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 04/20/2023

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
E 000	Initial Comments An unannounced recertification survey was conducted on 4/17/2023 through 4/20/2023. The facility was found in compliance with the requirement CFR 483.72, Emergency Preparedness. Event ID# PUWW11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted 4/17/2023 through 4/20/2023. 21 of 39 complaint allegations resulted in federal citations. Intakes investigated on the survey included: NC00196340, NC00193712, NC00192934, NC00192134, NC00191343, NC00194361, NC00191764, NC00200214, NC00200229, NC00200199, NC00196588, NC00197292. Event ID# PUWW11	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to assess the self-administration of medications for 2 of 2 residents (Resident #5 and Resident #47) reviewed for self-administration. The findings included: 1. Resident #5 was admitted to the facility on	F 554	F 554 Self Administration of Medications Resident #5, albuterol was removed from the resident's room unit manager on 4/20/23. Self Administration of Medication Assessment was completed on 4/20/23 and determined that resident # 5 is unable to self administer medications. Resident # 47 Witch Hazel-Glycerin pads	5/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/09/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING ______ B. WING ______	C 04/20/2023

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 554 Continued From page 1

02/06/21 with multiple diagnoses including acute and chronic respiratory failure and chronic obstructive pulmonary disease.

The quarterly Minimum Data Set (MDS) assessment dated 02/24/23 indicated Resident #5's cognition was intact.

Resident #5 had a physician's order dated 02/27/23 for Albuterol Sulfate HFA inhaler 2 puff inhale orally every 4 hours as needed for shortness of breath.

Resident #5 was observed on 04/17/23 at 12:15 PM to have the Albuterol Sulfate inhaler on his overbed table. When interviewed, Resident #5 stated he had been using the inhaler since his admission. He stated the facility had always left the inhaler with him, so he did not have to ask every 4 hours to use it.

Review of Resident #5's medical records revealed that he did not have an assessment for self-administration of medication nor a physician's order to self-administer medications.

An observation and interview conducted with Nurse #3 on 04/19/23 at 9:12 AM revealed Resident #5 had the Albuterol Sulfate inhaler on his bedside table. She stated the resident did not have an order to self-administer medications. She indicated he should have an order and an assessment to self-administer before medications can be left at bedside. She further stated she did not know who was responsible for assessing the resident for self-administration.

The Director of Nursing (DON) was interviewed on 04/19/23 at 3:20 PM. The DON stated she had

F 554

were removed from the resident's room unit manager on 4/20/23. Self Administration Assessment was completed on 4/20/23 and determined that resident # 47 is unable to self administer pads.

All residents requiring medication have the potential to be affected. A whole house lookback audit of residents/resident's rooms was completed by Nurse Leadership designee 4/21/23 for medications being kept at bedside.

Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding Self Administration of Medications and medications being kept at bedside. Ongoing education to be completed during New Employee Orientation and annual Education.

The Director of Nursing/designee will complete an audit of all residents/resident rooms for medications being kept at bedside weekly x4 weeks to begin 5/01/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

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 04/20/2023

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 554	Continued From page 2 only been the DON for 3 weeks. She stated residents must have a physician's order and an assessment prior to medications being left at beside. The DON added that she did not know Resident #5 was self-administering medications. 2. Resident #47 was admitted to the facility with multiple diagnosis which included unspecified hemorrhoids, constipation, and need for assistance with personal care. Resident #47 had a physician order dated 02/10/22 for Witch Hazel-Glycerin Pads, apply to hemorrhoids topically as needed for hemorrhoids. The quarterly Minimum Data Set (MDS) assessment dated 02/03/23 indicated Resident #47's cognition was moderately impaired. Resident #47 was observed on 04/17/23 at 10:19 AM to have the Witch Hazel topical pads at beside. When interviewed, Resident #47 indicated she wanted to keep them at bedside because staff used them every time she had a bowel movement for the treatment of hemorrhoids. Review of Resident #47's medical records revealed that she did not have an assessment for self-administration of medication nor a physician's order to self-administer medications. An observation and interview conducted with Nurse #3 at 04/19/23 at 9:15 AM revealed Resident #47 had the Witch Hazel topical pads at bedside. She stated the resident did not have an order to self-administer medications, and the Witch Hazel topical pads should not have been kept at beside. She stated they should have been	F 554	Director of Nursing will be responsible for implementation of the 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 04/20/2023

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 554	Continued From page 3 kept in the treatment cart and did not know why the Witch Hazel topical pads were in Resident #47's room. The Director of Nursing (DON) was interviewed on 04/19/23 at 3:20 PM. The DON stated she had only been the DON for 3 weeks. She stated residents must have a physician's order and an assessment prior to medications being left at beside.	F 554		
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 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;	F 584		5/17/23

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 04/20/2023

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 4 §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 and staff interviews, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) vents (Rooms #104, #111, #206, #207, #302, #308, #310, #312, #316, #404, #405, #407 and #408). This was for 13 of 16 resident rooms reviewed for comfortable, clean, and homelike environment. The findings included: 1. On 4/17/23 from 10:30 AM to 12:00 PM the following was observed: - Room 302 PTAC vent had a large amount of grey dust particles and thick yellow material throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. - Room 308 PTAC vent had a thick amount of white substance throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. - Room 310 PTAC vent had scattered particles of potato chip and a thick white material throughout	F 584	F584 Safe, Clean and Homelike Environment Upon identification, the identified PTAC units in rooms 104, 111,206, 207, 302,308, 310,312, 316, 404, 405, 407, 408 were cleaned by the Maintenance Director/ designee on or before 5/3/23. A whole house audit of PTAC units was conducted by the Maintenance Director/designee and any identified units out of compliance were cleaned on or before 5/3/23. All residents have the potential to be affected. Education for the PTAC cleaning expectations will be completed by the Senior Administrator/designee on or before 5/8/23 with the Maintenance and Housekeeping staff. This education will also be completed upon hire for staff to include new contracted agency	

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 04/20/2023

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
the vent area. The room was occupied and the PTAC was running at the time of the observation.
- Room 312 PTAC vent had a large amount of grey dust particles. The room was occupied and the PTAC was running at the time of the observation.
- Room 316 PTAC vent had a large amount of dried white material and grey dust particles throughout the vent area. The room was occupied and the PTAC was running at the time of the observation.

On 4/19/23 at 2:54 PM, an observation of rooms 302, 308, 310, 312 and 316 was conducted during a round with the Maintenance Director. He explained housekeeping cleaned the outside of the PTAC and anything inside the vents would be cleaned by the Maintenance department. The Maintenance Director added that the PTACs were to be cleaned monthly. He confirmed the vents were dirty with various particles in them and required cleaning.

Housekeeper #1 was interviewed on 4/19/23 at 3:03 PM. She explained that housekeepers cleaned the outside of the PTAC units and used a brush to the outer vents to help remove the dust but anything inside the vents would be taken care of by the Maintenance department.

The Administrator was interviewed on 4/20/23 at 11:17 AM and stated she would expect the PTACs to be clean.
2. On 4/18/23 from 08:30 AM to 12:00 PM the following was observed:

a. Room 404 PTAC vent had a large amount of grey dust particles throughout the vent area. The room was occupied and the PTAC was running at

F 584

orientation.

The Senior Administrator/ designee will complete 5 random PTAC audits x4 weeks to begin on 5/1/23, then bi-weekly x2 weeks, then monthly x1 month.

Center leadership increased the frequency of monitoring from a monthly task in Tels Maintenance System to twice monthly to sustain compliance.

Results of these audits will be brought before the Quality Assurance Performance Improvement Committee by the Administrator/designee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

The Senior Administrator will be responsible for implementation of the 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 04/20/2023

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 the time of the observation. b. Room 405 PTAC vent had a thick amount of grey dust participles throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. c. Room 407 PTAC vent had scattered grey dust particles and a piece of paper throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. d. Room 408 PTAC vent had a large amount of grey dust particles. The room was occupied and the PTAC was running at the time of the observation. On 4/19/23 at 2:56 PM, an observation of rooms 404, 405, 407, and 408 was conducted during a round with the Maintenance Director. He explained housekeeping cleaned the outside of the PTAC and anything inside the vents would be cleaned by the Maintenance department. The Maintenance Director added that the PTACs were to be cleaned monthly. He confirmed the vents were filled with various particles in them and required cleaning. Housekeeper #1 was interviewed on 4/19/23 at 3:03 PM. She explained that housekeepers cleaned the outside of the PTAC units and used a brush to the outer vents to help remove the dust but anything inside the vents would be taken care of by the Maintenance department. The Administrator was interviewed on 4/20/23 at 11:17 AM and stated she would expect the PTACs to be clean. 3. On 04/18/23 from 2:32 PM to 3:23 PM the	F 584		

