STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 11/28/22 through 12/01/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FPR211.	E 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		12/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2022

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F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have code status in the medical record for 1 of 1 resident reviewed for code status (Resident #46). Findings included: Resident #46 was readmitted to the facility on 11/03/22 with diagnoses which included anemia, coronary artery disease, heart failure and hypertension. Review of Resident #46' significant change Minimum Data Set (MDS) assessment dated 11/09/2022 revealed the resident's cognition was moderately impaired. An interview with Resident #46 was conducted on 11/28/2022 at 11:29AM. The resident indicated she did not recall any staff member reviewing code status with her. A review of Resident #46's physician orders for the month of November 2022 revealed no order for code status. An interview with Nurse #1 was conducted on	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F578 A corrective action for facility failed to have code status in the medical record for 1 of 1 resident reviewed for code status (Resident #46). For resident #46, the current code status order was immediately entered into the resident's chart. This was completed by the Administrator on 11/21/2022. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/15/2022, the nurse consultant	

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F 578	Continued From page 2 11/30/22 at 9:20 AM. She stated Resident #46's code status should be in the electronic medical record. Resident #46's electronic record was reviewed with Nurse #1, and she indicated the code status should be at the top of the resident's electronic record which would have populated when the code status order was entered. An interview with the Admission Coordinator was conducted on 12/01/22 at 12:25 PM. She stated that she reviewed code status information with families or the residents during the admission to the facility. She stated the Social Worker (SW) was responsible for reviewing the code status with families or residents during a readmission. The Admission Coordinator indicated she did not know the reason why Resident #46's code status was not indicated in her electronic record. The Social Worker (SW) was unavailable for an interview. An interview was conducted on 12/01/2022 at 11:15 AM with the Director of Nursing (DON). The DON revealed it was her expectation for the resident's code status to be in the medical record on the same day of admission. She indicated Resident #46 should have had orders with her code status in the record. On 12/01/22 at 2:12 PM an interview was conducted with the Administrator who stated she expected all residents to have code status indicated in their electronic medical record when admitted or readmitted to the facility.	F 578	audited all current resident's physician orders to ensure all resident's had a code status entered. This was completed on 12/15/2022. Systemic changes In-service education began on 12/21/22 by the Director of Nursing and Staff Development Coordinator and was provided to all full time, part time, and as needed Nurse and agency nurses. Topics included: " Code status policy In-service education began on 12/21/2022 by the Administrator and was provided to all full time, part time, and as needed Director of Nursing, Support Nurses, MDS Nurse, and SW. Topics included: " Clinical review for code status This information has been integrated into the standard orientation training and in the required in-service refresher courses for above mentioned staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not received the education by 12/29/2022 will not be allowed to work until it has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor tag F578 using the Code Status QA tool for auditing physician orders for current code status order. Audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented to	

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F 578	Continued From page 3	F 578	the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident and staff, the facility failed to ensure residents diagnosed with Post-Traumatic Stress Disorder (PTSD) had person-centered care plans developed with individualized approaches that direct staff on how to care for their assessed needs for 2 of 3 residents (Resident #24 and Resident #52) reviewed for PTSD. The findings included:	F 742	F-742 1.Treatment/Services Mental/Psychosocial Concerns Corrective actions for Resident #24 The care plan for resident #24 was revised in order to include their diagnosis of Post-Traumatic Stress Disorder, including resident-specific interventions. This was completed by the facility MDS Nurse on 11/30/22. Corrective actions for Resident #52 The care plan for resident #52 was revised in order to include their diagnosis of	12/29/22

