STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted onsite 01/18/22 - 01/20/22 and remotely through 01/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # X4U411.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted onsite 01/18/22 - 01/20/22 and remotely through 01/24/22. Event ID # X4U411. 1 of the 1 complaint allegation was not substantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		2/11/22

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

Electronically Signed | 02/09/2022

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner and Physician interviews the facility staff failed to notify the Physician according to the order for a blood glucose result of 447 mg/dl (milligrams per deciliter) for 1 of 5 residents (Resident # 11) whose medications were reviewed. Findings included.	F 580	State Non-Compliance: Facility failed to notify clinician/document Insulin protocols. Corrective action: Education began immediately by facility educator and managers on sliding scale protocol with 100% of clinical staff educated by 2/11/2022. Audit tool created (Verge □ electronic) to monitor	

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F 580	Continued From page 2	F 580		

Resident #11 was admitted to the facility on 03/29/18 with diagnoses to include Diabetes and Alzheimer's Dementia.

A physician's order dated 06/11/21 revealed an order for Humalog Sliding Scale Insulin 4-12 units as needed for high blood sugar. Administration instructions included; for blood glucose 201-250 mg/dl administer 4 units, 251-300 mg/dl administer 6 units, 301-350 mg/dl administer 8 units, 351-400 mg/dl administer 10 units, and blood glucose greater than 400 mg/dl administer 12 units and call the physician.

The Minimum Data Set (MDS) quarterly assessment dated 07/26/21 revealed Resident #11 was severely cognitively impaired. She had no behaviors and no rejection of care. She received insulin during the assessment period.

A care plan dated 09/21/21 revealed Resident #11 had glucose imbalance.The goal of care was to be free of sign or symptoms of hyperglycemia or hypoglycemia. Interventions included to administer medications as ordered, assess blood glucose, and monitor labs.

A physician's order dated 10/12/21 for Resident #11 revealed to perform point of care glucose twice a day.

A review of the blood sugar readings from 12/01/21- 12/31/21 for Resident #11 revealed on 12/24/21 Resident #11's blood sugar reading was recorded as 447 mg/dl at 5:54 PM.

A review of the electronic medical records on 12/24/21 for Resident #11 revealed no documentation that the physician was notified

compliance of documentation on 2/7/2022. Currently there are 10 residents on a sliding scale. Weekly chart audits for these 10 residents began 2/7/2022 and will continue for a minimum of 90 days with goal being >90%.

Who responsible:
Educator/Manager

Sustainability of Compliance:
Will continue to monitor for sustainability compliance of 90 days at >90% compliance to follow with monthly chart auditing of 5 random charts to be reported in our regulatory meetings as requested

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F 580	Continued From page 3 according to the order of a blood sugar of 447 mg/dl. A phone interview was conducted on 01/21/22 with Nurse #2. She stated Resident #11 did refuse care and medications at times including her insulin. She stated if Resident #11's blood sugar was 447 she would have administered insulin. She stated she couldn't recall if she notified the physician on 12/24/21 of the elevated blood sugar. An interview was conducted on 01/20/22 at 2:00 PM with the Director of Nursing. She indicated the nurses were expected to follow the physician's order. A phone interview was conducted on 01/21/22 at 2:00 PM with the Nurse Practitioner. She stated Resident #11 did receive sliding scale insulin as needed for blood sugars greater than 200. She stated the physician should have been notified according to the order for a blood sugar greater than 400, and stated she was not notified on 12/24/21 of the elevated blood sugar. A phone interview was conducted on 01/24/22 at 2:30 PM with the Physician. She stated Resident #11 did have a blood sugar reading recorded on 12/24/21 of 447 at 5:54 PM. She stated the nurses usually notified her of any concerns by text messaging. She stated she did not recall receiving notification on 12/24/21 of any concerns regarding Resident #11 and stated she did not have a text message on 12/24/21 regarding an elevated blood sugar for Resident #11.	F 580		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		2/28/22

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F 636	Continued From page 4	F 636		

§483.20 Resident Assessment
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

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F 636	Continued From page 5 with the resident, as well as communication with licensed and nonlicensed direct care staff 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 record review and staff interviews the facility failed to complete comprehensive Minimum Data Set (MDS) assessments for 3 of 18 residents within 14 days of the ARD (Assessment Reference Date) as outlined in the RAI (Resident Assessment Instrument) User's Manual; Residents #40, #49 and #14. Findings included: 1a. Resident #40 was admitted to the facility on 02/16/18 with diagnoses that included, in part: Type 2 diabetes mellitus with neurological manifestations uncontrolled, COVID-19 2019, vertigo, hypertension, atrial flutter and Alzheimer's disease.	F 636	State Non-Compliance Multiple Minimum Data Set (MDS) records were reviewed with assessments not completed in a timely manner and significant changes not documented within the allotted time frame. Corrective Action: Audit was completed 1/21/2022 for outstanding assessments; education was provided to MDS nurse regarding the importance of timely assessments. Timeline was provided for outstanding assessments to be complete. October □ December assessments complete on or before 2/8/2022. January & February assessments to be completed on or	