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 04/20/2023

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 following was observed: a) Room 206 PTAC vent had a moderate amount of grey dust and lint build up throughout the vent. The PTAC was running at time of observation and the room was occupied. b) Room 207 PTAC vent had a large amount of grey dust and white particles throughout the vent. The PTAC was running at time of observation and the room was occupied. On 4/19/23 at 02:59 PM an observation of rooms 206 and 207 was conducted during a round with the Maintenance Director. He stated the Maintenance department cleaned the filters and grills in the PTAC units once a month. He confirmed the vents in rooms 206 and 207 had lint and debris built up in them and need to be cleaned. Housekeeper #1 was interviewed on 4/19/23 at 3:03 PM. She explained that housekeepers cleaned the outside of the PTAC units and used a brush to the outer vents to help remove the dust but anything inside the vents would be taken care of by the Maintenance department. The Administrator was interviewed on 4/20/23 at 11:17 AM and stated she would expect the PTACs to be clean. 4. On 4/18/23 from 09:30 AM to 12:30 PM the following was observed: a. Room 104 PTAC vent had grey dust particles and white pieces of debris throughout the vent. The room was occupied and the PTAC was running at the time of the observation.	F 584		

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 04/20/2023

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 b. Room 111 PTAC vent had grey dust participles and brown and black pieces of debris throughout the vent. The room was occupied and the PTAC was running at the time of the observation. On 4/19/23 at 2:56 PM an interview with the Maintenance Director. He stated housekeeping was responsible for cleaning the outside of the PTAC, and anything inside the vents should have been cleaned by the maintenance department. The Maintenance Director further stated the PTACs were cleaned monthly. He confirmed the vents were filled with various particles in them and required cleaning. Housekeeper #1 was interviewed on 4/19/23 at 3:03 PM. She stated housekeepers cleaned the outside of the PTAC units and the inside of the vents were cleaned by the Maintenance department. The Administrator was interviewed on 4/20/23 at 11:17 AM and stated she would expect the PTACs to be free of dust and debris.	F 584		
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 reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of feeding tube (Resident #89) and bowel continence (Resident #70). This was for 2 of 23 resident records reviewed.	F 641	F641 Accuracy of Assessments The identified residents with errors, #89 and #70 had modifications of the errors identified re-submitted on 4/20/23 by the Minimum Data Set nurse.	5/17/23

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 04/20/2023

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 9

The findings included:

1. Resident #89 was admitted to the facility on 2/18/22 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy status (presence of a feeding tube-PEG tube).

A review of Resident #89's physician orders revealed an order dated 2/18/22 to flush PEG tube with 250 milliliters (ml) of water twice a day.

The annual Minimum Data Set (MDS) assessment dated 2/24/23 indicated Resident #89 was cognitively intact. It did not include the presence of a feeding tube nor the amount of water received via the feeding tube during the seven day look back period.

Resident #89's active care plan, last reviewed 3/13/23, included a focus area for a feeding tube present to meet nutritional needs due to history of a stroke and dysphagia. Tube feeding had been discontinued due to excellent meal intake. One of the interventions included flushing the feeding tube with 250 ml of water twice a day.

On 4/20/23 at 10:39 AM, an interview occurred with the MDS Nurse who reviewed the nutrition area on the 2/24/23 MDS and stated it was an oversight not to have coded the fluid received via the feeding tube.

During an interview with the Administrator on 4/20/23 at 11:17 Am, she stated it was her expectation for the MDS to be coded accurately.

2. Resident #70 was admitted on 4/11/22 with a diagnosis of Parkinson's Disease and colostomy

F 641

All residents have the potential to be affected. The MDS nurse/designee will audit the assessments completed for the last 30 days from 4/24/23 to include bowel, feeding and oxygen coding for assessment accuracy on or before 5/1/23.

Education completed by Senior Administrator/designee for MDS staff and nursing leadership on assessment accuracy on or before 5/1/23.

The Interim Administrator /designee will complete 5 random MDS audits for coding accuracy for the identified sections x4 weeks to begin 4/24/23, then bi-weekly x2 weeks, then monthly x1 month.

Results of these audits will be brought before the Quality Assurance Performance Improvement Committee by the Administrator for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

The Senior Administrator will be responsible for implementation of the plan.

Date of compliance will be 5/17/2023.

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 04/20/2023

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 10 (a piece of the colon diverted to an artificial opening in the abdominal wall to bypass a damped part of the colon). Review of Resident #70's cumulative Physician orders included an order dated 4/12/22 for daily colostomy care. Resident #70's care plan dated 4/12/23 last revised on 2/8/23 had him care planned for a risk of skin breakdown related to the colostomy. The quarterly Minimum Data Set (MDS) dated 3/3/23 indicated Resident #70 had severe cognitive impairment and was coded as always incontinent of bowel. The MDS Nurse was interviewed on 4/20/23 at 10:40 AM. She stated she should have coded his bowel continence as not rated due to his colostomy. She stated it was an oversight. The Administrator was interviewed on 4/20/23 at 11:45 AM. She also stated Resident #70's bowel continence should have been coded as no rated due to his colostomy.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		5/17/23

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 04/20/2023

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 11 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care	F 656	F656 Develop/Implement Comprehensive Care 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 04/20/2023

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 12

plan in the area of contractures. This was for 1 (Resident #70) of 23 residents reviewed for care planning. The findings included:

Resident #70 was admitted on 4/11/22 with a diagnosis of Parkinson's Disease and a contracture to his left hand.

Resident #70's care plan dated initiated 4/12/22 and last revised on 3/1/23 did not include a comprehensive care plan related to his left-hand contracture.

The quarterly Minimum Data Set (MDS) dated 3/3/23 indicated Resident #70 had severe cognitive impairment and coded for impairment to one side of his upper extremities.

The MDS Nurse was interviewed on 4/20/23 at 10:40 AM. She stated she should have developed a care plan for Resident #70's left hand contracture and stated it was an oversight.

The Administrator was interviewed on 4/20/23 at 11:45 AM. She also stated Resident #70's left hand contracture should have been care planned with appropriate interventions.

F 656

Care plan was updated for Resident # 70 to reflect left-hand contracture by the Director of Nursing/designee on 4/21/23.

All residents with contractures have a potential to be affected. A whole house care plan audit was completed by nursing leadership/designee for all residents with contractures was completed on 5/3/23 to ensure residents with contractures are care planned for diagnosis. All current residents with contractures were assessed to ensure a care plan was in place related to contracture.

Education was completed on or before 5/323 by Nurse Practice Educator or designee for licensed nurses (Full-time, Part-time, PRN and Agency) on all shifts and weekends, and MDS Coordinator regarding initiating a care plan related to resident contractures.

Center will conduct weekly Clinical Rounds with Nursing and therapy and C.N.A□s to monitor for changes in residents ROM, presence of new and/or worsening contractures and ensure that care plans are in place accordingly. Results of these rounds will be brought before the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

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 04/20/2023

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 13	F 656	The Director of Nursing will be responsible for implementation of this plan. Date of compliance will be 5/17/2023.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide scheduled showers for a resident requiring total staff assistance with bathing/showering. This was for 1 (Resident #70) of 3 residents reviewed for activities of daily living. The findings included: Resident #70 was admitted on 4/11/22 with a diagnosis of Parkinson's Disease. Resident #70's care plan dated 5/2/22 last revised on 11/1/22 read he refused his colostomy bag changes and eating. The care plan also read he refused care but there no documentation stating what care he refused. The annual Minimum Data Set (MDS) dated 1/26/23 indicated Resident #70 was coded with severe cognitive impairment, exhibiting no behaviors and he required total staff assistance with bathing. An observation was completed on 4/17/23 at 11:11 AM. Resident #70 was in bed wearing a	F 677	F677 ADL Care for Dependent Residents Resident #70, was given a shower on 4/19/23 and 4/20/23 and is currently receiving a shower twice per week. All residents requiring assistance with showers have the potential to be affected. A whole house 30 day lookback audit was completed by Director of Nursing/Unit Managers/Nurse Practice Educator/Wound Nurse (Nursing Leadership) for the dates of 3/23/23 to 4/21/23 for all residents/resident showers to determine if residents had received two showers per week and the showers were documented accordingly. Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding shower schedules. Education to include offering	5/17/23

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 04/20/2023

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 677 Continued From page 14

facility gown and an odor was noted. Also observed was his hair and facial hair appeared unkept. An interview was completed with Nursing Assistant (NA) #9 who was in the room at the time stated he was supposed to get a shower today.

Another observation was completed on 4/18/23 at 8:57 AM. NA #1 and NA #7 were in the room at the time. NA #1 stated she completed Resident #70's bed bath to include washing his contracted left hand and filed his fingernails. Resident #70 appeared clean, groomed and absent of any odors.

Review of the shower documentation for Resident #70 was reviewed from 1/1/23 to 4/19/23. In January 2023 the documentation read he received a total of 4 showers on 1/4/23, 1/5/23, 1/11/23 and 1/25/23. In February 2023 the documentation read he refused a shower on 2/2/23 and received a total of 1 shower on 2/22/23. In March 2023 the documentation read he received a total of 2 showers on 3/1/23 and 3/2/23, and in April 2023 he did not receive a shower until 4/19/23.

