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WOODLANDS NURSING & REHABILITATION CENTER	**400 PELT DRIVE FAYETTEVILLE, NC 28301**

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F 000	INITIAL COMMENTS The surveyor entered the facility on 8/30/23 to conduct a complaint investigation and exited the facility on 8/30/23. Additional information was obtained on 8/31/23 and 9/1/23. Therefore the exit date was changed to 9/1/23. (Event 24HD11) The following intake was investigated NC00205608. One of three complaint allegations resulted in a deficiency.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support	F 660		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 09/21/2023

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.

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F 660	Continued From page 1 person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.	F 660		

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F 660	Continued From page 2 (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Physician interview, and Responsible Party interview the facility failed to implement a discharge planning process that identified changes resulting in modifications to a resident's discharge plan for one (Resident # 1) of three residents reviewed for discharge. The facility failed to follow up on a pending x-ray result before discharging a resident home. When the results came in after the resident was discharged, they showed the resident had a fracture. The findings included: Resident # 1 was admitted to the facility on 7/12/23. The resident had diagnoses which in part included dementia, hypertension, diabetes, a history of metabolic encephalopathy, and debility. Resident # 1's care plan, dated 7/13/23, noted the plan was for Resident # 1 to discharge home after therapy was completed. Resident # 1's admission Minimum Data Set assessment, dated 7/21/23, coded the resident as cognitively impaired. She was assessed to need extensive assistance with her transfers and walking.	F 660	Past noncompliance: no plan of correction required.	

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F 660	Continued From page 3 The Rehabilitation Director was interviewed on 8/30/23 at 1:40 PM and reported the following. Resident # 1 had lost an appeal for her insurance to cover her stay any longer. Therefore, she was planning to discharge home with family. The last day therapy provided treatment services was on 7/27/23. At that time, Resident # 1 was ambulatory. Therapy was working on the resident climbing steps. At discharge, staff were still doing 75% of the work to help Resident # 1 up the steps. The facility Social Worker was interviewed on 9/1/23 at 1:10 PM and reported the following. She saw Resident # 1 on the morning of 7/28/23. Insurance was no longer covering for Resident # 1 to be at the facility. The family was planning to take her home on 7/29/23 and discharge home health had been set up. On 7/28/23 at 10:00 AM Nurse # 2 documented a nursing entry for Resident # 1 noting the following. The resident had been found on the floor at the end of the bed laying on her right side. She was alert and oriented. She complained of left hip pain (the hip opposite of the one on which she was found). The physician ordered a two-view x-ray of the left hip. Nurse # 2 was interviewed on 8/31/23 at 1:37 PM and reported the following. She verified Resident #1 had a fall on 7/28/23 and she completed an assessment of the resident. She indicated the resident was not complaining of pain in the hip on which she was found, but rather the opposite hip. She completed her assessment and found no obvious deformity. The physician ordered an x-ray. She administered some pain medication,	F 660		

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and the pain medication was helpful. The X-ray technician did not arrive before her shift ended.

Nurse # 3 was assigned to care for Resident # 1 on the 3:00 PM to 11:00 PM shift on 7/28/23. An attempt was made to interview Nurse # 3 on 8/31/23 at 2:30 PM and she could not be reached.

During an interview with the Director of Nursing (DON) on 9/1/23 at 11:10 AM, the DON reported she had spoken to Nurse # 3 on 8/4/23 while she (the DON) was investigating the care Resident # 1 had received at the facility. The DON indicated Nurse # 3 reported that the x-ray results did not arrive on 7/28/23 during the 3:00-11:00 PM shift and the resident had not complained of pain. during her shift. Nurse # 3 had reported to the DON that she passed the information (that the resident had fallen, and x-rays were pending) on to Nurse # 4 during change of shift report.

Nurse # 4 was assigned to care for Resident # 1 on the 11:00 PM to 7:00 AM shift which began on 7/28/23. An attempt was made to reach Nurse # 4 on 8/31/23 at 2:28 PM and the nurse could not be reached for interview.