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F 636	Continued From page 6 Review of a comprehensive annual MDS assessment for Resident #40 revealed the assessment had an ARD date of 12/14/21 and was due on 12/28/21. At the time of the review 01/18/22 the assessment had not been completed with 17 sections that remained incomplete. 1b. Resident #49 was admitted to the facility on on 12/13/12. Diagnoses included, in part: Stroke, left hemiplegia, osteoarthritis, atrial fibrillation, urinary retention and Alzheimer's disease. Review of a comprehensive annual MDS assessment for Resident #49 revealed the assessment had an ARD date of 10/01/21 and a completion date of 11/29/21. The assessment was not completed within 14 days of the ARD date as outlined in the RAI User's Manual. In an interview conducted with the MDS Nurse on 01/19/22 at 3:00 PM she stated she had not been able to complete the MDS assessments on time, (within 14 days of the ARD dates), because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past there had been three MDS nurses to do the same amount of work. In an interview with the Director of Nursing on 01/19/22 at 4:30 PM she stated she expected the MDS assessments to be completed on time. 2) Resident # 14 was admitted to the facility on 01/16/18 with diagnoses to include Alzheimer's	F 636	before 2/28/2022. Responsible Person: MDS Nurse/Director of Nursing Sustainability of Compliance: Electronic auditing tool set up in Verge to monitor daily with discussion regarding any barriers at the interdisciplinary team meeting. Monitoring will be ongoing for a minimum of 90 days to 100% compliance in maintained for 90 consecutive days (3 months). After the 90 days, there will be random, 5-8 MDS assessments per month reviewed to verify compliance. Compliance will be reported monthly during the regulatory committee meeting.	

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F 636	Continued From page 7 dementia, chronic obstructive pulmonary disease, and chronic kidney disease. A review of the Minimum Data Set (MDS) assessments revealed the last comprehensive assessment had an Assessment Reference Date (ARD) of 11/10/21 with a scheduled completion due date of 11/16/21. As of 01/21/22 Resident # 14's comprehensive MDS assessment was not completed and was 56 days past the completion date. An interview was conducted with the MDS nurse on 1/19/22 at 1:00 PM. She stated she was late completing many of the MDS assessments in the facility because there was only one MDS nurse for 77 residents and she was also asked to work on the unit at times. She stated the Director of Nursing (DON) was aware they needed another MDS nurse but stated she did not reach out to the DON to let her know how many of the assessments were late. An interview was conducted with the DON along with the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed timely.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		2/28/22

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F 637	Continued From page 8 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Base on record review and staff interview, the facility failed to complete 2 significant change in status Minimum Data Set (MDS) assessments within 14 days for 1 of 1 (Resident #28) reviewed for Hospice. The Findings included: Resident #28 was admitted to the facility on 06/09/21 with diagnoses that included dementia, schizophrenia, calciphylaxis non-healing left lower extremity, venous embolism, peripheral vascular disease (PVD), hypertension, gastrostomy, diabetes, and pain. A Hospice Care note dated 08/23/21 was reviewed and indicated Resident #28 received Hospice services that started on 06/27/21 due to resident's imminent death, and discontinued Hospice serviced on 08/23/21 due to Resident #28's stability and lack of decline. A record review revealed a significant change in condition MDS had an Assessment Reference Date (ARD) date 07/09/21 and a completion date of 08/06/21, which indicated the significant change in condition MDS assessment was not completed within 14 days after the Hospice election. A record review revealed a significant change in condition MDS had an ARD date 09/01/21 and a	F 637	State Non-Compliance Multiple Minimum Data Set (MDS) records were reviewed with assessments not completed in a timely manner and significant changes not documented within the allotted time frame. Corrective Action: Audit was completed 1/21/2022 for outstanding assessments; education was provided to MDS nurse regarding the importance of timely assessments. Timeline was provided for outstanding assessments to be complete. October □ December assessments complete on or before 2/8/2022. January & February assessments to be completed on or before 2/28/2022. Responsible Person: MDS Nurse/Director of Nursing Sustainability of Compliance: Electronic auditing tool set up in Verge to monitor daily with discussion regarding any barriers at the interdisciplinary team meeting. Monitoring will be ongoing for a minimum of 90 days to 100% compliance in maintained for 90 consecutive days (3 months). After the 90 days, there will be random, 5-8 MDS assessments per month reviewed to verify compliance.	