Review of the bed bath documentation for April 2023 read Resident #70 did not receive a bed bath on 4/4/23, 4/7/23, 4/8/23, 4/9/23, 4/11/23, 4/12/23 and 4/13/23.

The Administrator stated on 4/20/23 at 9:24 AM that Resident #70 was scheduled for his showers on Monday's and Wednesday's and were completed by a shower team consisting of NA # 3 and NA # 4.

Interviews were completed on 4/20/23 at 9:37 AM

F 677

showers to each Resident on their scheduled shower days and to document, on shower sheets, when showers are given and/or refused. Ongoing education to be completed during New Employee Orientation and annual Education.

The Director of Nursing/designee will audit 25 random residents/resident shower sheets to determine compliance to shower schedule and any refusals of showers weekly x4 weeks to begin 5/01/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance

Director of Nursing will be responsible for implementation of the plan.

Date of compliance will be 5/17/2023.

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 04/20/2023

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 677	Continued From page 15 with NA #3 and NA #4. Both confirmed they were the facility's shower team and NA #4 stated Resident #70 was assigned to her to shower. NA #3 stated she was out of work last week and NA #4 stated she was pulled to work the floor Monday 4/17/23 so she did not give Resident #70 his shower. Both NA #4 and NA #3 stated the shower team starting in September and in the beginning they were often pulled to work on the floor, but both stated that it had improved, and they were not pulled off the shower team as much. NA #4 stated most of the time, third shift already had Resident #70 up in his chair, dressed and bathed. A telephone interview was completed on 4/19/23 at 5:35 PM with NA #5. She stated she worked the third shift, and that Resident #70 was not to be gotten up and bathed on third shift. NA #5 stated it was the shower team's responsibility to give a resident's showers. On 4/20/23 at 11:00 AM, NA #6 stated she worked third shift. She stated the facility had a shower team and they completed all the showers. She also stated she did not recall ever getting Resident #70 up and giving a bed bath on third shift. The Administrator was interviewed on 4/20/23 at 11:45 AM. She also stated Resident #70's should be receiving his showers on the days he was supposed to get a shower.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		5/17/23

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 04/20/2023

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 684	Continued From page 16 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations and staff, Nurse Practitioner (NP), Medical Director (MD) interviews and record review, the facility failed to have systems in place to identify a contracture which resulted in an avoidable wound where 3 fingernails on the resident's left hand punctured 2 areas into the palm of his contracted left hand requiring the need for wound care. The facility also failed to complete and document weekly assessments of the wound (Resident #70). This was for 1 of 2 residents reviewed providing care according to professional standards of practice. The findings included: 1. Resident #70 was admitted on 4/11/22 with a diagnosis of Parkinson's Disease. The quarterly Minimum Data Set (MDS) dated 10/26/22 indicated Resident #70 had severe cognitive impairment, was not coded for rejection of care, required extensive staff assistance with personal hygiene and he was coded for no limitation in range of motion to his upper extremities. Resident #70's care plan dated 5/2/22 last revised on 11/1/22 read he refused care but there was no documentation stating what care he refused.	F 684	F684 Quality of Care Resident #70 palm was assessed by RN Wound Nurse on 5/8/23 and found to be resolved/healed, Wound Nurse documented healed status of wound in medical record. Resident # 70 currently has a hand splint in place and is donned according to order daily. Resident # 70 had a new therapy screen on 4/25/23. All residents noted with Limited range of motion/contractures have a potential to be affected. A whole house lookback audit was completed by Nurse Leadership designee for all residents with the potential for contractures on 4/21/23, with follow up with therapy and physician as indicated. All residents with current wounds have the potential to be affected. Nursing Leadership completed a 100% audit of current residents with wounds on 4/21/23, to ensure that weekly Wound Documentation was in place. Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A	

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 04/20/2023

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 684

Continued From page 17

The MDS Nurse was interviewed on 4/20/23 at 10:40 AM. She stated since she coded Resident #70 with no impairment to his left upper extremity, there must have been no observed evidence of it when she completed his quarterly MDS on 10/26/22.

Review of a skin assessment completed by Nurse #3 dated 1/3/23 read there were no identified skin injuries or wounds.

An interview was completed on 4/20/23 at 11:10 AM with Nurse #3. She stated she completed Resident #70's skin assessment on 1/3/23 and did not remember seeing any concerns to any open areas or injuries to his left hand. Nurse #3 stated she was aware he had some contracting of the fingers on his left hand, but she thought therapy was aware of it.

Review of shower and nail care documentation dated 1/4/23 read Nursing Assistant (NA) #4 provided a shower and nail care on 1/4/23 on first shift.

An interview was completed on 4/20/23 at 9:37 AM with NA #4. She stated when she showered Resident #70 on 1/4/23, she did not observe the fingernails required trimming. NA #4 stated she did not recall providing nail care on 1/4/23 to Resident #70.

Review of an incident report dated 1/4/23 at 10:56 PM and completed by the Treatment Nurse read she was notified by NA #3 that Resident #70 had a wound on his left hand and she observed that

F 684

(Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding identification of contractures and nail care . Education included identifying limitations in range of motion/contractures, reporting limitations/contractures, process for referrals to therapy for limited range of motion and nail care. Ongoing education to be completed during New Employee Orientation.

Education was completed by the Director of Nursing on 5/8/23 with the Wound Nurse on the process and requirement for Weekly Wound Documentation on all wounds.

Center will conduct weekly Clinical Rounds with Nursing and therapy and C.N.A's to monitor for changes in residents ROM, presence of new and/or worsening contractures with appropriate therapy referrals and/or physician notification as indicated. Director of Nursing/designee to audit 5 residents with wounds weekly x4 weeks to begin 5/01/23, then bi-weekly x2 weeks, then monthly x1 month to ensure Weekly Wound Documentation is in place. Results of these rounds and audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

Director of Nursing will be responsible 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 04/20/2023

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 684	Continued From page 18	F 684		

the fingernails on his left hand had punctured into his left palm. There was a small amount of bloody drainage noted. The incident report read that his fingernails were clipped, and orders were given to cleanse the wound to left palm with wound cleanser, pat dry, apply calcium alginate (a dressing used to absorb the wound fluid resulting in a gel that maintains a moist environment to minimize bacterial infections) and dry dressing daily.

Interviews were completed on 4/20/23 at 9:37 AM with NA #3 and NA #4. Both confirmed they were the facility's shower team. NA #4 stated she provided Resident #70 his nail care on his shower days when he would allow it because he often jerked his hand away, but she could not recall if he did that on 1/4/23. She stated they were supposed to notify the nurse whenever he refused and document it on the shower sheet. NA #4 stated when she showered Resident #70 on 12/1/22, 12/7/22, 12/14/22, 12/21/22 and 1/4/23, she had difficulty opening his hand due to his contracture so she would only wash in inner part of his palm that was visible and only trim the fingernails she could get to whenever Resident #70 would cooperate with her trimming his fingernails. NA #4 stated she could not recall how long or when she started having difficulty opening Resident #70 left hand due to a contracture, but she did not report it to anyone. NA #3 stated she was the aide who first identified Resident #70's fingernails on this left hand had grown so long they punctured his palm and noted difficulty opening his hand to fully see the wounds. She recalled assisting another aide in moving Resident #70 up in his bed when she noticed some bloody drainage and what looked like a hole in his palm, so she let the Treatment Nurse

implementation of the 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 04/20/2023

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 684	Continued From page 19 know. NA #3 stated since that happened, they were to file his nails down instead of cutting them. Review of Resident #70's electronic medical record did not include documented evidence of any wound assessments after the wound was identified on 1/4/23. An interview was completed on 4/20/23 at 9:11 AM with the Treatment Nurse. She stated when NA #3 discovered the wounds to Resident #70's hand, she completed an assessment and the incident report. She stated she observed 2 open areas to his left palm. The Treatment Nurse stated the areas presented with a small amount of serosanguineous (clear drainage with tinged blood) drainage but no odor. The Treatment Nurse stated it was not considered a pressure ulcer but rather it was classified on the incident report as an abrasion that was self-inflicted. She recalled calling one of the Physicians on-call who gave her wound care orders on 1/4/23. A few weeks later, she contacted the NP who gave new orders for the Bacitracin. She stated she did not perform any weekly wound assessments on Resident #70's wounds to his left palm because the area was not considered a pressure ulcer but rather a laceration and she understood that they had healed. She stated the nurses were still applying Bacitracin with a dry dressing and gauze wrap for protection every day. She stated the shower team aides were to provide nail care on a resident's shower days. Review of an interdisciplinary team (IDT) note completed by the MDS Nurse dated 1/5/23 read they discussed the wound to Resident #70's left palm identified on 1/4/23 due to his fingernails and interventions were implemented. The	F 684		

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 04/20/2023

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 684	Continued From page 20	F 684		

intervention was to ensure his fingernails were clipped as needed and treatment orders were in place.

