resident #67 was admitted to the facility on 6/30/15 and most recently readmitted on 10/21/16 with multiple diagnoses that included schizophrenia. Record review indicated Resident #67 had a level II Preadmission Screening and Resident Review (PASRR). The annual MDS assessment dated 10/29/17 indicated a "No" to question A1500 which asked if Resident #67 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. An interview was conducted with the Social Worker (SW) on 12/1/17 at 10:40 AM. She confirmed Resident #67 was a level II PASRR. The MDS dated 10/29/17 for Resident #67 that indicated she was not a level II PASRR was reviewed with the SW. She confirmed the MDS was coded inaccurately.	F 641	Resident # 167 Minimum Data Set (MDS) assessments, Section A1500 PASRR, Resident #125 Section O100K Hospice and Resident #68 Section L0200 Dental were modified to reflect accurate coding. The Center Reimbursement Coordinator did not verify accuracy before submitting. The Center Reimbursement Coordinator shall audit MDS assessments Sections A1500 PASRR, O100K Hospice and L0200 Dental currently in progress for accuracy before completion/transmission. The Clinical Reimbursement Manager (Regional MDS Nurse) will educate the Center Reimbursement Coordinator and Licensed Nursing Staff on the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) for Sections O100K Hospice and L0200 Dental for proper accuracy and completion. The Center Reimbursement Coordinator will educate the Social Worker for Section A1500 for proper accuracy and completion. Audits to be conducted randomly by the Center Reimbursement Manager (Regional MDS Nurse) or Center Nurse Executive weekly for four weeks, monthly for two months, quarterly for three months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 14 An interview was conducted with the interim Director of Nursing (DON) on 12/1/17 at 12:29 PM. She indicated her expectation was for the MDS to be completed accurately. 2. Resident #125 was admitted to the facility on 8/25/17 with multiple diagnoses including Congestive Heart failure. The Admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated that Resident #125 had moderate cognitive impairment and she was not receiving hospice care while a resident at the facility. Review of Resident #125 medical records revealed that the resident was picked up by hospice of 8/26/17. On 12/1/17 at 10:38 AM, the hospice staff member was interviewed. She indicated that Resident #125 was picked up by hospice on 8/26/17. On 12/1/17 at 12:10 PM, the MDS Nurse was interviewed. She verified that Resident #125 was a hospice resident since 8/26/17 and the MDS assessment should have been coded for hospice but it was not. She further indicated that the nursing staff was responsible for the nursing assessment which included the hospice care and the nursing assessment was auto populated to the MDS. On 12/1/17 at 12:35 PM, the interim Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be accurate. 3. Resident #68 was admitted 10/23/17 with cumulative diagnoses of pneumonia, cerebral	F 641	and then annually for Minimum Data Set (MDS) for Sections A1500 PASRR, O100K Hospice and L0200 Dental for accuracy prior to transmission to determine compliance. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Center Reimbursement Manager (Regional MDS Nurse) or Center Nurse Executive to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, members complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 15	F 641		

vascular accident (CVA), chronic obstructive pulmonary disease (COPD) and schizophrenia.

The admission Minimum Data Set (MDS) dated 10/30/17 indicated Resident #68 had severe cognitive impairment, no behaviors and coded for extensive assistance with personal hygiene. She was coded as having no evidence of broken teeth or cavities.

Resident #68 ' s latest revised care plan dated 11/14/17 included no mention of dental concerns. In an observation on 11/28/17 at 12:28 PM, Resident #68 was sitting up in bed. She was determined non-interviewable. Observed were missing front teeth on bottom and top with discoloration to bottom remaining teeth with evidence of tartar.

In an interview on 11/30/17 at 10:20 AM, Nursing Assistant (NA) #3 stated Resident #68 was dressed and her activities of daily living (ADLs) had been completed before she arrived this morning. She stated she had not been assigned Resident #68 until today. NA #3 stated when she assisted Resident #68 with her breakfast on 11/30/17, she noted some missing teeth.

In an interview and assessment with Nurse #1 on 11/30/17 at 10:22 AM, Nurse #1 noted missing front top and bottom teeth with obvious staining and tarter on remaining teeth.