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F 637	Continued From page 9 completion date of 10/25/21, which indicated the significant change in condition MDS assessment was not completed within 14 days after the Hospice discontinuation. An interview was conducted with the MDS Nurse on 01/20/22 at 8:40 AM. She stated she was the only MDS Nurse in the facility, and often was pulled to take care of residents and work the medication cart, and did not have time to complete Resident #28's change in condition MDS assessment within the 14 days required. An interview was conducted with the Facility Director (FD)/Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 01/20/22 at 2:00 PM regarding Resident #28's MDS documentation related to her 2 change in condition assessments (07/09/21 and 09/01/21). The FD/DON and the RDCS both stated they expected the 2 change in condition MDS assessments to be completed timely, within 14 days.	F 637	Compliance will be reported monthly during the regulatory committee meeting.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete quarterly Minimum Data Set (MDS) assessments for 7 of 18 residents within 14 days of the ARD (Assessment Reference Date) as outlined in the RAI (Resident	F 638	State Non-Compliance Multiple Minimum Data Set (MDS) records were reviewed with assessments not completed in a timely manner and significant changes not documented	2/28/22

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F 638	Continued From page 10 Assessment Instrument) User's Manual; Residents #60, #56, #11, #26, #39, #51, #28, #12, #25, #29. Findings included: 1a. Resident #60 was admitted to the facility on 08/31/18. Diagnoses included, in part: Type 2 diabetes mellitus, hypertension, chronic bilateral hand and right hip pain, atrial flutter, rheumatoid arthritis, and chronic lumbar stenosis with neurogenic claudication. The most recent quarterly MDS assessment for Resident #60 was reviewed. The assessment had an ARD date of 09/24/21 and a completion date of 12/05/21. The assessment was not completed within 14 days of the ARD date as outlined in the RAI User's Manual. 1b. Resident #56 was admitted to the facility on 07/06/18 with diagnoses that included, in part: Stage 4 chronic kidney disease, Type 2 diabetes mellitus with renal complications, osteoarthritis, hypertension, coronary artery disease status post stents x 3, paroxysmal atrial fibrillation status post a failed cardioversion, pulmonary hypertension and restrictive lung disease. The most recent quarterly MDS assessment for Resident #56 was reviewed. The assessment had an ARD date of 10/05/21 and a completion date of 12/06/21. The assessment was not completed within 14 days of the ARD date as outlined in the RAI User's Manual. In an interview conducted with the MDS Nurse on 01/19/22 at 3:00 PM she stated she had not been able to complete the MDS assessments on time,	F 638	within the allotted time frame. Corrective Action: Audit was completed 1/21/2022 for outstanding assessments; education was provided to MDS nurse regarding the importance of timely assessments. Timeline was provided for outstanding assessments to be complete. October □ December assessments complete on or before 2/8/2022. January & February assessments to be completed on or before 2/28/2022. Responsible Person: MDS Nurse/Director of Nursing Sustainability of Compliance: Electronic auditing tool set up in Verge to monitor daily with discussion regarding any barriers at the interdisciplinary team meeting. Monitoring will be ongoing for a minimum of 90 days to 100% compliance in maintained for 90 consecutive days (3 months). After the 90 days, there will be random, 5-8 MDS assessments per month reviewed to verify compliance. Compliance will be reported monthly during the regulatory committee meeting.	

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F 638	Continued From page 11	F 638		

(within 14 days of the ARD dates), because she had been frequently assigned to work as a staff nurse. She remarked she was currently the only MDS Nurse at the facility and in the past there had been three MDS nurses to do the same amount of work.

In an interview with the Director of Nursing on 01/19/22 at 4:30 PM she stated she expected the MDS assessments to be completed on time.

2a) Resident #11 was admitted to the facility on 03/29/18 with diagnoses to include Diabetes and Alzheimer's dementia.

A review of the Minimum Data Set (MDS) assessments revealed the last quarterly assessment had an Assessment Reference Date (ARD) of 10/25/21, with a 14-day scheduled completion due date of 11/08/21. As of 01/21/22 Resident #11's quarterly MDS was not completed and was 74 days past the 14-day completion date.

An interview was conducted with the MDS nurse on 1/19/22 at 1:00 PM. She stated she was late completing many of the MDS assessments in the facility because there was only one MDS nurse for 77 residents and she was also asked to work on the unit at times. She stated the Director of Nursing (DON) was aware they needed another MDS nurse but stated she did not reach out to the DON to let her know how many of the assessments were late.

An interview was conducted with the DON along

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 12	F 638		

with the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed timely.

2b) Resident # 26 was admitted to the facility on 07/17/17 with diagnoses to include Seizures, Diabetes, and Congestive Heart Failure.

A review of the Minimum Data Set (MDS) assessments revealed the last quarterly assessment had an Assessment Reference Date (ARD) of 11/29/21 with a 14-day scheduled completion due date of 12/13/21. As of 01/21/22 Resident #26's quarterly MDS was not completed and was 39 days past the 14-day completion date.