Review of an Occupational Therapy (OT) evaluation dated 1/17/23 revealed a referral was made due to increased skin to skin contact in Resident #70's left palm with nursing reporting fingernail marks in his left palm due to the development of a contracture. The goal read Resident #70 would be able to tolerate a left upper extremity orthotic grip splint or a therapy carrot to promote skin integrity and reduce further contracture.

An interview was completed on 4/19/23 at 10:58 AM with the OT. He stated he received a referral on 1/17/23 to evaluate concerns about a contracture that developed to Resident #70's left hand. He stated he provided therapy to stretch out the fingers on his left hand and prescribed a palm guard for protection. He stated there was no additional skilled need to continue therapy after 3/3/23. The OT stated the process was for the nursing department to make a referral to therapy about a resident with newly identified in changes in range of motion, but he had not received any referral about Resident #70's left hand until 1/17/23. The OT stated it was difficult to say the contracture could have been avoided but the worsening of his contracture was avoidable if it had been identified earlier.

A new wound care order dated 2/14/23 read to cleanse the wound to his left palm with wound cleanser, pat dry, apply Bacitracin (a topical antibiotic ointment) and dry dressing daily.

Review of a new Physician order dated 2/24/23

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 04/20/2023

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 684	Continued From page 21	F 684		

read a palm guard was recommended to Resident #70's left hand and as tolerated and to check his skin integrity every shift.

Review of the February, March and April 2023 treatment administration record (TAR) included documented evidence with nurses' initials that treatment was provided as ordered and skin integrity was being checked every shift.

Review of the OT discharge summary dated 3/3/23 read Resident #70 was now tolerating a modified palm guard to his left hand. The treatment results were communicated to the IDT.

An observation of Resident #70 was completed on 4/17/23 at 11:11 AM. He was in bed with a palm guard to his left hand.

An interview was completed on 4/17/23 at 11:11 AM with NA #9. She stated she did not recall if Resident #70's left hand was contracted prior to the injury found on 1/4/23. She stated if it was contracted, she assumed the nurses and therapy already knew about it. NA #9 stated the shower team would be providing Resident #70 a shower today. She also stated the shower team provided his nail care and the nurses applied his palm guard daily. NA #9 stated on the days he received a bed bath, and she was able to clean his left hand, but it was difficult because he didn't like anyone to mess with his hand.

An interview was completed on 4/18/23 at 8:57 AM with NA #1 in Resident #70's room. NA #1 stated she completed Resident #70's bed bath and she went ahead and filed his fingernails. An observation was completed of Resident #70's left

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 04/20/2023

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 684	Continued From page 22 hand with NA #1. She was able to open his left hand and fingers with some difficultly due to the contracture and his resistance. She stated she had not been assigned Resident #70 in a long time and could not recall if he already had the contracture to his left hand prior to what happened with his fingernails. Observed was a scarred area to his left lower palm where his 3rd and 4th fingernails appeared to have made contact. Another scar was observed to his upper palm that appeared to be from where his 2nd fingernail made contact. There were no observed open areas. A telephone interview was completed on 4/19/23 at 10:15 AM with the NP. She stated she did not recall anyone letting her know about Resident #70's fingernails and resulting wounds in his left palm. She also stated something like that should never occur to any resident in a nursing facility and was avoidable with basic hygiene. An interview was completed on 4/20/23 at 12:20 PM with the MD. He stated what happened to Resident #70 should never happen in the long-term care setting and was unacceptable. The Administrator stated on 4/20/23 at 9:24 AM the shower team was responsible for providing nail care on the resident's shower days and the floor aides provided nail care as needed. The Administrator was interviewed on 4/20/23 at 11:45 AM. She stated Resident #70's should have never developed an injury because of his fingernails.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		5/17/23

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 04/20/2023

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 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 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to apply hand splints for contracture management for 2 of 3 residents reviewed for limited range of motion (Residents #89 and #55). The findings included: 1. Resident #89 was admitted to the facility on 2/18/22 with diagnoses that included a history of a stroke and contracture to the right hand and wrist. An Occupational Therapy (OT) initial evaluation dated 8/15/22, indicated Resident #89 would receive therapy for contracture to the right hand and wrist.	F 688	F688 Prevent decrease in ROM Resident # 89 Right wrist and hand grip splint is currently being donned per physician order. Resident # 55 ,Right elbow support and hand therapy carrot is currently being donned/applied per physician order. All residents noted with Limited range of motion/contractures requiring a splint/orthotic have a potential to be affected. A whole house lookback audit was completed 4/21/23 by Nurse Leadership designee for all residents requiring a splint, with appropriate therapy referrals and physician notification as	

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 04/20/2023

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 Review of Resident #89's physician orders included an order dated 8/30/22 to wear a right wrist and hand grip splint up to four hours as tolerated. An OT discharge summary dated 8/31/22 indicated Resident #89 received OT therapy for a right hand and wrist contracture. Upon discharge, the OT recommendation was for Resident #89 to wear the right wrist and hand splint for four hours a day. An annual Minimum Data Set (MDS) assessment dated 2/24/23 indicated Resident #89 was cognitively intact and displayed no behaviors or rejection of care. He was coded with limited range of motion to one upper extremity. The care plan, last reviewed 3/13/23, included a focus area for exhibits or is at risk for alterations in functional mobility related to contracture deformity to the right hand and wrist. One of the interventions was recommendation for right wrist and hand grip splint up to four hours as tolerated. A review of Resident #89's Nurse Aide (NA) flow records for April 2023 did not include an entry for the use of the right wrist and hand splint. A review of the April 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include an entry for Resident #89's right wrist and hand splint application or removal. An observation of Resident #89 was completed on 4/17/23 at 12:20 PM. The resident was up in his wheelchair in the common area. His right	F 688	indicated. Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding splint/orthotic placement . Education to include placement of resident splint/orthotic per physician order for limitations in range of motion/contractures, Ongoing education to be completed during New Employee Orientation. The Director of Nursing/designee will complete an audit of all resident splint placement weekly x4 weeks , then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible for implementation of the plan. Date of compliance will be 5/17/2023.	

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 04/20/2023

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	F 688		

hand was curled in a fist resting in his lap and his right leg was on a footrest. Resident stated he did not wear his splint often because "no one put it on." Resident #89 was unable to state when he wore the right wrist and hand splint last.

On 4/18/23 at 9:13 AM, Resident #89 was observed lying in bed watching TV and the right wrist and hand splint was lying on a nightstand in his room.

Resident #89 was observed lying in his bed watching TV on 4/18/23 and 2:00 PM and stated during an interview conducted in conjunction with the observation, he had not been asked to put the right wrist and hand splint on "for a while".

NA #1 was interviewed on 4/18/23 at 2:45 PM and stated if a resident had a splint the nurses put them on and took them off. She was unaware if Resident #89 had a splint.

Resident #89 was observed on 4/19/23 at 10:45 AM, sitting in his wheelchair in the common area with the splint present to the right wrist and hand. During an interview he stated that the OT put it on that morning for him.

On 4/19/23 at 10:58 AM, the OT was interviewed and stated he placed the right hand and wrist splint on Resident #89 this morning but did not state why. He further explained that when a resident was discharged from OT services the NAs were trained on how to put the splint on and an order was placed to clarify the use of the splint. He added there was an order for the splint and in the care plan that was visible to the NAs and nursing 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 04/20/2023

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		F 688		

Continued From page 26
Nurse Manager #1 was interviewed on 4/19/23 at 11:28 AM and stated when a resident was discharged from OT services an order was placed regarding the splint parameters and then generally nursing would be responsible for putting on the splints as well as removing them.

On 4/19/23 at 11:35 AM, an interview occurred with Nurse #1 who was assigned to Resident #89. She stated she was not sure who was to put on the resident's splint and was not aware he had one as there was no order for it.

An interview occurred with NA #2 who was familiar with Resident #89 and explained she had worked at the facility for about six months. She stated "whoever got to the resident first puts on the splint. That could be the nurses, nurse aide or therapy." She was unable to state why Resident #89 did not have the splint on earlier in the week only to say that "sometimes he refused to wear it because he uses that hand to propel in the wheelchair".

On 4/19/23 at 1:30 PM, an interview occurred with the Administrator who explained the order for Resident #89's right wrist and hand splint did not show up on the NA flow record or nursing MAR/TAR because when OT put in the order it was put in under an auxiliary tab which did not go anywhere. She further stated there was a drop-down box when the order was put in and OT should have checked the TAR box, so the order showed for nursing staff to put the splint on and remove.
2. Resident #55 was admitted to the facility on 9/17/2019 with diagnoses that included a history of a traumatic brain injury and contracture to the right wrist and hand.

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 04/20/2023

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		F 688		

Continued From page 27

A quarterly Minimum Data Set (MDS) assessment dated 1/4/2023 indicated Resident #55 was severely cognitively impaired and displayed no rejection of care. She was coded with limited range of motion to one upper extremity.