In an interview on 11/30/17 at 11:40 AM, NA #2 stated it can be challenging to perform oral care of Resident #68 due to her resistance and cognition. She stated she had noted missing teeth to upper and lower but did not notice any cavities or tartar.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 16 In an interview on 12/01/17 at 9:47 AM, NA #1 stated she normally worked second shift until 11/27/17. NA #1 stated Resident #68 was resistant to oral care at bedtime and she had noted missing teeth. In an interview on 12/01/17 at 12:00, The MDS nurse stated the floor nurses were responsible to ensure the nursing assessment was an accurate reflection of Resident #68 ' s physical status. The MDS nurse stated by completing and electronically signing the MDS for submission, she was only attesting to the MDS completion, not necessarily the accuracy. In an interview on 12/01/17 at 12:29 PM, the Director of Nursing (DON)stated it was her expectation that any MDS completed and submitted be accurate and expected Resident #68 dental assessment reflect her actual status.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to have a comprehensive and individualized care plan in the areas of respiratory care (Resident #44), dialysis (Resident #176) and Preadmission Screening and Resident Review (PASRR) (Resident #67 and #54) for four of eighteen sampled residents. The findings included: 1. Resident #44 was admitted to the facility on 10/28/17. Cumulative diagnoses included	F 656	The Center Nurse Executive immediately updated resident□s #44 and #176 person-centered care plan with respect with to respiratory care and dialysis. The Social Worker immediately updated care plans of resident #67 and #54. Facility staff failed to follow the facility policy which leads to a deficiency in the area of development of comprehensive care plan. The facility failed to accurately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 Chronic Obstructive Pulmonary disease (COPD) and respiratory failure. An Admission Minimum Data Set (MDS) dated 10/28/17 indicated Resident #44 was cognitively intact. Diagnoses included COPD and respiratory failure. The MDS indicated Resident #44 received oxygen therapy during the assessment period. A review of Resident #44's comprehensive plan of care, most recently revised 11/27/17, revealed no plan of care for COPD, respiratory failure and the use of oxygen therapy. On 11/30/17 at 3:30 PM, an interview was conducted with the interim Director of Nursing. She stated the nursing team completed the care plan for Resident #44. She reviewed the care plan ad stated her expectation was for Resident #44 to have a care plan in place for her diagnosis of COPD and the use of oxygen therapy. 2. Resident #176 was admitted to the facility on 11/10/17. Cumulative diagnoses included End Stage Renal Disease (ESRD) and renal dialysis device. A review of Resident #176's comprehensive plan of care dated 11/11/17 stated Resident #176 was at risk for impaired renal function and at risk for complications related to hemodialysis and renal insufficiency. Approaches included, in part, monitor dialysis access site for + thrill/ +bruit every shift and as needed. Bruit is an abnormal swishing sound heard with a stethoscope over a blood vessel. Thrill is the vibration felt over the chest wall by using one's hand.	F 656	capture any specialized services or rehabilitative services provided in the facility including three items: respiratory care, dialysis, and PASSR II. The Center Nurse Executive completed an audit to identify any other potential residents affected by the deficit practices. None were found to be deficient. The Social Worker completed an audit to identify any other potential resident affected by the deficient practice and found 8 residents that needed their care plan updated. The interdisciplinary team will receive training conducted by the Nurse Practice Educator regarding comprehensive person-centered care plans. Comprehensive person-centered care plan reviews will be completed by the Inter-Disciplinary Team per facility guidelines. The Clinical Reimbursement Manager (Regional MDS Nurse), Nurse Practice Educator, and/or Center Nurse Executive will complete care plan reviews for all residents who are new admissions and/or had a change in condition in the area of dialysis and/or respiratory care weekly x 4 weeks, then monthly x 2 months, quarterly x 3 quarters, and then yearly or until pattern of compliance is achieved. The Center Reimbursement Coordinator will complete care plan audits for Level II PASSR for current and new admissions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 An Admission MDS dated 11/17/17 indicated Resident #176 was cognitively intact. Diagnoses included ESRD. On 11/28/17 at 4:51 PM, an interview was conducted with Resident #176. She stated she went to dialysis every Monday, Wednesday and Friday and received dialysis through a catheter that was inserted in her right groin area. She stated she used to have a dialysis fistula in her left arm but it had clotted and been surgically removed prior to her admission to the facility. On 11/30/17 at 4:49 PM, an interview was conducted with the interim Director of Nursing who stated she expected the care plan to reflect the status of the resident and Resident #176 had a catheter used for dialysis and not a shunt/ fistula. She did not know how the approach monitoring for the thrill/ bruit occurred on the plan of care and said it might have automatically been added to the plan of care. 3. Resident #67 was initially admitted to the facility on 6/30/15 and most recently readmitted on 10/21/16 with multiple diagnoses that included schizophrenia, anxiety, depression, psychotic disorder, and insomnia. Record review indicated Resident #67 had a level II Preadmission Screening and Resident Review (PASRR). The annual Minimum Data Set (MDS) assessment dated 10/29/17 indicated Resident #67's cognition was intact. She had hallucinations and delusions during the MDS review period. Resident #67 had other behaviors 1-3 days during the review period. She was administered antipsychotic medication and	F 656	weekly x 4 weeks, then monthly x 2 months, quarterly x 3 quarters, and then yearly or until pattern of compliance is achieved. Audit results will be reported monthly by the Clinical Reimbursement Manager (Regional MDS Nurse) and the Center Reimbursement Coordinator to Quality Assurance Performance Improvement to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20	F 656		

antianxiety medication on 7 of 7 days.

A review of Resident #67's comprehensive plan of care, most recently reviewed on 11/6/17, revealed no identification or incorporation of her PASRR level II determination.

An interview was conducted with the Social Worker (SW) on 12/1/17 at 10:40 AM. She confirmed Resident #67 was a level II PASRR. The comprehensive plan of care for Resident #67 was reviewed with the SW. She verified there was no incorporation of Resident #67's level II PASRR in her care plan. The SW stated the level II PASRR should have been incorporated into the comprehensive plan of care.