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F 742	Continued From page 4 1. Resident #24 was admitted to the facility on 10/19/2021 with multiple diagnoses that included depression and Post Traumatic Stress Disorder (PTSD). A review of the "Trauma-Informed Care and Diverse Resident Admission Assessment." dated 03/10/2021 revealed Resident#24 was identified with a traumatic life altering circumstances of war. The annual Minimum Data Set (MDS) assessment dated 09/13/22 indicated Resident #24's cognition was intact. He had no behaviors and no rejection of care. A review of Resident #24's care plan revised on 09/16/22. Revealed Resident #24 was not care planned for individualized approaches related to her history of trauma. An observation and interview were conducted for Resident #24 on 11/29/2022 at 10:30 AM. The resident was lying in bed and no behavioral symptoms were noted. The resident indicated he did not have any psychiatrist services at the moment. An interview was conducted with Nursing Assistant (NA) #1 on 11/29/22 at 10:55 AM. She indicated that she was unaware Resident #24 had a history of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #24. During an interview with the Social Worker (SW) on 11/29/21 at 1:00 PM, She verified that Resident #24's care plan included no person centered and individualized approaches to care	F 742	Post-Traumatic Stress Disorder, including resident-specific interventions. This was completed by the facility MDS Nurse on 11/30/22. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents who have a diagnosis of Post-Traumatic Stress Disorder will be completed in order to determine if all are care planned for past trauma and to determine if care plan contains resident-specific interventions. 3. This audit will be completed by the facility MDS Nurse no later than 12/22/22. Any resident who is identified as having a diagnosis of Post-Traumatic Stress Disorder and their care plan does not reflect past trauma will have their care plan revised and updated in order ensure that it reflects past trauma and resident-specific interventions. This will be completed by the facility Minimum Data Set Coordinator no later than 12/22/22. Systemic Changes The Regional Minimum Data Set Consultant will provide in-service training for the facility Minimum Data Set Nurse and Social Services Director on 12/19/22 that includes the importance of thoroughly reviewing residents□ medical chart in order to identify if they have a history of trauma and/or diagnosis of Post-Traumatic Stress Disorder. The facility must take necessary steps to ensure that each resident receives	

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F 742	Continued From page 5 for Resident #24 in relation to her diagnosis of PTSD. The SW acknowledged that a care plan that provided the staff with non-pharmacological interventions and approaches to care was essential for the staff to know how best to care for Resident #24. During an interview with Minimum Data Set (MDS) nurse on 11/29/2022 at 1:22 PM, she verified that Resident #24 had a diagnosis of PTSD. She stated that it was essential for the facility staff to have a care plan in place that provided them with person-centered approaches to care for Resident #24 in relation to her history of PTSD. An interview was conducted with Nurse #1 on 11/30/22 at 11:30 AM. She indicated that she was unaware Resident #24 had a diagnosis of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #24 An interview was conducted with the Director of Nursing (DON) and Administrator on 11/30/22 at 12:14 PM. They both indicated their expectation was for a care plan to be developed that included person-centered and individualized approaches to care for residents who had a diagnosis of PTSD. 2. Resident #52 was admitted to the facility on 05/12/2022 with multiple diagnoses that included depression, anxiety, and Post Traumatic Stress Disorder (PTSD). Review of hospital discharge summary dated 05/12/2022 revealed Resident#52 was discharged from the hospital with a diagnosis of PTSD.	F 742	appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Residents who are admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome. All residents who are identified as having past trauma must have this reflected on their care plan along with specific and individualized interventions. Having this information on the care plan provides guidance to direct care staff in order for them to provide the care necessary for each resident. Resident-specific items care planned for residents with past trauma will minimize the risk for the resident being re-traumatized and/or triggered. The facility must provide the appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. The determination of what is	

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F 742	Continued From page 6 The quarterly Minimum Data Set (MDS) assessment dated 11/15/22 indicated Resident #52's cognition was intact. He had no behaviors and no rejection of care and had a diagnosis of PTSD. A review of Resident #52's care plan revised on 11/16/22. Revealed Resident #52 was not care planned for individualized approaches related to her history of PTSD. An observation and interview were conducted for Resident #52 on 11/28/2022 at 11:30 AM. The resident was lying in bed and no behavioral symptoms were noted. During interview he indicated he was unhappy at the facility because he had been sick and was just readmitted from the hospital recently. He indicated he would like to move to another facility. An interview was conducted with Nursing Assistant (NA) #1 on 11/29/22 at 10:55 AM. She indicated that she was unaware Resident #52 had a history of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #52. An interview was conducted with Nurse #1 on 11/30/22 at 11:30 PM. She indicated that she was unaware Resident #52 had a diagnosis of PTSD. She further indicated there were no specific interventions or approaches to care for Resident #52. During an interview with the SW on 11/29/21 at 1:00 PM, She verified that Resident #52's care plan included no person centered and individualized approaches to care for Resident	F 742	appropriate is person-centered and would be based on the individualized assessment and comprehensive care plan. To the extent that the care plan identifies particular treatment and services, the facility must make reasonable attempts to provide these services directly or assist residents with accessing such services. A facility must determine through its facility assessment what types of behavioral health services it may be able to provide. Some examples of treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for autonomy; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. The coping skills of a person with a history of trauma or PTSD will vary, so assessment of symptoms and implementation of care strategies should be highly individualized. Facilities should use evidence-based interventions, if possible. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing the care plans for all residents who have been identified as having a	