A review of Resident #55's active orders revealed a physician's order for right elbow support and hand therapy carrot as tolerated and to check each shift. The orders was dated 1/4/2023

An OT discharge summary dated 1/25/2023 indicated Resident #55 received OT therapy from 1/11/2023 through 1/24/2023 for a right elbow and wrist contracture. Upon discharge, the OT recommendation was for Resident #55 to wear the right elbow support and therapy carrot as tolerated to reduce risk for contracture and skin integrity problems.

The care plan, last reviewed 4/17/2023, included a focus area for risk for alterations in functional mobility related to contracture deformity to the right elbow and wrist. Interventions included right elbow support and hand therapy carrot as tolerated.

A review of Resident #55's Nurse Aide (NA) flow records for April 2023 indicated the resident was to wear a right elbow support and hand therapy carrot as tolerated.

A review of the April 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not contain an entry for Resident #55's right elbow splint or hand

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 04/20/2023

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		F 688		

Continued From page 28
carrot application or refusal.

An observation of Resident #55 was completed on 4 /17/2023 at 9:54AM. She was lying in bed with her eyes closed. She was not wearing elbow support or hand carrot. They were observed on the dresser next to her bed

On 4/18/23 at 2:55 AM, Resident #55 was observed lying in bed without her elbow support or hand carrot. They were observed on the dresser next to her bed.

Resident #55 was observed on 4/19/2023 at 11:00AM lying in her bed with eyes closed. She was not wearing her elbow support or hand carrot. They were observed on the dresser next to her bed.

NA # 9 was interviewed on 4/19/23 at 11:15 AM and stated she provided care for Resident #55 on 4/18/2023 and 4/19/2023 and was unaware Resident #55 had a splint. She further stated the therapy staff and the nurses apply the splints. She had not been trained how to apply splints.

On 4/19/2023 at 11:30 AM an interview was conducted with Nurse #6, who was assigned to Resident #55. Nurse #6 stated therapy, nurses, or NAs could apply the splint. She stated the resident is known to refuse but did not recall if she or the other staff were documenting refusals. She did not recall the last time she had seen the resident wearing the splint.

On 4/19/2023 at 11:39 AM AM, the OT was interviewed. He stated when Resident #55 was discharged from OT services, the NAs were trained on how to apply the splint, a picture 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 04/20/2023

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 29 how to apply the splint was scanned into the resident's medical record, and an order was placed in the medical record to clarify the use of the splint. He further stated the order and the care plan are all visible to the NAs and if they had questions, they could ask the nurse or therapy services. Nurse Manager #1 was interviewed on 4/19/23 at 11:28 AM and stated when a resident was discharged from OT services an order was placed regarding the splint parameters and then generally nursing would be responsible for putting on the splints as well as removing them. On 4/19/23 at 1:30 PM, an interview occurred with the Administrator. She stated splints should be applied per physician's order by either the NA or the Nurse assigned to the patient and refusals should be documented.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to implement their smoking policy for conducting quarterly smoking assessments, ensuring a resident assessed as an unsafe smoker was	F 689	F689 Accidents/Hazards Resident # 69 had a Smoking assessment completed on 4/18/23 , and his care plan updated to reflect	5/17/23

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 04/20/2023

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 689

Continued From page 30

supervised, smoking materials were secured, and cigarette butts were disposed of safely for 1 of 3 residents (Resident #69) reviewed for accidents.

Findings included:

Review of the facility smoking policy read in part, supervised smoking is defined as "The observer must be in the direct area of the smoker, within eye contact, and able to respond to emergency situations." It further read in part, "Smoking materials for supervised smokers will be required to be locked at the nurse's station. No residents will be allowed to maintain their own lighter or matches. Residents will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely and, if necessary, will be supervised. The resident should properly dispose of ashes or butts.

Resident #69 was admitted to the facility on 09/02/21 with diagnosis that included Bi-Polar disorder, Parkinson's disease, Dementia, lack of coordination and anxiety.

Resident #69's smoking evaluation dated 04/04/22 revealed resident was an unsafe smoker and required direct supervision while smoking due to resident dropping cigarettes a lot due to hand weakness.

Resident #69 ' s quarterly Minimum Data Set (MDS) assessment dated 02/09/23 revealed his cognition was moderately impaired, no behaviors, was assessed as independent with locomotion on and off the unit, and he utilized a wheelchair.

Resident #69 ' s care plan, last reviewed on 02/23/23, revealed a focus that read he may

F 689

Supervised Smoking. Resident # 69 is currently being supervised for all smoking times.

All resident smokers have a potential to be affected. A new smoking assessment was completed by nursing leadership for all smokers was completed by Nurse Leadership designee on 4/25/23 to ensure safe smoking and supervision provided as indicated. All current residents that smoke were assessed to ensure that their smoking materials were secured appropriately.

Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding smokers, supervised and unsupervised. Education included assistance with utilization of lighting cigarettes, supervising smoking in accordance with assessed needs, ensuring disposal receptacles are available in smoking areas, monitoring compliance with policy, maintaining resident smoking materials at the nurses station and smoking assessments to be completed quarterly and with significant changes. Ongoing education to be completed during New Employee Orientation. All current resident smokers to be educated on smoking policy. Ongoing education to be completed with new admissions, quarterly and with change of condition with the ability to smoke safely.

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 04/20/2023

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 689	Continued From page 31 smoke with supervision per smoking assessment. The interventions included: assistance with utilization of lighting cigarette, supervise patient with smoking in accordance with assessed needs, ensure that appropriate cigarette disposal receptacles are available in smoking areas, monitor compliance to smoking policy, educate resident on the facility's smoking policy, and maintain patients smoking materials at nurses' station. Resident #69 ' s medical record revealed no evidence of a smoking assessment being completed after 04/04/22. Record review revealed Resident #69 was listed on the smokers list as an unsupervised smoker. An interview was conducted on 04/18/23 at 11:24 AM with the Social Worker (SW). The SW stated she kept the smoking list current and updated to reflect the hall, resident name, and if the smoker was supervised or not supervised. She also stated nursing staff notified her if the status of a resident had been changed or if a resident had been admitted or discharged from the facility. A copy of the list was kept at each nursing station. The SW stated she was unaware Resident #69 was a supervised smoker and she did not recall who or when it was changed to unsupervised on the list. An observation and interview were conducted on 04/18/23 at 9:31 AM with Resident #69. He stated he went outside to smoke when he wanted to and that he was not supervised by staff. He also stated he always kept his cigarettes and lighter in his cooler bag on his wheelchair. Strong odor of	F 689	The Director of Nursing/designee will complete an audit of all resident smokers, supervised and unsupervised, for smoking safety, proper disposal of cigarette butts and proper storage of smoking materials Daily x4 weeks, then bi-weekly x2 weeks, then weekly x1 month, randomly thereafter. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible for implementation of the plan. Date of compliance will be 5/17/2023.	

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 04/20/2023

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 689	Continued From page 32	F 689		

burnt cigarettes coming from a small insulated cooler bag located on his wheelchair was noted. Resident #69 stated after he puts the cigarette out, he puts the butts in his cooler bag because he did not want to leave them on the ground. He further stated he made sure the cigarettes were out before putting them in the bag. He verified there were ashtrays in the smoking area, but he did not sit next to one. He indicated he had been smoking unsupervised, keeping his smoking materials, and placing his cigarette butts in his cooler bag for a long time.

An interview and observation were conducted on 04/18/23 at 9:36 AM with Nurse #5. He stated Resident #69 always kept his smoking supplies, including his lighter, with him and that he went out to smoke when he wanted to go without supervision. He then stated Resident #69 had been smoking unsupervised since he had been working at the facility which was November of 2022. He verified that smoking assessments were to be performed quarterly by the nursing staff when the system triggered them, and the last documented smoking assessment was dated 04/02/22 which determined he was a supervised smoker. Nurse #5 indicated User Defined Assessment (UDA) for smoking were originally initiated by nursing on admission when a smoking assessment was performed. The system was supposed to automatically schedule the assessment to be completed quarterly. The system generated assessment then appeared in red

in the electronic record under "assessments" for completion. It was unknown why the smoking assessment did not trigger to be completed quarterly. He further stated no smoking

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 04/20/2023

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 689	Continued From page 33	F 689		

assessments were scheduled or due at time of survey. He then stated he was unaware Resident #69 required supervision when smoking because according to the smoking list, he was listed as unsupervised. An observation was made of Nurse #5 retrieving Resident #69 ' s cigarettes and lighter that were in the bottom zipper area of an insulated cooler bag and approximately 8 cigarette butts from the main compartment of the cooler bag which was located on his wheelchair in his room.

An interview was conducted on 04/18/23 at 10:45 AM with Nursing Assistant (NA) #9. She stated she worked with Resident #69 once or twice a week. She also stated she was unaware he required supervision while smoking because she had not retrieved smoking items for him in the past, he always kept them with him. She then stated there was a list located at the nurses ' station that specifies who is supervised or not supervised. She further stated the smoking supplies for residents that were supervised during smoking are kept at the nursing station in a locked area.