An interview was conducted with the MDS nurse on 1/19/22 at 1:00 PM. She stated she was late completing many of the MDS assessments in the facility because there was only one MDS nurse for 77 residents and she was also asked to work on the unit at times. She stated the Director of Nursing (DON) was aware they needed another MDS nurse but stated she did not reach out to the DON to let her know how many of the assessments were late.

An interview was conducted with the DON along with the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed timely.

2c) Resident # 39 was admitted to the facility on 06/21/21 with diagnoses to include Alzheimer's dementia.

A review of the Minimum Data Set (MDS) assessments revealed the last quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 13	F 638		

assessment had an Assessment Reference Date (ARD) of 12/15/21 with a 14-day scheduled completion due date of 12/29/21. As of 01/21/22 Resident #39's quarterly MDS was not completed and was 23 days past the 14-day completion date.

An interview was conducted with the MDS nurse on 1/19/22 at 1:00 PM. She stated she was late completing many of the MDS assessments in the facility because there was only one MDS nurse for 77 residents and she was also asked to work on the unit at times. She stated the Director of Nursing (DON) was aware they needed another MDS nurse but stated she did not reach out to the DON to let her know how many of the assessments were late.

An interview was conducted with the DON along with the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed timely.

2d) Resident # 51 was admitted to the facility on 08/27/18 with diagnoses to include Vascular dementia, Diabetes, and Congestive Heart Failure.

A review of the Minimum Data Set (MDS) assessments revealed the last quarterly assessment had an Assessment Reference Date (ARD) of 01/03/22 with a 14-day scheduled completion due date of 01/17/22. As of 01/21/22 Resident # 51's quarterly MDS was not completed and was 4 days past the 14-day completion date.

An interview was conducted with the MDS nurse on 1/19/22 at 1:00 PM. She stated she was late

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 14	F 638		

completing many of the MDS assessments in the facility because there was only one MDS nurse for 77 residents and she was also asked to work on the unit at times. She stated the Director of Nursing (DON) was aware they needed another MDS nurse but stated she did not reach out to the DON to let her know how many of the assessments were late.

An interview was conducted with the DON along with the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed timely.

3a. Resident #28 was admitted to the facility on 06/09/21 with diagnoses that included dementia, schizophrenia, calciphylaxis non-healing left lower extremity, venous embolism, peripheral vascular disease (PVD), hypertension, gastrostomy, diabetes, and pain.

A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS with an Assessment Reference Date (ARD) date 11/30/21, with a 14-day projected completion due date of 12/14/21. As of 01/20/22 Resident #28's quarterly MDS was still not completed, being 37 days past the 14-day completion date.

An interview was conducted with the MDS Nurse on 01/20/22 at 8:40 AM. She stated she was she was behind because she was the only MDS Nurse and was asked to leave the MDS office to assist in other areas of the facility as well as working on the medication cart when needed. She stated she realized her MDS assessments were falling behind, she informed her Director of Nursing (DON) DON and was still waiting for additional assistance.

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 15	F 638		

An interview was conducted with the Facility Director (FD)/Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 01/20/22 at 2:00 PM regarding Resident #28's MDS documentation being late. The FD/DON stated they are looking to hire more nurses, but still expected resident's MDS assessments to be completed timely, within 14 days.

3b. Resident #12 was admitted to the facility on 07/19/19 with diagnoses that included dementia and Alzheimer's.

A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS with an Assessment Reference Date (ARD) date 10/26/21, with a 14-day projected completion due date of 11/09/21. As of 01/20/22 Resident #12's quarterly MDS was still not completed, being 71 days past the 14-day completion date.

An interview was conducted with the MDS Nurse on 01/20/22 at 8:40 AM. She stated she was she was behind because she was the only MDS Nurse and was asked to leave the MDS office to assist in other areas of the facility as well as working on the medication cart when needed. She stated she realized her MDS assessments were falling behind, she informed her Director of Nursing (DON) DON and was still waiting for additional assistance.

An interview was conducted with the Facility Director (FD)/Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 01/20/22 at 2:00 PM regarding Resident #28's MDS documentation being late. The FD/DON stated they are looking to hire more nurses, but still expected resident's MDS assessments to be

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 16	F 638		

completed timely, within 14 days.

3c. Resident #25 was admitted to the facility on 10/02/17 with diagnoses that included dementia, cerebral infarction, seizures, anemia, hypertension, paraplegia, dysphagia, and pain.

A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS with an Assessment Reference Date (ARD) date 11/24/21, with a 14-day projected completion due date of 12/08/21. As of 01/20/22 Resident #25's quarterly MDS was still not completed, being 51 days past the 14-day completion date.

An interview was conducted with the MDS Nurse on 01/20/22 at 8:40 AM. She stated she was she was behind because she was the only MDS Nurse and was asked to leave the MDS office to assist in other areas of the facility as well as working on the medication cart when needed. She stated she realized her MDS assessments were falling behind, she informed her Director of Nursing (DON) DON and was still waiting for additional assistance.