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F 742	Continued From page 7 #52 in relation to her diagnosis of PTSD. The SW acknowledged that a care plan that provided the staff with non-pharmacological interventions and approaches to care was essential for the staff to know how best to care for Resident #24. During an interview with Minimum Data Set (MDS) nurse on 11/29/2022 at 1:22 PM, she verified that Resident #52 had a history of PTSD. She stated that it was essential for the facility staff to have a care plan in place that provided them with person-centered approaches to care for Resident #52 in relation to her history of PTSD. An interview was conducted with the Director of Nursing (DON) and Administrator on 11/30/22 at 12:14 PM. They both indicated their expectation was for a care plan to be developed that included person-centered and individualized approaches to care for residents who had a diagnosis of PTSD.	F 742	history of trauma or have a diagnosis of Post-Traumatic Stress Disorder in order to ensure that the care plan is reflective of this condition as well as resident-specific interventions and to ensure that this plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 12/29/2022	
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	F 812		12/29/22

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F 812	Continued From page 8 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, record review and interviews with facility staff, the facility failed to date opened food items stored for use in the reach-in refrigerator and to discard foods past their use by date for 1 of 1 reach-in refrigerator. This practice had the potential to affect foods served to the residents. The findings included: On 11/28/22 at 10:36 AM an observation of the of the reach-in refrigerator was conducted with the Dietary Manager. The observation revealed a plastic container of what appeared to be left over pudding unlabeled and there was no date or time noted, and a cheese sandwich unlabeled with no date. There was also a plastic container of leftover sliced mixed fruit dated 11/17/22 and peaches with date of 11/17/22. On 11/28/22 at 10:50 AM the Dietary Manager stated food items that did not contain a label should have been labeled properly. She added the items past seven days old should have been discarded by the dietary staff. The Dietary Manager also continued to explain that staff had	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 11/29/2022. During initial walk through of the kitchen, it was noted dietary services had failed to date/label a container of leftover pudding and a cheese sandwich; and discard a plastic container of sliced mixed fruit and peaches dated 11/17/22 in the reach in refrigerator. On 11/29/2022 the Dietitian Consultant and Nutrition Service Coordinator	

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F 812	Continued From page 9 called out the weekend and one of cooks had quit so someone had forgot to remove the expired food and failed to label the containers. She was unsure if the items were checked over the weekend and stated all foods in storage should have been labeled and expired dated foods should have been removed after seven days. She stated she did not have enough people in the kitchen on the weekend to complete all the tasks. During an interview with the Administrator on 12/01/22 at 2:00 PM she stated food items stored in any of the facility refrigerators should be labeled and dated correctly.	F 812	discarded non-labeled/dated and outdated items from reach in refrigerator. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 11/29/2022, the Dietary Service Director, Dietitian Consultant, and Nutrition Service Coordinator completed a kitchen walk through to ensure all food items were within their dates and dated properly. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by Dietary Manager on 11/30/22. Topics included: " Storage and dating policies and regulations. " Use By Dates " Inspections on shifts to observe all food are within their dates and tossed if out of date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Dietary Service Director will complete weekly kitchen inspection audits and the	

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F 812	Continued From page 10	F 812	Administrator will complete at least monthly. 4. Quality Assurance monitoring procedure. The Dietary Service Director, Dietitian, or designee will monitor procedures for proper food storage weekly x 3 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	