On 04/18/23 from 11:01-11:15 AM a continuous observation was made of Resident #69 in the smoking area. He was sitting in his wheelchair; no staff were observed with resident. He was observed smoking a cigarette, he dropped the lit cigarette onto the ground reached down and retrieved the lit cigarette, smashed it on the bottom of his shoe and proceeded to put the butt into the cooler bag hanging on his wheelchair.

An interview was conducted on 04/18/23 at 11:16 AM with Nursing Assistant (NA) #10. She stated she was not aware that Resident #69 was a

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 04/20/2023

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 689	Continued From page 34	F 689		

supervised smoker. She stated he went out whenever he wanted to smoke.

An interview was conducted on 04/18/23 at 11:55 AM with Unit Manager #2. She stated she went out and observed Resident #69 in the smoking area periodically and he had been safe with smoking cigarettes. She indicated she had not documented a quarterly smoking assessment on him. She verified the last smoking assessment was performed 04/04/22.

She indicated nurses were responsible for completing the User Defined Assessments (UDA ' s) that are appeared in red in the electronic record.

An interview was conducted on 04/18/23 at 11:59 AM with the Administrator. She stated if a resident was a supervised smoker all smoking supplies were to be kept at the nurses ' station. She reported if the resident was not a supervised smoker, they could keep their cigarettes but their lighters and/or matches were to be kept at the nurses ' station. She also stated the cigarette butts should be disposed of in the ashtrays located in the smoking area. She then

stated she was unaware Resident #69 was smoking unsupervised, that he kept his smoking supplies with him, that a quarterly smoking assessment had not been completed on him quarterly, or that he did not dispose the cigarette butts in a safe manner. She further stated she expected staff to supervise residents that were not deemed safe with smoking alone, keep smoking supplies stored in a safe and secure location, perform quarterly smoking assessments on residents that smoke, and to monitor for safe

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 04/20/2023

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 689	Continued From page 35 disposal of cigarette butts.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a bottle of tube feeding formula was dated when opened for use (Resident #200). This 1 of 4 residents reviewed with feeding tubes. The findings included: Resident #200 was admitted to the facility on 3/20/23 with diagnoses that included dysphagia	F 693	F693 Tube Feeding Management Resident # 200 had Tube feeding formula bottle labeled with Resident name, date, time opened, rate the tube feeding formula should infuse, per physician order on 4/20/23 and currently has tube feeding formula labeled accordingly daily. All residents noted receiving tube feeding	5/17/23

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 04/20/2023

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 693	Continued From page 36 and gastrostomy (G-tube) status. Review of a physician order dated 4/1/23 read: Tube feed formula 1.5 CALORIES- Administer continuous via pump 70 milliliters (ml) per hour 20 hours per day. Downtime 2:00 AM until 6:00 AM. The admission Minimum Data Set (MDS) assessment dated 4/6/23 indicated Resident #200 was severely impaired for daily decision making and required total assistance for all Activities of Daily Living (ADLs). The MDS further revealed that Resident #200 had a feeding tube and 51% or more of daily calories and 501 ml or more of daily fluid intake came from the feeding tube. An observation of Resident #200 was made on 4/17/23 at 12:12 PM as she was resting in a gerichair. She was observed to have a feeding tube that was connected to a pump and was infusing the tube feed formula at 70 ml per hour. The tube feeding label contained no name, no date, no time, and no rate at which the tube feeding formula should infuse. An observation and interview were conducted with Nurse #3 on 4/17/23 at 2:45 PM. Nurse #3 confirmed that she was caring for Resident #200 and that the tube feeding bottle was not labeled appropriately. She stated she had not hung a new bottle of formula since coming on shift at 7:00 AM and that the night shift nurse hung the new bottle and not labeled it appropriately. Nurse #3 stated the tube feeding bottle should have the resident name, time, and date it was hung as well as the rate of administration with each new bottle that was hung.	F 693	formulas have a potential to be affected. A whole house lookback audit was completed by Nurse Leadership designee for all residents requiring a tube feeding formula on 4/21/23 to determine if labeled and dated appropriately. Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding labeling tube feeding formula bottles, water flush and syringe . Education to include labeling tube feeding formula bottles, water flush and syringe when open with resident name, date and time bottle is opened, rate the tube feeding formula should infuse. Ongoing education to be completed during New Employee Orientation. The Director of Nursing/designee will complete an audit of all residents receiving tube feeding for labeling tube feeding formula bottles, water flush and syringe when opened with resident name, date and time bottle is opened, rate the tube feeding formula should infuse 5 x week x4 weeks, then bi-weekly x2 weeks, then weekly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible 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 04/20/2023

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 693	Continued From page 37 The Administrator was interviewed on 4/19/23 at 3:15 PM and stated when the nurse hung a new bottle of tube feeding formula, they were expected to label the bottle with the resident name, date, time, and rate of administration on the label to the bottle. The Administrator stated the tube feeding bottles were good for 24 hours once hung so it was important to label them when the bottle was hung so it could be discarded appropriately. A phone interview was completed with Nurse #2 on 4/20/23 at 12:11 PM. She was assigned to care for Resident #200 on 4/17/23 on the 11:00 PM to 7:00 AM shift. Nurse #2 confirmed hanging the bottle of tube feed formula for Resident #200 and failed to label it appropriately. She stated it was an oversight.	F 693	implementation of the plan. Date of compliance will be 5/17/2023.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to provide a dressing change to a Central venous catheter (CVC) line (a thin, flexible tube (catheter) that is placed into a large vein above the heart) as ordered. This was for 1 of 1 (Resident #14) resident reviewed for infections.	F 694	F694 Parental IV Resident # 14 had dressing changed to the Central venous line 4/17/23. The Central Line has been discontinued on 4/19/23. All residents with central venous lines	5/17/23

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 04/20/2023

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 694

Continued From page 38

The findings included:

Resident #14 was originally admitted to the facility on 09/14/22. She had a recent hospitalization from 03/28/23 through 04/03/23. She was readmitted to the facility on 04/03/23 with a diagnosis of urosepsis.

Resident #14 ' s quarterly Minimum Data Set dated 02/27/23 indicated her cognition was undetermined due to her persistent vegetative state/no discernible consciousness.

Review of Resident #14's hospital discharge summary dated 04/03/23 revealed she was to continue to receive Intravenous (IV) antibiotic for another 2 doses. Discharge paperwork indicated a CVC was placed to her left subclavian vein on 03/31/23.

Review of Resident #14's readmission Physician orders dated 04/03/23 included an order to receive an Intravenous (IV) antibiotic once a day for 2 days. The completion date of her IV antibiotic was 04/05/23.

Resident #14 was care planned on 04/06/23 for a Valved Peripherally Inserted Central Catheter in the left subclavian with potential for catheter related bloodstream infection, phlebitis, deep vein thrombosis, catheter occlusion, and catheter migration. Interventions included: change stabilization dressing/securement device using sterile technique on admission, weekly, and prn.

Review of Resident #14 ' s active physician orders revealed an order that in part read Intravenous (IV): Change Catheter Site Transparent Dressing weekly, every Monday, on

F 694

have a potential to be affected. All current residents with central venous lines had an audit completed on 4/21/23 by Nurse Leadership to ensure dressings were changed per order/protocol.

Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding dressing change to central venous lines . Education to include changing central venous lines per physicians order. Ongoing education to be completed during New Employee Orientation.

The Director of Nursing/designee will complete an audit of residents with central venous line dressings audit to be completed for dressing changes per physician order 3 times per week x4 weeks, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

Director of Nursing will be responsible for implementation of the plan.

Date of compliance will be 5/17/2023.

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 04/20/2023

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 694	Continued From page 39	F 694		

day shift (7 AM-3 PM).

Review of the April 2023 Medication Administration Record (MAR) revealed the active order to change the catheter site transparent dressing was signed by Nurse #5 as being completed on 04/10/23 and 04/17/23.

An observation was made on 04/17/23 at 10:48 AM with Resident #14. She had a CVC to the left subclavian area. The insertion site was covered with a transparent dressing dated for 03/31/23.

An observation was made on 04/18/23 from 3:03 PM through 3:06 PM. The same dressing was still in place to Resident #14's CVC line.