An interview was conducted with the interim Director of Nursing on 12/1/17 at 12:29 PM. She stated she expected the level II PASRR to be incorporated into the comprehensive plan of care.

4. Resident #54 was admitted to the facility on 6/11/08 with multiple diagnoses that included schizophrenia, depression, psychotic disorder, anxiety, and traumatic brain injury.

Record review indicated Resident #54 had a level II Preadmission Screening and Resident Review (PASRR).

The quarterly Minimum Data Set (MDS) assessment dated 10/28/17 indicated Resident #54's cognition was severely impaired. He was administered antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days.

A review of Resident #54's comprehensive plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 of care, most recently reviewed on 11/29/17, revealed no identification or incorporation of his PASRR level II determination. An interview was conducted with the Social Worker (SW) on 12/1/17 at 10:40 AM. She confirmed Resident #54 was a level II PASRR. The comprehensive plan of care for Resident #54 was reviewed with the SW. She verified there was no incorporation of Resident #54 ' s level II PASRR in his care plan. The SW stated the level II PASRR should have been incorporated into the comprehensive plan of care. An interview was conducted with the interim Director of Nursing on 12/1/17 at 12:29 PM. She stated she expected the level II PASRR to be incorporated into the comprehensive plan of care.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 22 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to consistently provide restorative services for range of motion for 1 of 3 residents (Resident #41) reviewed. The findings included: Resident #41 was admitted to the facility on 8/31/16 with multiple diagnoses that included muscular dystrophy, multiple sclerosis, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 10/4/17 indicated Resident #41 ' s cognition was intact. He required the extensive assistance of 2 or more staff with bed mobility, transfers, toileting, dressing, and personal hygiene. He was not steady on his feet and was only able to stabilize with staff assistance. Resident #41 had impaired range of motion on both sides of his lower extremities. A review of Resident #41 ' s plan of care, with a review date of 10/27/17, indicated he required assistance for all Activities of Daily Living (ADLs) related to diagnoses of muscular dystrophy with muscle atrophy. A review of Resident #41 ' s Nursing Assistant (NA) care tasks indicated he was to receive restorative program range of motion 7 days per week. A review of Resident #41 ' s restorative program range of motion documentation in the electronic medical record from 11/2/17 through 11/30/17 revealed range of motion was provided on 9 out	F 688	Range of Motion for resident #41 was corrected on December 1, 2017. The program was updated by the Center Nurse Executive as a task in Point of Care for the CNA□s to see as a range of motion program. Facility failed to consistently provide restorative services for range of motion. This deficient practice has potential to affect all other residents who need ROM and Restorative Programs. Residents with range of motion programs were reviewed by the Center Nurse Executive, Nurse Practice Educator and Unit Manager(s) to ensure that the CNAs can see the tasks in Point Click Care for Range of Motion and all were complete and the tasks were turned on in Point Click Care. Education for nursing staff was completed by the Center Nurse Executive and Nurse Practice Educator on the facility policy on the range of motion program. Education will be completed with new hires on orientation, annually and as needed to maintain compliance. The Unit Managers will conduct random audits for residents with a range of motion program to ensure completion. This will occur weekly for four weeks, monthly for two months, quarterly for three months and annually thereafter. Concerns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 23 of 29 calendar days. Resident #41 refused range of motion on 4 of 29 days (11/18, 11/19, 11/23, 11/28). There were 16 days during the review period of 11/2/17 through 11/30/17 that Resident #41 was not provided range of motion. The 16 days that range of motion services were not provided were: 11/2 - 11/10, 11/12-11/14, 11/21, and 11/24-11/26. An interview was conducted with Resident #41 on 11/28/17 at 3:21 PM. He stated there had been a change in the restorative program and there were no longer restorative NAs. He indicated the NAs on the halls were now supposed to provide restorative services to the residents on their assignment. Resident #41 stated he was supposed to receive range of motion services daily. He revealed he had not received range of motion daily as scheduled since the change in the restorative program. An interview was conducted with the interim Director of Nursing (DON) on 11/30/17 at 3:46 PM. She indicated the restorative program was recently changed in October 2017. She explained the facility previously had a restorative aide providing restorative services, but this had changed and now the NAs on the floor were providing restorative services to the residents on their assignment. The interim DON stated restorative program range of motion was documented in the electronic medical record. She indicated if range of motion was provided the NA was to document the duration. She stated if the resident refused range of motion, the NA was to document the refusal. The interim DON indicated if there was no documentation the range of motion was provided or of the refusal it indicated the range of motion was not completed	F 688	identified through audits will be addressed at that time. Audit results will be reported by the Unit Managers monthly to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 24	F 688		

by the NA.

The interview with the interim DON continued. She stated she was familiar with Resident #41 and stated he was supposed to received range of motion services 7 days per week. She stated yesterday, 11/29/17, Resident #41 reported to her he had not received range of motion and he asked her to provide the range of motion. She indicated she had provided him with range of motion on 11/29/17 as per his request. The range of motion documentation for Resident #41 that indicated he had received range of motion on 9 out of the last 29 days was reviewed with the interim DON. The interim DON revealed that based on the documentation Resident #41 had not been provided range of motion services as scheduled on 16 of the last 29 days.

