STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345481	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Nursing & Rehabilitation Center	**400 Pelt Drive , Fayetteville, North Carolina, 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/04/2025 through 08/08/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D2444-HI.	E0000		08/19/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/4/2025 through 8/8/2025. Event ID #1D2444-H1. The following intakes were investigated: 841381, 841385, 841388, 841394, 841405, 841406, 841412, 841414, 841417, 841420, 841422, 841426, 841427, 841436, 2562756, 2563288, and 2578706. 45 of the 45 complaint allegations did not result in a deficiency.	F0000		08/19/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	Plan of Correction F0641 – Accuracy of Assessments (Oxygen Therapy Coding) 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #4's Minimum Data Set (MDS) dated 7/21/2025 was reviewed by the MDS Coordinator on 8/7/2025 and it was confirmed that oxygen therapy was not coded in Section O. The MDS was immediately corrected on 8/7/25 by the MDS Coordinator to reflect the resident's use of continuous oxygen therapy. The MDS was resubmitted and accepted into the state database on 8/8/25 in Batch #2051. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents receiving oxygen therapy have the potential to be affected. A facility-wide audit of current residents receiving oxygen therapy was completed by the Clinical Reimbursement Specialist on 8/14/2025 to ensure accurate coding of oxygen therapy on their most recently completed MDS assessment. The audit results are as follows:	08/23/2025

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 reverse for further 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.

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

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F0641 SS = D	Continued from page 1 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of oxygen therapy for 1 of 1 resident reviewed for oxygen therapy (Resident #4). The findings included: Resident #4 was admitted to the facility on 6/13/24 with diagnoses which included chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. The MDS dated 7/21/25 indicated Resident #4 was cognitively intact and was not coded for oxygen therapy. The Care Plan, last revised 7/21/25, included the focus of requiring oxygen therapy with an intervention that specified to give medications as ordered by physician. An observation and interview with Resident #4 were conducted on 8/7/25 at 10:55 AM. He was observed lying in his bed with oxygen being administered via nasal canula tubing (a tube with nasal prongs that allows oxygen delivery from an oxygen source) which was connected to an oxygen concentrator. He was awake and alert. When asked if he knew what his oxygen rate was supposed to be he stated that he really was not sure. He explained he had COPD and some other lung issues and used oxygen continuously. An interview was conducted with the MDS Coordinator on	F0641	Continued from page 1 11 residents identified with oxygen orders. 9 of 11 residents received oxygen during their ARD lookback timeframe. All 9 residents who received oxygen during their ARD lookback were correctly coded with oxygen on their MDS. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/14/2025, the Clinical Reimbursement Consultant provided targeted education to the facility MDS Coordinator on accurate MDS coding practices, with emphasis on Section O (Special Treatments and Procedures – Oxygen therapy). This education included specific coding requirements and coding tips from Chapter 3 of the RAI manual with a focus on the importance of thoroughly reviewing the resident's medical record prior to coding the MDS assessment in order to determine whether or not they have received oxygen therapy at any time during the 14 day ARD lookback period. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The DON or designee will audit 5 random MDS assessments weekly for 4 weeks, then monthly for 2 months, focusing on accuracy of oxygen therapy coding. Results will be reviewed during the monthly Quality Assurance (QA) committee meetings. Any discrepancies will be addressed through retraining and corrective action. Compliance Date: 08/23/2025	

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F0641 SS = D	Continued from page 2 8/7/25 at 11:28 AM. The MDS Coordinator stated she did not code Resident #4's oxygen therapy on the 7/21/25 MDS assessment due to "operator error." An interview was conducted with the Director of Nursing (DON) on 8/7/25 at 12:04 PM. The DON stated it was her expectation that the MDS Coordinator be aware of residents on oxygen therapy and to make sure the MDS assessments were accurately coded. An interview was conducted with the Administrator on 8/8/25 at 1:38 PM. The Administrator stated it was her expectation that the MDS assessments were coded accurately.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) application for a resident with newly evident mental health diagnoses for 1 of 1 sampled resident reviewed for PASRR (Resident #62). The findings included: Resident #62 was readmitted to the facility on	F0644	PLAN OF CORRECTION F0644 – Coordination of PASRR and Assessments 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #62 was readmitted on 04/07/2025 with newly evident mental health diagnoses. A PASRR Level II screening request was submitted to NCMUST by the facility Social Worker on 8/8/2025 after identification of the oversight. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents with diagnosis of any serious mental illness has the potential to be affected. All residents readmitted within the past 6 months were reviewed by the facility Social Worker on 8/21/2025 to identify any missed PASRR Level II screenings. Any residents with newly evident serious mental illness were referred for PASRR Level II screening immediately. Audit results were: 6 of 66 residents audited were identified as needing a new PASRR screening. 6 residents identified had a new PASRR screening request submitted to NCMUST upon identification. This was completed by the facility Social Worker. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:	08/23/2025

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F0644 SS = D	Continued from page 3 04/07/2025 with diagnoses including major depressive disorder, post-traumatic stress disorder, and adjustment disorder with anxiety. The admission Minimum Data Set dated 04/01/2025 had Resident #62 coded as cognitively intact and was not currently considered by the state level II PASRR process to have serious mental illness. A review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) for PASRR screenings dated 01/26/2010 revealed a negative PASRR level I determination. An interview with the Social Worker was conducted on 08/08/2025 at 11:15 AM. She stated Resident #62 did not have any mental health diagnoses in 2010 when the PASRR level I was completed but she did have the diagnoses of major depressive disorder, post-traumatic stress disorder, and adjustment disorder with anxiety when she was readmitted on 04/07/2025. Those diagnoses should have prompted a PASRR level II screening to be completed but it slipped through the cracks. An interview with the Director of Nursing (DON) was conducted on 08/08/2025 at 11:37 AM. She stated Resident #62 did have mental health diagnoses of major depressive disorder, post-traumatic stress disorder, and adjustment disorder with anxiety when she was readmitted on 04/07/2025. The Social Worker was expected to submit a PASRR level II screening when she was admitted but it was overlooked and there was not a plan of correction (POC) completed prior to investigation.	F0644	Continued from page 3 On 8/22/2025 the Clinical Reimbursement Specialist Consultant provided education on PASARR screening requirements and triggers for Level II screening to the facility Social Worker and Administrator. This education focused on the requirement that if a serious mental illness or Intellectual or Developmental Disabilities/ related condition was not discovered at the preadmission screen, and that condition later emerged or was discovered, the facility should report those symptoms, diagnoses, etc., to the NC Medicaid PASRR department to assess for further screening needs. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The DON or designee will conduct monthly audits of all admissions and readmissions to ensure compliance using the Quality Assurance Tool this will be completed weekly x 4 weeks then monthly x 6 months. Findings will be reported to the QA committee. Any missed screenings will be corrected immediately and reviewed for root cause. Compliance Date: 08/23/2025	