An interview was conducted on 04/18/23 at 3:08 PM with Nurse #5. He verified that he signed the Medication Administration Record (MAR) to reflect the CVC line dressing was changed on 04/10/23 and again on 04/17/23. He stated he did not know why he signed the MAR as the dressing being changed when it had not been changed. He also stated he did not have the dressing kit on hand, and it had to be ordered from pharmacy. He further stated that pharmacy would send the dressings every week when a resident was receiving a medication through a CVC line or a peripherally inserted central catheter (PICC) line. Nurse #5 proceeded into the 100/200 hall medication room and retrieved a CVC/PICC dressing change kit that was in a drawer. The back-up medication/supply system was in the medication room and a CVC/PICC line dressing kit was visible through the glass door. Nurse #5 verified a CVC/PICC dressing change kit was located and available in the back-up system. He then stated he could have retrieved a kit from 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 04/20/2023

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 694	Continued From page 40 back-up system if there was not one in the draw. He further stated he did not look to see if a kit was available in the back-up system on 04/10/23 or 04/17/23. An interview was conducted on 04/18/23 at 3:16 PM with the Administrator. She stated the CVC/PICC line dressing kits are obtained through the pharmacy and were always normally on hand. She verified the dressing change kits were available in the facility back-up medication/supply system. She provided a list of items available in the back-up medication/supply system that included 4 Intravenous (IV) CVC/PICC dressing kits. A phone interview was conducted on 04/19/23 at 10:24 AM with the Nurse Practitioner. She stated Resident #14 returned from the hospital with a CVC line because she had two more days of Intravenous (IV) antibiotic to be given and the dressing should be changed weekly per orders. An interview was completed on 04/20/23 at 11:17 AM with the Administrator. She stated that Resident #14's CVC line dressing should have been changed on admission and every 7 days per orders. She further stated she was unaware the dressing had not been changed per orders.	F 694		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		5/17/23

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 04/20/2023

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 695	Continued From page 41 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Nurse Practitioner (NP) and Medical Director interviews and record review, the facility failed to obtain Physician orders for continuous oxygen (Resident #38) and failed to provide oxygen as ordered (Resident #37). This was for 2 of 6 residents reviewed for respiratory care. The finding included: 1. Resident #38 was admitted on 3/1/23 with diagnoses of Congestive Heart Failure (CHF), Aortic Stenosis, Chronic Obstructive Pulmonary Disease (COPD) and Atrial Fibrillation. Review of Resident #38's comprehensive care plan dated 3/2/23 read she was at risk for respiratory complications related to COPD, asthma and allergic rhinitis. The admission Minimum Data Set dated 3/8/23 indicated Resident #38 was cognitively intact, exhibited no behaviors and was not coded for the use of oxygen. Review of Resident #38's cumulative Physician orders from 3/1/23 to 4/18/23 did not include any orders for the use of oxygen. Review of a nursing note dated 4/2/23 at 4:20 AM documented by Nurse #2 indicated Resident #38 was sent to the hospital due to an altered mental status related to hypoxia. She stated she could not breath and her oxygen saturation rate was 70% on room air. The normal oxygen saturations rates on room air are 95% or higher. Resident	F 695	F695 Respiratory Care Resident # 38 had an order obtained for continuous oxygen use on 4/19/23. Resident # 37 is currently receiving oxygen as ordered. All residents receiving oxygen have a potential to be affected. A whole house Oxygen audit was completed on 4/26/23 by Nurse Leadership designee for all residents receiving oxygen to ensure orders in place and correct for rate set. Education was completed on or before 4/28/23 by Nurse Practice Educator or designee for licensed nurses and C.N.A (Full-time, Part-time, PRN and Agency) on all shifts and weekends, regarding resident Oxygen order, setting and use . Education to include obtaining physician order for oxygen use, administer oxygen per physician order, assessing resident Oxygen flow rate . Ongoing education to be completed during New Employee Orientation. The Director of Nursing/designee will complete an audit of all residents receiving Oxygen to ensure Oxygen order, oxygen in use, flow rate accuracy daily x4 weeks, then bi-weekly x2 weeks, then randomly x1 month. Results of these audits will be brought before the Quality	

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 04/20/2023

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 695	Continued From page 42 #38 appeared cyanotic (skin bluish or purplish in color), appeared lethargic and difficult to arouse. All of her vital signs were within normal ranges and her oxygen saturation rate had increased to 98% while on an oxygen mask running at greater than 5 liters per minute (L/M). Resident #38's oxygen saturation rate would drop when she fell asleep. The Physician on call was notified and made aware of Resident #38's status. He gave orders to send her to the hospital for an evaluation. Review of Resident #38's emergency room records date 4/2/23 read her chief complaint was shortness of breath (SOB). The final diagnoses were atypical chest pain and a pleural effusion due to her CHF. The report did not mention anything about her being prescribed oxygen on discharge 4/2/23. Review of a nursing note dated 4/5/23 at 6:24 PM documented by Unit Manager (UM) #1 indicated Resident #38 was sent out to the hospital due to SOB. All of her vital signs were within normal limits except her oxygen saturation was 94% on room air. Review of Resident #38's emergency room records date 4/5/23 read her chief complaint was respiratory distress. The final diagnoses were abnormal blood pressure and anxiety. The report did not mention anything about her being prescribed or on oxygen on discharge 4/5/23. An interview was completed on 4/20/23 at 9:20 AM with UM #1. She recalled contacting the NP on 4/5/23 about Resident #38's complaint of SOB and her wanting to be sent to the hospital for an evaluation. UM #1 stated she was alert and orient	F 695	Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible for implementation of this plan. Date of compliance will be 5/17/2023.	

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 04/20/2023

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 695	Continued From page 43	F 695		

at the time and did not recall if Resident #33 was wearing any oxygen at that time, but the NP ordered her to be evaluated at the hospital.

Review of a nursing note dated 4/5/23 at 10:10 PM completed by UM #1 read Resident #38 returned from the emergency room with no new orders, no complaints and was eating a sandwich. The was no mention of any oxygen.

Review of a nursing note dated 4/6/23 at 5:40 PM completed by UM #1 read Resident #38's oxygen saturation rate was 97% on oxygen using a nasal cannula. The note did not indicate how many of liters Resident #38's oxygen was running at.

Review of the NP and MD progress notes from 4/1/23 to 4/11/23 made no mention about use of oxygen and any new orders for oxygen.

An observation and interview was completed on 4/17/23 at 11:59 AM with Resident #38. She stated she was not on oxygen at home prior to her recent admission to the facility on 3/1/23. She was wearing an oxygen nasal cannula. Observation of the oxygen concentrator was running at the red line greater than 5 L/M.

Observation completed on 4/18/23 at 8:52 AM and 2:26 PM revealed her oxygen concentrator still running at greater than 5 L/M.

Review of Resident #38's April 2023 medication administration records from 4/1/22 through 4/18/23 did not include any documentation for the use of oxygen.

Review of Resident #38's documented oxygen saturation percentages from 4/1/23 to 4/18/23

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 04/20/2023

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 695	Continued From page 44	F 695		

ranged from 98% on room air and 99% while wearing supplemental oxygen.

Another observation was completed on 4/19/23 at 9:30 AM. There was no change noted to her oxygen settings from the previous observations.

An interview was completed on 4/19/23 at 10:35 AM with the Respiratory Therapist (RT). She stated she started last week and had not received a referral for Resident #38, and she was not on her caseload.

A telephone interview was completed on 4/19/23 at 10:15 AM with the NP. She stated she was not aware that Resident #38 was wearing continuous oxygen at over 5 L/M and that it may be possible that the Physician on call was consulted. The NP stated she would not order continuous oxygen at greater than 5 L/M for a resident due to the risk of anaerobic respirations that can be dangerous. Anaerobic respirations is defined as respirations through which the body's cells can breakdown into sugar to generate energy. She stated she would address this with the facility immediately.

An interview was completed on 4/19/23 at 10:40 AM with Nurse #1. She stated she thought Resident #38 had an order for continuous oxygen at 3 L/M, but she did not see any orders for oxygen in the electronic medical record. Asked to observe Resident #38's oxygen concentrator she noted it was running at 5 L/M. Nurse #5 was already in Resident #38's room obtaining her oxygen saturation. She stated there were new orders just received to change Resident #38's oxygen rate to 2 L/M.

Review of Resident #38 electronic medical record

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 04/20/2023

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 695	Continued From page 45	F 695		

included the following new orders dated 4/19/23:
*RT to evaluation and treatment
*Oxygen at 2 L/M via NC continuously-evaluate heart rate, respiratory rate, pulse, oxygen saturation, skin color and breath sounds on every shift
*change oxygen tubing weekly and clean external filter on concentrator every Tuesday nigh

Review of a nursing note dated 4/19/23 at 11:17 AM read the NP was notified of oxygen saturation and oxygen running at 2 L/M via nasal cannula to maintain oxygen saturation above 90%.

The Administrator was interviewed on 4/20/23 at 11:45 AM. She stated it was not acceptable to administer Resident #38 oxygen especially at greater than 5 L/M.

A telephone call was completed on 4/20/23 at 12:10 PM with Nurse #2. She stated she was unable to get in touch with the MD but may have spoken to the Physician on call. She stated she and another co-worker decided to put an oxygen mask on Resident #38 and turn the oxygen up to greater than 5 L/M due to what appeared to be extreme respiratory distress while waiting for emergency services to arrive to take her to the hospital. She stated she was not aware that Resident #38 was still wearing the oxygen at greater than 5 L/M at present.

An interview was completed on 4/20/23 at 12:20 PM with the MD. He stated he was not aware that oxygen had been placed on Resident #38 and still running at over 5 L/M and considered that unacceptable.

2. Resident #37 was admitted to the facility

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 04/20/2023

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 695	Continued From page 46	F 695		

3/12/20 with recent readmission of 3/19/23. Her diagnoses included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia.