An interview was conducted with the Facility Director (FD)/Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 01/20/22 at 2:00 PM regarding Resident #28's MDS documentation being late. The FD/DON stated they are looking to hire more nurses, but still expected resident's MDS assessments to be completed timely, within 14 days.

4.Resident #29 was admitted to the facility on 1/14/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 638	Continued From page 17 A review of Resident #29's Minimum Data Set (MDS) assessment revealed the most recent quarterly MDS had an Assessment Reference Date (ARD) of 12/02/21 and was observed as not completed on 1/19/22. An interview was conducted with the MDS Nurse on 1/19/21 at 10:55 AM. She stated she knew Resident #29's MDS was overdue. She indicated she had been assigned to be a staff nurse at times and she was unable to complete the MDS assessment in a timely manner. An interview was conducted on 1/20/22 at 12:15 PM with the Director of Nursing (DON) and the Regional Director of Clinical Services. They both stated they expected the MDS assessments to be completed and submitted within the required time frame.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 18 residents reviewed for MDS accuracy. Resident #28 was not accurately coded for Hospice services. Findings included: Resident #28 was admitted to the facility on 06/09/21 with diagnoses that included dementia,	F 641	State Non-Compliance Multiple Minimum Data Set (MDS) records were reviewed with assessments not completed in a timely manner and significant changes not documented within the allotted time frame. Corrective Action: Audit was completed 1/21/2022 for outstanding assessments; education was	2/28/22

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 641	Continued From page 18 schizophrenia, calciphylaxis non-healing left lower extremity, venous embolism, peripheral vascular disease (PVD), hypertension, gastrostomy, diabetes, and pain. Record review indicated Resident #28 had a hospice order placed on 06/27/21 related to problem: Imminent Death. The Quarterly Minimum Data Set (MDS) assessment dated 07/09/21 indicated Resident #28 was not coded for Hospice care. Record review indicated Resident #28 had a hospice order placed on 08/23/21 to discharge resident from Hospice services due to stability and lack of decline. The Quarterly Minimum Data Set (MDS) assessment dated 09/01/21 indicated Resident #28 was coded for Hospice care. An interview was conducted with the MDS Nurse on 01/20/22 at 8:40 AM. She reviewed the 07/09/21, 09/01/21 quarterly assessments for Resident #28 and noted they were coded inaccurately and that the Hospice care box for 07/09/21 quarterly MDS should have been checked yes, and the Hospice care box for 09/01/21 quarterly MDS should have been checked no. She stated they both should have been marked accurately. An interview was conducted with the Facility Director (FD)/Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 01/20/22 at 2:00 PM regarding Resident #28's MDS documentation related to her Hospice care. The FD/DON and the RDCS both stated they expected the MDS to be coded accurately.	F 641	provided to MDS nurse regarding the importance of timely assessments. Timeline was provided for outstanding assessments to be complete. October □ December assessments complete on or before 2/8/2022. January & February assessments to be completed on or before 2/28/2022. Responsible Person: MDS Nurse/Director of Nursing Sustainability of Compliance: Electronic auditing tool set up in Verge to monitor daily with discussion regarding any barriers at the interdisciplinary team meeting. Monitoring will be ongoing for a minimum of 90 days to 100% compliance in maintained for 90 consecutive days (3 months). After the 90 days, there will be random, 5-8 MDS assessments per month reviewed to verify compliance. Compliance will be reported monthly during the regulatory committee meeting.	
F 800 SS=E	Provided Diet Meets Needs of Each Resident	F 800		2/1/22

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 800	Continued From page 19 CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain garden salad at 41 (F.) or below on the lunch tray line. This item could be potentially hazardous if not served at the appropriate temperatures. The findings include: An observation of the lunch meal tray line on 01/19/22 at 10:55 AM. Temperature monitoring by the Dietary Manager (DM) on 01/19/22 at 11:00 AM revealed the following temperatures: 1st tray line garden salad 46 degrees F., and 2nd garden salad taken right out of the tray line refrigerator 43 degrees F. During an interview with the Dietary Manager (DM) and Dietary Area Manager (DAM) on 10/19/22 at 11:35 AM, stated that they expected dietary staff to serve cold foods 41 degrees F. or below, and if temperatures of cold foods were higher than 41 degrees F., the food items should be discarded prior to serving. They both confirmed that the tray line refrigerator's temperature was set at 43 degrees F., and not below 41 degrees F., which resulted in all cold food taken out of the refrigerator to be placed on residents' trays were 43 degrees F. or higher. Both the DM and the ADM stated that the garden	F 800	State Non-Compliance: Temperature of trayline refrigerator was found to be out of range; setting was set at 43 degrees and changed to 41 degrees. New electronic temperature monitoring system (Smart Sense) and equipment installed and went live on 1/4/2022. Corrective Action: Temperature range was noted to have inaccurate settings for trainline refrigerator in the electronic monitoring system (Smart Sense). Temperatures for the dietary refrigerated were re-set immediately. Dietary manager and maintenance staff were trained on new system and how to document corrective action on 2/1/2022. The Smart Sense system is a 24/7 electronic monitoring system that sends alerts to designated staff when out of range. Once notification is received, justifications and corrections can be documented within the electronic system. Who Responsible: Dietary Manager/Maintenance Sustainability of Compliance:	