A second interview was conducted with the interim DON on 11/30/17 at 5:30 PM. She revealed the facility was aware of problems with restorative services being completed and/or documented by the NAs. She reported these restorative services included range of motion and splinting. She indicated an inservice was conducted with some of the NAs on 11/17/17. She stated all NAs had not received the inservice as of this date (11/30/17).

An interview was conducted with NA #2 on 12/1/17 at 9:52 AM. She reported she had worked at the facility since 1995 and she was familiar with Resident #41. She confirmed the NAs on the floor were now responsible for providing restorative services to residents on their assignment. NA #4 stated Resident #41 received range of motion services daily. She indicated if range of motion was provided to Resident #41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25 she documented it. She indicated if range of motion was refused by Resident #41 she documented the refusal. She stated if range of motion was not documented then it was probably not completed. The range of motion documentation that indicated NA #2 had not provided range of motion to Resident #41 on 11/12 and 11/26 was reviewed with NA #2. NA #2 revealed she was unable to recall why range of motion was not provided to Resident #41 on 11/12 or 11/26. A follow up interview was conducted with the interim DON on 12/1/17 at 12:29 PM. She stated she expected range of motion to be provided as scheduled.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 26 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide the nutritional supplement as ordered by the physician for 1 of 3 sampled residents reviewed for nutrition (Resident #72). Findings included: Resident #72 was admitted to the facility on 12/21/15 with multiple diagnoses including Alzheimer's disease. The annual Minimum Data Set (MDS) assessment dated 11/3/17 indicated that Resident #72 had memory and decision making problems and she was dependent on the staff for eating. The assessment further indicated that Resident #72 has a weight loss and she was not on a prescribed weight loss regimen. Resident #72's weights were: 5/3/17 - 130 pounds (lbs.) 6/14/17 - 128 lbs. 7/12/17 - 127 lbs. 8/22/17 - 120 lbs. 9/27/17 - 116 lbs. 10/19/17 - 114 lbs. 11/3/17 - 112 lbs. On 10/4/17, Resident #72 had a physician's order for house supplement 3 times a day with meals. The Dietary notes for Resident #72 dated 10/13/17 indicated that Resident #72's weight on 10/11/17 was 115 lbs., an 11.8% weight loss in 6 months. The notes further indicated that house supplement was recently added on 10/4/17. Resident #72's care plan dated 11/3/17 was	F 692	Resident # 72 is currently receiving house shakes per the physician order. The Dietary Staff failed to put the house shakes/supplements on the residents meal tray. They will now be on individual residents Medication Administration Records which will require follow up by licensed nursing staff. All residents with orders for house shakes/supplements have potential to be effected by this deficient process. All residents who receive a house supplement were audited by the Center Nurse Executive and all had their orders updated or verified that they would populate on the Electronic Medication Administration Record and would require follow up documentation by licensed staff. Licensed Nursing staff to be educated by the Center Nurse Executive and Nurse Practice Educator on providing supplements and following up on how much of the supplement was consumed by the resident and documenting it in Point Click Care. Audits to be conducted randomly by the Unit Manager(s) weekly for four weeks, monthly for two months, quarterly for three months and then annually for residents on house supplements to ensure that residents with orders for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 27 reviewed. One of the care plan problems was the resident was at nutritional risk. The goal was for the resident to maintain a stable weight. The approaches included house supplement 3 times a day. On 11/30/17 at 8:30 AM and at 12:45 PM, Resident #72 was observed when breakfast and lunch tray was served. There was no house supplement served during both observations. The house supplement was written on the dietary card of Resident #72. On 11/30/17 at 1:05 PM, Nurse # 4 was interviewed. She stated that she was assigned to Resident #72. Nurse #4 stated that supplements ordered with meals, the dietary department was responsible for providing it with meals. She indicated that she normally initialed the Medications Administration Record (MAR) to indicate that the house supplement was provided to the resident but she was not checking the tray if it was actually provided to the resident. On 12/1/17 at 8:37 AM, the Dietary Manager was interviewed. She stated that if the nutritional supplement was ordered with meals and was written on the dietary card, the dietary staff was responsible for providing it to the resident every meals. She added that she would in-service the dietary staff about house supplement. On 12/1/17 at 8:45 AM, the Dietary Aide (DA) was interviewed. She was the DA who served lunch in the dining room on 11/30/17. The DA admitted that she didn't serve the nutritional supplement to Resident #72 on 11/30/17 during lunch. The DA also observed the breakfast tray of Resident #72 at 8:40 AM and verified that the supplement was	F 692	house supplements are receiving them. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Unit Managers to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 28 not served and stated that she would get a house supplement from the kitchen and would give it to the resident. On 12/1/17 at 12:30 PM, the interim Director of Nursing (DON) was interviewed. She stated that she expected the dietary staff to send the house supplement each meal as ordered.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 29 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 3 of 5 residents (Residents #53, #54, and #66) reviewed for unnecessary medications. The findings included: 1. Resident #53 was admitted to the facility on 10/8/15 with diagnoses that included anxiety. A physician ' s order dated 12/8/16 indicated Xanax (antianxiety medication) 0.5 milligrams as needed (PRN) every 8 hours for Resident #53. There was no stop date for this PRN Xanax order. The annual Minimum Data Set (MDS) assessment dated 10/14/17 indicated Resident	F 758	Resident #53□s order was rectified to 14 days and then reeval, Resident # 54 and Resident #66□s order was discontinued by the Center Nurse Executive. The facility failed to ensure physician□s orders for as needed (PRN) psychotropic medications were time limited in duration. 22 Residents with orders for as needed (PRN) psychotropic medications have had their physician□s review and update the orders to include a stop date and /or discontinued if not in use. Education was provided to Licensed Nursing staff by the Nurses Practice Educator regarding the requirement of an as needed (PRN) psychotropic medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 30 #53 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #53 received antianxiety medication on 7 of 7 days during the MDS review period. Resident #53's current physician's orders were reviewed on 11/30/17. The Xanax PRN order for Resident #53 was still in place and had no stop date. An interview was conducted with the interim Director of Nursing (DON) on 12/1/17 at 10:10 AM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations. She indicated the facility was aware several residents had PRN orders for psychotropic medications that had no stop dates and they were currently working to discontinue any orders that were not time limited. 2. Resident #66 was initially admitted on 9/23/15 and most recently readmitted on 11/13/15 with diagnoses that included anxiety. A physician ' s order dated 9/6/17 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) as needed (PRN) daily for Resident #66. There was no stop date for this PRN Ativan order. The annual Minimum Data Set (MDS) assessment dated 10/27/17 indicated he cognition was intact. She had other behavioral issues on 1-3 days during the review period and no rejection of care. Resident #66 received antianxiety medication on 7 of 7 days during the MDS review period.	F 758	having an appropriate diagnosis, indication for use and being time limited to 14 days unless the physician completes an assessment and renews the order. The Behavior Committee including the Center Nurse Executive , Unit Managers and Social Services meets weekly and reviews all residents on psychotropic medications to ensure as needed (PRN) medications are addressed appropriately. Audits to be performed by the Center Nurse Executive, Nurse Practice Educator and Unit Manager(s) of as needed (PRN) psychotropic medications to ensure that they have an appropriate diagnosis, indication for use and are time limited. Any issues identified during the audit are to be addressed at that time by contacting the prescriber and obtaining appropriate orders. The audits will be completed weekly for four weeks, monthly for two months, quarterly for 3 quarters and annually thereafter. Any identified issues will be addressed at the time of discovery. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Center Nurse Executive, Nurse Practice Educator or Unit Mangers to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31	F 758	Director is responsible for the follow up.	