During an interview with the Director of Nursing (DON) on 9/1/23 at 11:10 AM, the DON reported she had spoken to Nurse # 4 on 8/4/23 while she was investigating the care Resident # 1 had received at the facility. The DON indicated Nurse # 4 reported Resident # 1 had not complained of pain during his shift. Nurse # 4 had reported to the DON that he had checked the fax machine for x-ray results and there were none there during his shift. Nurse # 4 also reported to the DON that he passed the information (that the resident had

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fallen, and x-rays were pending) on to Nurse # 1 during change of shift report.

On 7/29/23 at 12:30 PM Nurse # 1 documented the following nursing note in Resident #1's record. "Resident has been discharged from facility with daughter. Resident was brought out to car with wheelchair. Resident needed a significant amount of assistance from family to enter into car. Resident was alert and could make needs known. Complained of pain in right hip. Resident was discharged with medications and instructions for medication were gone over with daughter. Daughter voiced understanding."

On 7/29/23 at 2:30 PM the physician noted a "late entry" which in part read, "This is a discharge visit as the patient has reached maximum benefits with therapy at this time and will be discharging home. Patient had a fall today, but patient denies pain to me." (During an interview on 9/1/23 at 3:47 PM with Resident # 1's physician, the physician clarified he was aware the fall was 7/28/23 and not 7/29/23).)

On 7/29/23 at 4:02 PM Nurse # 1 documented the following note in Resident # 1's record, "This nurse just received x-ray results. Shows a mildly comminuted impacted intertrochanteric fracture with various deformity. Physician notified and advised nurse to have family take resident to the [Emergency Room] ER. Daughter informed and stated that she had already taken her to the ER."

Nurse # 1 was interviewed on 8/31/23 at 1:53 PM and reported the following. On 7/29/23 she had not received anything in report about Resident # 1 falling the previous day or that an x-ray was done and results were still pending. The resident did

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F 660	Continued From page 6 have some left hip pain that morning, and the nurse knew the physician had been in to see Resident #1 that morning and thought it was okay to send her home. He had written her prescriptions and did not mention a pending x-ray result. The family came and assisted Resident # 1 to the wheelchair. She then accompanied the resident and her family to the car which was a Sports Utility Vehicle (SUV). Per facility protocol she was not supposed to assist in getting the resident into a private vehicle but she observed as two family members assisted. The resident did not have trouble standing, but she had trouble turning and getting into the vehicle and appeared to have some hip pain. It took about five to ten minutes for the resident to get in the vehicle. When she was in the vehicle, the nurse returned to her unit. She still had medications to pass and then she reviewed Resident # 1's record. She saw for the first time that Resident # 1 had fallen the previous day (7/28/23) and an x-ray had been done with no results ever received. She called the x-ray company and they told her they would send the report. It took a little time for the report to come through. When the report was sent, it noted Resident # 1 had a fractured hip. She immediately called the physician who instructed that she call the family and inform them the resident needed to go to the hospital. She called the family and they said they had already taken the resident to the hospital. Resident # 1's Responsible Party was interviewed on 8/30/23 at 11:55 AM and reported the following. Resident # 1 had hip pain after her last fall (7/28/23) at the facility. They (the facility) had an x-ray completed of the resident's hip, and she had inquired about the results on the day of her fall, but the staff kept saying they were waiting on	F 660		

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the results. On the day of discharge, she had assisted Resident # 1 to the wheelchair. The staff told her it was okay for the resident to go home so she interpreted that the x-ray had been okay. It took a long time to get Resident # 1 in the vehicle and she still had some hip pain at that time. Therefore, instead of taking her home, she took her to the hospital where they identified that she had a fractured hip. After she had already taken Resident # 1 to the hospital, the facility called and let her know the x-ray results showed Resident # 1's hip was fractured.

Review of Resident # 1's hospital records revealed she was evaluated in the ED (emergency department) on 7/29/23 at 12:54 PM and found to have a left hip fracture. The ED physician noted, "On evaluation, patient is lying comfortably in bed and is in no acute distress. Inspection of the left lower extremity reveals minimally shortened and externally rotated left lower extremity with focal bony tenderness to palpation (tenderness limited to the bone when examined by touch) of the left anterior (front) hip. Patient has decreased range of motion of the left hip secondary to pain. Unremarkable examination of the right lower extremity." On 7/31/23 the resident underwent surgery and was discharged from the hospital on 8/3/23.