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 800	Continued From page 20 salad should have been kept cool below 41 degrees F. just prior to serving and was not. During an interview with the Facility Director/Director of Nursing (DON) and Corporate Consultant on 01/19/22 at 4:00 PM, they both reported it was their expectation the facility's kitchens follow all regulatory guidelines for food and kitchen sanitation safety.	F 800	Smart Sense electronic monitoring allows for 24/7 temperature monitoring. The Dietary Manager/designee will be responsible for all alerts along with ensuring notifications are addressed and 100% compliance of corrective action documented. Temperature compliance will be monitored for 90 days with 100% compliance reported in monthly regulatory committee meetings.	
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. (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 observations, staff interviews and record reviews, the facility failed to maintain tray line refrigerators below 41 degrees F. (Fahrenheit) in 1 of 1 tray line refrigerator (a	F 812	State Non-Compliance: Temperature of trayline refrigerator was found to be out of range; setting was set at 43 degrees and changed to 41	2/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 reach in refrigerator). This practice had the potential to affect the food served to all residents. The findings included: An observation on 01/19/22 at 11:00 AM of the tray line reach in refrigerator, noted temperature was 42.3 degrees F. The refrigerator's white "Smart Temp" monitor was 42.8 F. Review of the temperature electronic log by the Dietary Manager (DM) for 01/2022, showed that all refrigerator temperature readings for the newly installed "Smart Temp", which was installed 2 weeks ago, revealed all temperatures were 42.8 F. DM stated he did not know what temperature the tray line refrigerator should be kept at, and since they did not alarm, the temperature must have been okay. An observation on 01/19/22 at 11:15 AM of the tray line reach in refrigerator, showed a temperature of 42.8 degrees F. Inside were 10 individual garden salads, 11 individual cups of whole strawberries, and a large square stainless-steel pan of parsley. Temperatures were obtained by the DM utilizing their Smart Temp electronic monitor located on the side of the refrigerator. One additional garden was tested in the refrigerator to be 42.3 degrees F. Interview with DM on 01/19/22 at 11:20 AM, DM stated the hospital was responsible for monitoring refrigerator temperatures electronically through their new Smart Temp System and that he was unaware that the temperatures in the tray line refrigerator was too high until 01/19/22. An interview was conducted with the DM and Area Dietary Manager (ADM) on 01/19/22 at 11:25 AM. During the interview the ADM and DM	F 812	degrees. New electronic temperature monitoring system (Smart Sense) and equipment installed and went live on 1/4/2022. Corrective Action: Temperature range was noted to have inaccurate settings for trainline refrigerator in the electronic monitoring system (Smart Sense). Temperatures for the dietary refrigerated were re-set immediately. Dietary manager and maintenance staff were trained on new system and how to document corrective action on 2/1/2022. The Smart Sense system is a 24/7 electronic monitoring system that sends alerts to designated staff when out of range. Once notification is received, justifications and corrections can be documented within the electronic system. Who Responsible: Dietary Manager/Maintenance Sustainability of Compliance: Smart Sense electronic monitoring allows for 24/7 temperature monitoring. The Dietary Manager/designee will be responsible for all alerts along with ensuring notifications are addressed and 100% compliance of corrective action documented. Temperature compliance will be monitored for 90 days with 100% compliance reported in monthly regulatory committee meetings.	

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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

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F 812	Continued From page 22 stated they had adjusted the "Smart Temp" monitor on the tray line refrigerator down to the appropriate temperature of 41 degrees F. During an interview with the Facility Director/Director of Nursing (DON) and Corporate Consultant on 01/19/22 at 4:00 PM, they both reported it was their expectation the facility's kitchens follow all regulatory guidelines for food and kitchen sanitation safety. Observation of the tray line refrigerator on 01/20/22 at 12:00 PM, after the Smart Temp monitor was reset at 41 degrees F. on 01/19/22, revealed a tray line refrigerator Smart Temp monitor reading of 41 degrees F.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population	F 838		2/15/22