A pharmacy consultation report dated 11/15/17 indicated Resident #66 had a PRN order for an Ativan 0.5 mg daily which was in place for greater than 14 days without a stop date. The pharmacy recommendation was to discontinue the PRN Ativan. The psychiatric mental health nurse practitioner agreed with the recommendation and signed the form on 11/21/17.

Resident #66 ' s current physician ' s orders were reviewed on 11/30/17 at 9:00 AM. The Ativan PRN order for Resident #66 was still in place and had no stop date.

Resident #66 ' s current physician ' s orders were again reviewed on 11/30/17 at 10:50 AM. The Ativan PRN order was discontinued.

An interview was conducted with the interim Director of Nursing (DON) on 12/1/17 at 10:10 AM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations. She indicated the facility was aware several residents had PRN orders for psychotropic medications that had no stop dates and they were currently working to discontinue any orders that were not time limited.

3. Resident #54 was admitted to the facility on 6/11/08 with multiple diagnoses that included epilepsy and traumatic brain injury.

A physician ' s order dated 7/17/17 indicated Ativan 2 milligrams/milliliter, inject 1 milligram as needed (PRN) intramuscularly for Resident #54. There was no stop date for this PRN Ativan order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 32 The quarterly Minimum Data Set (MDS) assessment dated 10/28/17 indicated Resident #54 ' s cognition was severely impaired. He had no behaviors and no rejection of care. Resident #54 was administered antianxiety medication on 7 of 7 days during the MDS review period. Resident #54's current physician's orders were reviewed on 11/30/17. The Ativan PRN order for Resident #54 was still in place and had no stop date. An interview was conducted with the interim Director of Nursing (DON) on 12/1/17 at 10:10 AM. She stated her expectation was for all PRN orders for psychotropic medications to be time limited in duration as per the regulations. She indicated the facility was aware several residents had PRN orders for psychotropic medications that had no stop dates and they were currently working to discontinue any orders that were not time limited.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard expired foods in two of two nourishment refrigerators. The findings included: 1. On 11/30/17 at 11:40AM, an observation of the nourishment refrigerator on 300/400 hall was conducted. There were 6 cartons of Great Shakes observed thawed and undated. Instructions on the carton read to discard fourteen (14) days after thawing. On 11/30/17 at 11:45 PM, a tour of the nourishment refrigerators was conducted with the Dietary Manager. She stated the night shit cook filled up the nourishment refrigerators and the dietary staff was responsible for removing expired items. She stated the Great Shakes were dated on the box when they were taken from the freezer to thaw and the date was not put on each individual carton. She discarded the Great Shakes. 2. On 11/30/17 at 11:50 AM, an observation of the nourishment refrigerator in 100/200 hall was conducted. There was one carton of Yoplait yogurt unlabeled with an expiration date of 11/20/17 and four (4) cartons of Activia yogurt unlabeled with an expiration date of 11/24/17. On 11/30/17 at 11:47 AM, a tour of the	F 812	Great Shakes and yogurts were discarded immediately upon discovery. The policy for dating and labeling food items was not followed. Dietary staff will date Great Shakes when they are removed from the freezer. CNA□s and Licensed Nurses will inspect for expiration dates and label food brought in by family. On December 1, 2017 the nourishment refrigerators were inspected by Dietary Manger and there were no expired foods observed. Dietary Staff, CNA□s and Licensed Nurses were educated on 483.60 (i) (2) Food Safety Requirements by the Dietary Manager and/or the Nurse Practice Educator. Signage was placed on nourishment refrigerators as reminders for staff and family regarding the facilities policy on inspecting, dating and labeling food put in the nourishment refrigerators. Nourishment refrigerators will be audited by Unit Mangers weekly for four weeks, monthly for two months, quarterly for three months then yearly. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34 nourishment refrigerator on 100/200 hall was conducted with the Dietary Manager. She stated all nursing and dietary staff should check the refrigerator for resident food and for expired foods and there was a note posted on the refrigerator that foods must be dated and labeled. She said the items in the refrigerator on 100/200 hall might have been put there by family and should have been given to the nurse so the items could have been labeled. She stated the items should have been discarded. She discarded the yogurts.	F 812	Managers to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility ' s Quality Assurance and Performance Improvement	F 865	Previous audits that were put in place in 2016 for F278. F279 and F329 were not carried forward to prevent reoccurrence.	12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 35 committee (QAPI) failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2016. This was for three (3) recited deficiencies which were originally cited on 11/17/16 (F278, F279, F329) during the recertification/complaint survey and on the current recertification/complaint survey on 12/01/17 (F641, F656, F758). The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: 1. F641. Assessment accuracy: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level II Preadmission Screening and Resident Review (Resident #67), hospice (Resident #125), and dental (Resident #68) for 3 of 18 residents reviewed. During the recertification/ complaint survey of 11/17/16, the facility was cited F 278 for failure to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses (Resident #58), medication (Resident #83), and dental status (Resident #63) for 3 of 15 sampled residents. 2. F656. Develop a comprehensive care plan. Based on observation, record review, resident and staff interviews, the facility failed to have a comprehensive and individualized care plan in the areas of respiratory care (Resident #44), dialysis (Resident #176) and Preadmission Screening	F 865	Areas of deficient practice as identified during the most recent annual survey F641, F656 and F758 have been corrected. A new Quality Assurance Performance Improvement team and tools have been initiated and members were educated on the importance of continued audits of previous cited deficiencies to maintain regulatory compliance going forward. Quality Assurance Performance Improvement efforts have improved as evidenced by audits performed specific to F641, F656 and F758. The efforts of the audits are intended to not only obtain regulatory compliance but to prevent regulatory non-compliance issues in the areas referenced in the Plan of Correction. The Center Executive Director will proactively start the process for assessing and determining the need for additional Quality Assurance/Quality Improvement efforts monthly through tracking and trending outliers of Quality Measures and other operational performance of clinical and non-clinical systems through self-identification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 36	F 865		

and Resident Review (PASRR) (Resident #67 and #54) for four of eighteen sampled residents.

During the recertification/complaint survey of 11/17/16, the facility was cited F 279 for failure to develop comprehensive plans of care related to the use of antipsychotic medications for 2 of 7 residents reviewed for unnecessary medications (Residents #58 and #117).

3. F758. Drug regime free from unnecessary medications. Based on record review and staff interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 3 of 5 residents (Residents #53, #54, and #66) reviewed for unnecessary medications.

During the recertification/complaint survey of 11/17/16, the facility was cited for F 329 for failure to consistently monitor and document behaviors to support a clinical rationale for initiation, continuation, and/or increase in dosage of psychotropic medication (Residents #63, #67, #94, and #117) and failed to identify a duplicate order for antihistamine medication resulting in a duplication of therapy (Resident #103) for 5 of 7 residents reviewed for unnecessary medications.