Review of Resident #37's active physician orders included an order dated 3/20/23 for oxygen at 2 liters per minute via nasal cannula continuously.

A significant change in status Minimum Data Set (MDS) assessment dated 3/24/23 indicated Resident #37 was cognitively intact. She displayed shortness of breath with exertion and when lying flat and was coded with the use of oxygen.

A review of Resident #37's active care plan, last reviewed 4/3/23, revealed a focus area for exhibits or is at risk for respiratory complications related to COPD exacerbation, chronic respiratory failure, and obstructive sleep apnea. On of the interventions included oxygen as ordered via nasal cannula.

Review of Resident #37's nursing progress notes from 3/19/23 to 4/19/23 did not reveal any refusals for oxygen use.

On 4/17/23 at 2:30 PM, Resident #37 was lying in bed watching TV with her oxygen flowing at 2 liters via nasal cannula.

On 4/18/23 at 10:48 AM, Resident #37 was observed lying in bed watching TV with her nasal cannula on. The oxygen concentrator was turned off and no oxygen was flowing. Resident #37 did not appear to be in any distress.

Resident #37 was observed lying in bed watching

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 04/20/2023

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 695	Continued From page 47 TV on 3/18/23 at 2:33 PM. The nasal cannula was in her nose, but the oxygen concentrator was turned off. During an interview with Resident #37 she stated she was unaware the oxygen concentrator was not on. There were no signs or symptoms of distress. An interview and observation occurred with Nurse #1 on 4/18/23 at 2:37 PM, who was assigned to care for Resident #37. She confirmed Resident #37 had her nasal cannula in her nose, and the oxygen concentrator was turned off. Nurse #1 stated she had not been aware the oxygen concentrator had been off and turned the concentrator back on to provide 2 liters of oxygen as ordered. During an interview with the Administrator on 4/20/23 at 11:17 AM, she indicated it was her expectation for oxygen to be delivered as ordered.	F 695		
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	F 812		5/17/23

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 04/20/2023

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 48 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, and staff interviews the facility failed to discard opened food items ready for use by the labeled discard date in 1 of 1 walk-in refrigerators and failed to label, and date opened food left in 1 of 2 nourishment room refrigerators (station 1 reach-in refrigerator). This practice had the potential to affect foods served to residents. The findings included: 1. a. During the initial tour of the main kitchen with the Dietary Manager (DM) on 04/17/23 at 10:06 AM revealed the following items were observed in the walk-in refrigerator available for use. - One square shaped container with approximately 30 slices of bologna with a label on top of the container that read opened on 04/07/23 and a discard date of 04/11/23. - One square shaped container 1/4-1/2 full of turkey with a label on top of the container that read opened on 04/07/23 and a discard date of 04/11/23. - One square shaped container 1/2 full of shredded cheese with a label on top of the container that read opened on 04/09/23 and a discard date of 04/16/23.	F 812	F812 Food Storage and Sanitation Upon identification, the items identified were removed by the District Dietary Manager on 4/17/23, and nourishment room were cleaned and non-dated and staff food items were discarded by the District Dining Manager on 4/17/2023 All residents have the potential to be affected. Education for the dining staff on sanitation expectations and food storage practices will be completed by the Dining Services Director/designee on or before 5/8/23. This education will also be completed upon hire for staff to include new contracted agency orientation. Education for all staff on sanitation expectations and food storage practices related to the nourishment room refrigerators will be completed by the Nurse Practice Educator/designee on or before 5/15/23. This education will also be completed upon hire for staff to include new contracted agency orientation. The Dining Manager/ designee will complete 5 random nourishment room/refrigerator audits x4 weeks to begin on 5/1/23, then bi-weekly x2 weeks, then monthly x1 month. The Dining Manager/designee will complete twice	

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 04/20/2023

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 49

b. On 04/17/23 at 10:30 AM in station 1 ' s nourishment room refrigerator, the following items were observed with nurse aide (NA) #1:

- Small glass covered bowl of pasta salad with no name or date labeled.

- Store bought bowl half full of watermelon with a sell by date of 04/13/23 on label. No name or opened date listed.

- 5 prefilled small containers of apple sauce with a poured date of 04/08/23. No discard date listed.

On 04/17/23 at 10:31 AM an interview with Nurse Aide #1 was conducted. She stated she throws items away if they were left in station 1 nourishment room refrigerator past 72 hours.

On 04/17/23 at 10:25 AM an interview was conducted with the Dietary Manager in reference to food labeling and discarding food on discard dates. She stated that it was everyone ' s responsibility for labeling food/beverages after opening and discarding foods/beverages on discard/expired dates. She also stated she did daily checks and that it was an oversite that she

missed the above items. She further stated, opened foods were to be thrown away 7 days after opening.

On 04/19/23 at 09:50 AM an interview was conducted with the Director of Operations. He stated dietary supplies the nourishment room refrigerators with fresh sandwiches in the evenings and would discard items that have reached the discard date. He also stated nursing staff were responsible for labeling food with a

F 812

weekly kitchen sanitation rounds to begin on 4/24/23 then bi-weekly x2 weeks, then monthly x1 month.

Results of these audits will be brought before the Quality Assurance Performance Improvement Committee by the Administrator for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance.

The Senior Administrator will be responsible for implementation of the plan.

Date of compliance will be 5/17/2023.

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 04/20/2023

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 50 name and date when brought in by families prior to putting them in the nourishment room refrigerators. On 04/19/23 at 01:45 PM an interview was conducted with the Administrator. She stated all opened food should be discarded no later than the labeled discard date and all items in refrigerators should be labeled with an open/stored date and name if applicable. On 04/19/23 at 03:30 PM an interview was conducted with the Director of Operations. He stated all opened perishable foods should be discarded no later than the labeled discard date. All items should have a "opened or poured" date labeled on the item.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		5/17/23

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 04/20/2023

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 867		F 867		

Continued From page 51
systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

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 04/20/2023

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 867	Continued From page 52 (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		

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 04/20/2023

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 867	Continued From page 53 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey completed on 4/28/2022. This was for 3 deficiencies that were cited in the areas of clean homelike environment, accuracy of assessments, and providing activities of daily living care for dependent residents. The duplicate citations during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F677- Based on observations, staff interviews and record review, the facility failed to provide scheduled showers for a resident requiring total staff assistance with bathing/showering. This was for 1 (Resident #70) of 3 residents reviewed for	F 867	F867 QAA Facility received three repeat citations during the complaint and recertification survey that had been cited during prior surveys. Revised plans have been developed by the Senior Administrator to address those areas with ongoing monitoring by the Quality Assurance Performance Improvement Committee. Plans for the following have been reviewed for sustained compliance for clean homelike environment (F 584), Assessment Accuracy (F641) and ADL Care (F 677). All residents have potential to be affected. Root Cause Analysis completed by the interdisciplinary Quality Assurance Team for each of these deficiencies to determine the systemic breakdown that led to the deficient practice with revised plans developed to address these areas to include lack of follow through due to	

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 04/20/2023

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 867 Continued From page 54
activities of daily living.

During the facility's recertification survey of record on 4/28/2022, the facility failed to trim and clean dependent residents' nails for 4 of 7 residents reviewed.

In an interview with the Interim Administrator on 4/20/2023 at 1:00 PM, she felt the repeat citation was due to staff turnover. She felt the staff would benefit from additional education.

2. F641- Based on record review and staff interview, The facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of feeding tube (Resident #89) and bowel continence (Resident #70). This was for 2 of 23 resident records reviewed.

During the facility's survey of record on 4/28/2022, the facility failed to code the MDS assessment accurately in the areas of activities of daily living and falls for 2 of 18 residents reviewed.

In an interview with the Administrator on 4/20/2023 at 1:00 PM, she felt the repeat citation in MDS accuracy was felt to be related to human error.

3. F584- Based on observations and staff interviews, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) vents (Rooms #104, #111, #206, #207, #302, #308, #310, #312, #316, #404, #405, #407 and #408). This was for 13 of 16 resident rooms reviewed for comfortable, clean, and homelike environment.

F 867

leadership changes, staffing inconsistencies and communication failures.

Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Senior Administrator. (QAPI team consists of Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resources Manager, Maintenance Director, Social Services Director, Homestead Program Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director) Licensed staff, nurses assistants, maintenance personnel, activities, receptionists, dietary, housekeeping, laundry, therapy and additional Interdisciplinary team members were all educated by the Administrator on Quality Assurance and recognizing areas for Performance Improvement and how to report these findings to the QAPI Committee on or before 5/15/2023.

The Administrator/designee to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Senior Administrator to review all monthly QAPI Minutes x 6 months and attend QAPI

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 04/20/2023

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 867	Continued From page 55 During the facility's survey of record on 4/28/2022, the facility failed to provide adequate lighting for 1 of 1 resident reviewed for environment. An interview with the Administrator was conducted 4/20/2023 at 1:00 PM and indicated the facility had experienced administrative turnover and possibly had failed to keep safeguards in place.	F 867	Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Senior Administrator will be responsible for implementation of the plan. Date of compliance will be 5/17/2023.	