The facility's medical director, who served as Resident # 1's physician during her residency, was interviewed on 9/1/23 at 3:47 PM and reported the following. He had seen Resident # 1 on the morning of discharge (7/29/23). He knew she had fallen the previous day but she had no complaints of pain when he saw her. He recalled the family wanted to leave the facility with Resident #1 by 11:00 AM. He knew the x-ray

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F 660	Continued From page 8 report was still pending at the time of his discharge visit on the morning of 7/29/23 and thought he had a conversation with the nurse on duty that morning, but he could not recall for sure. He thought the facility would wait to get the x-ray report back before letting the resident leave and was not sure where the breakdown was in communicating about that. The physician felt that standing the resident to get in the wheelchair and into the car probably did not worsen Resident # 1's fracture but he could not say for sure. He reported the fracture was a mild fracture. The Administrator and Director of Nursing were interviewed on 9/1/23 at 11:10 AM and reported the following. They were aware the resident had been discharged without the results of the x-ray being known and had investigated the incident. According to the DON, Nurse # 1 should have reviewed the record prior to discharging the resident to make sure all pending orders were completed and updated the physician when the resident had trouble getting into the vehicle. Also, the DON reported normally they did not have trouble getting an x-ray report from the mobile x-ray company. She had not been able to identify the specific breakdown because Nurse # 3 and Nurse # 4 reported they had passed along the information in shift change report that x-ray results were still pending following Resident # 1's fall, but Nurse # 1 had reported that she had not received the information in shift change report. The Administrator and DON stated they had completed a corrective action plan to address the incident. On 9/1/23 the facility provided the following corrective action plan with a completion date of 8/4/23.	F 660		

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" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident # 1 no longer resides at the facility.

" Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 07/31/23 the Director of Nursing identified residents that were potentially impacted by this practice by completing an 100 % audit all current residents with x-rays ordered to ensure they were received and reviewed timely, audits were completed on all current/discharged residents for the past 30 days. This was completed on 07/31/23. The results indicated that no other residents were identified with this concern.
" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

On 08/01/23, the Assistant Director of Nursing in-serviced all Nursing, Nursing Assistant and medication Aides staff (including agency) on following up on x-ray results and to report the results timely to the MD (medical physician).

On 08/01/23 All Nurses were also educated that if there is a complaint of pain or concern during discharge the resident is to be returned to the facility, assessed and the MD notified.

On 08/01/23 In-service for Nursing Assistants: Please inform the nurse if there are any concerns noted for a resident prior to discharge, for example a change in their condition, increase pain or family expressing any concerns.

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F 660	Continued From page 10 As of 08/04/23 100% of Nurses, Nursing Assistant and Medication Aides members have attended the in-service. The Director of Nursing will ensure that any of the above-identified staff who do not complete the in-service training by 08/04/23 will not be allowed to work until the training is completed. A copy of this in-service will be placed in the agency book so all new agency staff will have this training. This will also be added to the new orientation packet for all new staff. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing will monitor x-ray orders and results being received and reported in a timely manner, weekly for 2 weeks and monthly for 3 months for compliance by utilizing the QA discharge tool. The DON will audit all discharges to ensure there are no x-ray reports pending prior to discharge this will be completed weekly x3, then monthly until resolved utilizing the QA discharge tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and the on-going auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. Date of Compliance 08/04/23 During the complaint investigation of 8/30/23 to 9/1/23 the facility's action plan was validated by	F 660		

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F 660	Continued From page 11 the following. Two additional residents, who had been discharged since Resident # 1 resided at the facility, were placed on a sample for review. Record review, staff interviews, and physician interviews revealed staff were assuring diagnostic studies were done and results back before discharge. The facility provided documented evidence of their inservice training and audits which had been noted in the corrective action plan. It was validated with Nurse # 1 on 8/31/23 at 1:53 PM that she had attended the inservice training and was aware not to discharge a resident without reviewing the record. On 9/1/23 the facility's corrective action plan was verified as completed on 8/4/23.	F 660		