On 12/01/17 at 12:13 PM, an interview was conducted with the Administrator. She stated she assumed her role as Administrator on 9/25/17. Her first QAPI meeting was held October 17,2017. Before that date, she stated she asked for all the information and audits from prior surveys and reviewed the information. The audits revealed the facility was not 100% compliant with F641 (278), F656 (279) and F758 (329). The process they had put in place to fix the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 37 deficiencies last year was not working. The QAPI committee identified areas that were not in compliance and began auditing those areas. In the November QAPI meeting, all the audits were reviewed and there were still some issues with those areas. The Administrator stated the facility has continued to audit and will continue to review those areas until the facility is 100% compliant for three months and yearly thereafter. She stated there had been some staffing issues and staffing changes had been made.	F 865		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and physician interviews and record review, the facility failed ensure an antibiotic medication had an indication for use for 1 (Resident #23) of 1 residents reviewed with urinary catheters. The findings included: Resident #23 was admitted 5/19/14 with cumulative diagnoses of hypertension, anxiety and neurogenic bladder. A review of the Antibiotic Stewardship policy	F 881	Upon identification of the prophylactic antibiotic for the resident #23, the Center Nurse Executive made contact with resident□s attending physician and after further education on the Antibiotic Stewardship Program, recommended discontinuation of the prophylactic antibiotic. The physician, medication was discontinued on 12/09/17. The facility failed to ensure an antibiotic medication had an indication for use for a resident with an indwelling Foley catheter.	12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 38 dated last revised on 6/28/17 indicated the purpose of the policy was to reduce inappropriate antibiotic use, prevent development of antibiotic-resistant organism and prevent adverse outcomes for patients. Providers were to ensure a duration and indication for use especially in the absence of clinical symptoms. The most recent Minimum Data Set (MDS) dated 10/01/17 indicated Resident #23 was cognitively intact, no behaviors and required supervision with her activities of daily living. She was coded as having a urinary catheter. Resident #23 was care planned on 8/07/17 and last revised on 11/07/17 for a risk of infections related to her indwelling urinary catheter. Resident #23 was to remain on a prophylactic antibiotic per her Urologist. Interventions included administration of the medication as ordered, monitoring for symptoms associated with urinary tract infections such as frequency, odor, or sediment. Resident #23 was also care planned for the presence of her indwelling urinary catheter last revised on 8/18/17. The care plan indicated that Resident #23 would refuse at time to allow staff to change her leg bag to a bedside drainage bag at night. The most recent physician progress note dated 10/16/17 read Resident #23 reported her urinary catheter "felt wrong" and stated she wanted to wait to have catheter changed until she saw the Urologist. A Urology note dated 10/27/17 read Resident #23 ' s urinary catheter was changed and she was to	F 881	Audits of 8 residents currently receiving antibiotics was completed by the Center Nurse Executive and Nurse Practice Educator to ensure that they have an appropriate indication and duration. 5 residents of that audit had their orders discontinued. Education for Licensed Nurses and prescribing physicians and nurse practitioners on the facility antibiotic stewardship policy, and that antibiotics require an appropriate diagnosis and duration is to be completed by the Center Nurse Executive and Nurse Practice Educator. New admissions antibiotic orders are to be verified and clarified at the time of admission for new residents. Audits to be completed weekly for four weeks, monthly for two months, quarterly for three months and then annually by the Nurse Practice Educator. Completed audits will be submitted to the Quality Assurance Performance Improvement Committee by the Nurse Practice Educator to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 39	F 881		

return in one month. There were no new orders. She was to continue the Macrodantin.

A review of Resident #23 ' s November 2017 physician orders read an order for Macrodantin (antibiotic) 100 milligrams by month nightly initiated 8/17/17 and an order initiated 8/18/18 to have a bedside drainage bag at night and re-educated for refusals due to risk of backflow and increased risk of infections.

A review of Resident #23 ' s November 2107 Medication Administration Record indicated she received Macodantin nightly as ordered.

A review of Resident #23 ' s November 2017 Treatment Administration Record indicated only two refusals (11/15/17 and 11/28/17) to change her leg bag to a bedside drainage bag at night.

A review of Resident #23 ' s nursing notes and vital signs log for November 2017 indicated she remained afebrile, had no complaints of burning and no documented concerns related to character of her urine.

A review of a Urology note dated 11/28/17 read Resident #23 presented with urinary retention with a chronic indwelling urinary catheter. The note indicated her urinary catheter was changed and she was prescribed Macrodantin. The note read Resident #23 reported some burning her in bladder since last office visit. A review of systems completed per the Urologist on 11/28/17 at 12:26 PM read no blood in urine, no change in bladder habits, no difficulty emptying bladder, no frequency, hematuria, painful urination, pelvic pain, urgency or urine leakage. A review of the urinalysis completed at the Urologist office on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 40	F 881		

11/28/17 read Resident #23 was negative for leukocytes, blood and her urine microscopy was clear. These are indicators of the absence of a urinary tract infection. The plan was for Resident #23 to follow up with the Urologist in month or as needed.

In an interview on 11/29/17 at 10:05 AM, Resident #23 was deemed cognitively intact and stated she went out to her Urologist 11/28/17 for a catheter change. She stated she not comfortable with the staff ' s ability to change her leg bag to a bedside drainage bag and she was aware of the risk of wearing a leg bag at night. She stated she slept with her head elevated and was on an antibiotic prophylactically.

In an interview on 11/29/17 at 4:51 PM, Nurse #2 stated Resident #23 refused to allow anyone at the facility change her urinary catheter and refused to allow the nurses to change her leg bag to a bedside drainage bag at bedtime. Nurse #2 stated Resident #23 stated she was not worried about getting a urinary tract infection because she was on an antibiotic.