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F 838	Continued From page 23	F 838		

considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 838	Continued From page 24 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during day-to-day operations. This had the potential to affect all facility residents. Findings included: In an interview conducted with the Director, Population Health, on 01/19/22 at 4:30 PM she stated that she was not familiar with the facility assessment tool. She reported this was the first state survey she had experienced. She explained when the previous administrator left employment she took a lot of things with her and she thought if there had been a facility assessment it had been taken. She commented when she had looked through the reports in the office she had not found a facility assessment. During a second interview at 5:15 PM she stated she had called an administrator friend who told her the facility assessment requirement was part of the 2017 final rule by CMS (Centers for Medicare and Medicaid Services) and provided her with a template to help her complete a facility assessment tool for the facility. She stated she would write the facility assessment tool during the week following the survey.	F 838	State Non-Compliance: Facility assessment not complete due to facility leadership changes and current leadership unaware of requirement. Corrective Action: Interim Director immediately began compiling and completing a facility assessment on 1/21/2022. Facility Assessment will be completed and placed in the Emergency Preparedness Manuel on or before 2/15/2022. Responsible Person: Director of Nursing Sustainability of Compliance: Report of compliance to regulatory meeting as requested, annual review and revision as necessary.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		2/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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F 842	Continued From page 25	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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F 842	Continued From page 26	F 842		

record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, Nurse Practitioner and Physician interviews the facility failed to document the administration or the refusal of Humalog sliding scale insulin for blood glucose results greater than 200 mg/dl (milligrams per deciliter) for 1 of 5 residents (Resident # 11) whose medications were reviewed.

Findings included.

Resident #11 was admitted to the facility on 03/29/18 with diagnoses to include Diabetes and Alzheimer's Dementia.

State Non-Compliance:
Facility failed to notify clinician/document Insulin protocols.

Corrective action:
Education began immediately by facility educator and managers on sliding scale protocol with 100% of clinical staff educated by 2/11/2022. Audit tool created (Verge electronic) to monitor compliance of documentation on 2/7/2022. Currently there are 10 residents on a sliding scale. Weekly chart audits for these 10 residents began 2/7/2022 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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F 842	Continued From page 27 A physician's order dated 06/11/21 revealed an order for Humalog Sliding Scale Insulin 4-12 units as needed for high blood sugar. Administration instructions included; for blood glucose 201-250 mg/dl administer 4 units, 251-300 mg/dl administer 6 units, 301-350 mg/dl administer 8 units, 351-400 mg/dl administer 10 units, and blood glucose greater than 400 mg/dl administer 12 units and call the physician. The Minimum Data Set (MDS) quarterly assessment dated 07/26/21 revealed Resident #11 was severely cognitively impaired. She had no behaviors and no rejection of care. She received insulin during the assessment period. A care plan dated 09/21/21 revealed Resident #11 had glucose imbalance. The goal of care was to be free of sign or symptoms of hyperglycemia or hypoglycemia. Interventions included to administer medications as ordered, assess blood glucose, and monitor labs. A physician's order dated 10/12/21 for Resident #11 revealed to perform point of care glucose twice a day. A review of the blood sugar readings from 11/01/21- 11/30/21 for Resident #11 revealed on 11/11/21 Resident #11's blood sugar reading was recorded as 209 mg/dl at 4:48 PM. A review of the Medication Administration Record (MAR) dated 11/11/21 revealed no sliding scale insulin was documented as administered to Resident #11 for a blood sugar of 209 mg/dl. A review of the progress notes dated 11/11/21	F 842	will continue for a minimum of 90 days with goal being >90%. Who responsible: Educator/Manager Sustainability of Compliance: Will continue to monitor for sustainability compliance of 90 days at >90% compliance to follow with monthly chart auditing of 5 random charts to be reported in our regulatory meetings as requested.	

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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F 842	Continued From page 28	F 842		

revealed no documentation that sliding scale insulin was administered or refused for Resident #11.

A phone interview was conducted on 01/21/22 with Nurse #2. She stated Resident #11 did refuse care and medications at times including her insulin. She stated if the insulin was refused, she would reapproach the resident and sometimes she would still refuse. She stated she couldn't recall if she administered the insulin, or forgot to give the insulin, or if Resident #11 refused the insulin on 11/11/21. She stated she could have forgotten to document whether the insulin was given or refused.

A review of the blood sugar readings from 11/01/21- 11/30/21 for Resident #11 revealed on 11/24/21 Resident #11's blood sugar reading was recorded as 226 mg/dl at 4:23 PM.

A review of the Medication Administration Record (MAR) dated 11/24/21 revealed no sliding scale insulin was documented as administered to Resident #11 for a blood sugar of 226 mg/dl.

A review of the progress notes dated 11/24/21 revealed no documentation that sliding scale insulin was administered or refused for Resident #11.

A phone interview was conducted on 01/21/22 at 3:25 PM with Nurse #3. She stated Resident #11 was not always compliant with care. At times it was difficult to get her to take her medications. She stated as an agency nurse she was still becoming familiar with navigating the electronic medical record and could have missed documenting whether she gave the insulin or if it

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F 842	Continued From page 29	F 842		

was refused. She stated the electronic medical record doesn't prompt you to document whether the insulin was given or refused. She stated she could have given the insulin or could have missed it but stated Resident #11 didn't usually require coverage with sliding scale insulin. She stated although Resident #11 refused medications she always made sure she got her insulin in her. She stated it was also difficult to get her scheduled morning dose of long-acting insulin in and Resident #11 didn't understand why she needed insulin. She stated she knew she didn't give the insulin at times due to Resident #11's behaviors. She stated she must have forgotten to document whether the insulin was given or if it was refused in the medical record.