The physician left the surveyor a note dated 11/30/17 written on a prescription which read as follows: Please be advised that Resident #23 has been receiving chronic therapy with Macodantin for chronic cystitis, atonic bladder and ureteral stricture. The prescription was signed by the physician.

In an interview on 11/30/17 at 3:25 PM, Nursing Assistant (NA) #4 stated Resident #23 only allowed the aides to assist with the emptying of the leg bag and she always went to bed wearing her leg bag. She stated the nurses were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 41	F 881		

supposed to change her leg bag to a bedside drainage bag at night but Resident #23 refuses.

In an interview on 11/30/17 at 3:30 PM, Nurse #3 stated Resident #23 usually refuses to let her change her leg bag to a bedside drainage bag. She stated they have explained the risk to Resident #23.

In a telephone interview on 12/1/17 at 8:40 AM, the physician stated the Urologist prescribed the antibiotic and since the Urologist was the specialist, he followed the Urologist directive. The physician stated the Macrodantin was used to treat Resident #23 ' s bladder inflammation and it was a low dose of a "useless" antibiotic, not commonly used to treat urinary tract infections anymore.

In an attempted telephone interview with the prescribing Urologist on 12/01/17 at 8:50 AM, the Urologist nurse stated the Macrodantin was prescribed for Resident #23 as a prophylactic measure. A message of left with the nurse for the Urologist to call the surveyor when available. At the time of exit, the Urologist had not returned the surveyor call.

In an interview on 12/01/ 17 at 10:11 AM, the Director of Nursing (DON) stated it was her expectation that Resident #23 have a clinical indication for the continued use of an antibiotic in the absence for symptoms of a urinary tract infection. The DON stated Resident #23 refused to wearing a bedside drainage bag and the risk of urine backflow would be lessened if she would comply the physician recommendation. The DON stated she was not aware if the Urologist was aware of her refusal to wear a bedside drainage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 42 bag at night but stated the physician was aware.	F 881		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer ' s instructions and staff interview, the facility failed to have an oxygen filter on an oxygen concentrator machine for 1 of 3 sampled residents who received oxygen therapy (Resident #44). The findings included: Manufacturer's instructions for the (name) oxygen Concentrator stated "To avoid damage to the internal components of the unit, do not operate the concentrator without the filter installed or with a dirty filter. There is one cabinet filter on the back of the cabinet. Resident #44 was admitted to the facility on 10/28/17. Cumulative diagnoses included Chronic Obstructive Pulmonary disease (COPD) and respiratory failure. An Admission Minimum Data Set (MDS) dated 10/28/17 indicated Resident #44 was cognitively intact. Diagnoses included COPD and respiratory failure. The MDS indicated Resident #44 received oxygen therapy during the assessment period. On 11/28/17 at 4:15 PM, an observation of Resident #44 ' s (name) oxygen concentrator revealed there was no cabinet filter on the back of	F 908	On December 1, 2017 the filter was replaced on the oxygen concentrator for Resident 44 by the Director of Maintenance. Central Supply was reminded to replace the filter when they remove it to clean. Other concentrators were inspected to verify filter placement and all were accounted for and in place. Weekly rounds are completed by Central Supply who was educated on filter cleaning and placement by the Nurse Practice Educator. The Interdisciplinary Team was also educated on filter cleaning and placement. Oxygen concentrators will be audited by the Interdisciplinary Team weekly for four weeks, monthly for two months, quarterly for three months then yearly. Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee by the Interdisciplinary Team to identify trends and further opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued	12/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 43 oxygen concentrator. On 11/29/17 at 4:04 PM, an observation of Resident #44 ' s oxygen concentrator was conducted. There was no cabinet filter on the back of the oxygen concentrator. On 11/30/17 at 2:45 PM, an observation of Resident #44 ' s oxygen concentrator revealed there was no cabinet filter on the back of the oxygen concentrator. On 11/30/17 at 3:10 PM, an observation of Resident #44 ' s oxygen concentrator was conducted with the interim Director of Nursing. The Director of Nursing observed there was no cabinet filter on the back of the oxygen concentrator and stated she was not aware the concentrator should have an outside filter. On 12/01/17 at 9:15 AM, an interview was conducted with the Maintenance Director. He stated he was unaware that there were oxygen concentrators being used by residents without a cabinet filter in place on the machine. He stated he inspected the oxygen machine on a regular basis to make sure they were operating correctly. He was not sure how often he inspected the oxygen concentrators. The Maintenance Director stated the oxygen concentrator machines should have an outside cabinet filter in place. On 12/1/17 at 10:18 AM, the Maintenance Director provided a copy of the Task in Use form that stated oxygen concentrators should be cleaned and inspected weekly by maintenance. On 12/01/17 at 10:35 AM, an interview was	F 908	compliance and the Center Executive Director is responsible for the follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	**400 VISION DRIVE ASHEBORO, NC 27203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 44 conducted with the Administrator who stated her expectation was for the oxygen concentrators to have cabinet filters.	F 908		