A review of the blood sugar readings from 12/01/21- 12/31/21 for Resident #11 revealed on 12/03/21 Resident #11's blood sugar reading was recorded as 289 mg/dl at 5:16 PM.

A review of the Medication Administration Record (MAR) dated 12/03/21 revealed no sliding scale insulin was documented as administered to Resident #11 for a blood sugar of 289 mg/dl.

A review of the progress notes dated 12/03/21 revealed no documentation that sliding scale insulin was administered or refused for Resident #11.

An interview was conducted on 01/20/22 at 1:39 PM with Nurse #4. She stated Resident #11 had not refused insulin that she recalled, and she had administered sliding scale insulin to Resident #11 on occasion. She stated she never recalled Resident #11 having signs or symptoms of hyperglycemia or hypoglycemia. She stated the

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	345054	A. BUILDING _____ B. WING _____	C 01/24/2022

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F 842	Continued From page 30	F 842		

nurse aides performed the blood sugar checks and reported the results to the nurse. She stated she was aware of the residents who received insulin and made sure she was aware of the blood sugar readings so that she could administer insulin when needed. She stated if she didn't give the sliding scale insulin when her blood sugar was 289 it was done in error, but she couldn't recall whether she gave the insulin and forgot to document it, or if she just forgot to give the sliding scale, or if the resident refused the insulin.

A review of the blood sugar readings from 12/01/21- 12/31/21 for Resident #11 revealed on 12/24/21 Resident #11's blood sugar reading was recorded as 447 mg/dl at 5:54 PM.

A review of the Medication Administration Record (MAR) dated 12/24/21 revealed no sliding scale insulin was documented as administered to Resident #11 for a blood sugar of 447 mg/dl.

A review of the progress notes dated 12/24/21 revealed no documentation that sliding scale insulin was administered or refused for Resident #11 for blood sugar of 447 mg/dl.

A phone interview was conducted on 01/21/22 with Nurse #2. She stated Resident #11 did refuse care and medications at times including her insulin. She stated if the insulin was refused, she would reapproach the resident and sometimes she would still refuse. She stated if Resident #11's blood sugar was 447 she would have administered insulin. She stated the nurse aides checked the blood sugars and verbally reported the results to the nurse and if the blood sugar was 447 the nurse aides would have reported it immediately. She stated she couldn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 31	F 842		

recall if she administered the insulin, or forgot to give the insulin, or if Resident #11 refused the insulin on 12/24/21. She stated she could have just forgotten to document whether the insulin was given or refused.

An interview was conducted on 01/20/22 at 12:31 PM with Nurse Aide #1. She stated she had worked at the facility for 10 years. She stated Resident #11 had good days and bad days and needed cueing and encouragement. She stated Resident #11 resisted care a times. She stated she did check blood sugars for Resident #11 but didn't recall her having a blood sugar of 447. She stated she would have immediately reported a blood sugar of 447 to the nurse.

An interview was conducted on 01/20/22 at 1:00 PM with the Consultant Pharmacist. She stated Resident #11 received sliding scale insulin as needed. She stated there were occasions when the residents blood sugar was greater than 200 and she should have received insulin according to the physician's order. She stated Resident #11's blood sugar typically ranged in the 100's and she preferred not to have tight control and risk hypoglycemia because Resident #11 had some readings below 80 mg/dl. She stated there was no significant concern if she missed receiving the sliding scale at times and stated she also received a scheduled long-acting insulin every morning. She stated she expected to see documentation in the medical record whether the insulin was administered, held, or refused.

An interview was conducted on 01/20/22 at 2:00 PM with the Director of Nursing. She indicated the nurses were expected to document in the residents medical record when insulin was

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F 842	Continued From page 32	F 842		

administered, not administered, or refused.

A phone interview was conducted on 01/21/22 at 2:00 PM with the Nurse Practitioner. She stated Resident #11 did receive sliding scale insulin as needed for blood sugars greater than 200. She stated Resident #11 did refuse care and medications at times and indicated if the sliding scale insulin was held or refused, she would expect to see it documented in the medical record.

A phone interview was conducted on 01/24/22 at 2:30 PM with the physician. She stated Resident #11 did have a blood sugar reading recorded on 12/24/21 of 447 at 5:54 PM and the following day on 12/25/21 at 5:06 AM her blood sugar was 110 so maybe the insulin could have been given but there was no way she would know that. She stated the nurse should have administered the sliding scale insulin according to the order and if Resident #11 refused her insulin or if the insulin was held for any reason it needed to be documented in the medical record.