STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING ______ B. WING ______	09/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to respond immediately to the emergent need of a resident who verbalized difficultly breathing, shortness of breath and an empty oxygen cylinder, which resulted in anxiety, panic and frustration for 1 of 4 residents dependent on supplemental oxygen (Resident #40). Findings included: Resident #40 was admitted into the facility on 8/29/14. Diagnoses include Bronchitis, Chronic Airway Obstruction, Supplemental Oxygen Dependent, Anxiety and Atrial Fibrillation. The Minimum Data Set was in process of being completed. The FL2 (a level of care screening tool) dated 8/6/14 revealed Resident #40's mental orientation was constant to person, place and time. Ambulation and transfers required supervision. Special treatment included continuous oxygen therapy. The admission care plan dated 8/29/14 listed Chronic Obstructive Pulmonary Disease (COPD) as a diagnosis. Oxygen therapy was indicated as an approach to be used with care. A review of the Physician orders for August 2014 -	F 224	Woodlands Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposed the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. Corrective Action #1 - Resident #40 was taken to the 300/400 hall nurses station by NA#1 and the activities director to be assessed by the nursing staff. O2 saturation was measured at 95% on room air by the Med Aide. O2 canister was changed and reset to 2 liters/nasal cannula by the Medication Aide. The resident was then taken to her room by nurse # 1 where an assessment was completed by the unit manager with assistance from the Director Nursing Services (DNS) as per facility protocol: O2 Saturation; Lung assessment (crackles, wheezes, diminished lung sounds); oxygenation of nail beds; Level	9/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 09/26/2014

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 224	Continued From page 1 September 2014 revealed a physician order for oxygen at 2 liters per minute via nasal cannula continuous every day. A review of a disciplinary action notice signed by Nurse #1 on 9/4/14 in part read "unsatisfactory or incompetent work, failed to properly assess resident with respiratory status." On 9/4/14 at 10:07 am, an observation revealed Nurse #1 exited the med room on her way back to the medication cart and was stopped by Resident #40 at the nurse's station in her wheelchair as the nurse exited from the med room. The resident stated to her "I am short of breath and can not breathe, it is hard for me to get air, there's no air coming from my oxygen tank on the back of my wheelchair, I'm so frustrated right now, I need your help." The resident was observed with deep breathing, use of accessory muscles (internal and external intercostal muscles to aide in breathing which include neck and shoulders) with breathing and shortness of breath. Nurse #1 responded "Go to your room, I'll be there after a while" and walked away without assessing the resident's voiced concerns and continued with her med pass. The resident was observed to be 50 feet or greater from her room, which was located down the hallway and to the right in the corner and out of sight of Nurse #1. Resident #40 yelled "Somebody please help me, she (Nurse #1) is not listening to me, I am short of breath and can't breathe and I need someone to help me now. The resident was observed to be frustrated and there was no other staff present at the time she voiced her concerns to Nurse #1 - the resident began to panic as she looked for someone to help her. The oxygen cylinder gauge on the back	F 224	of consciousness. Based on the assessment, it was determined that the residentMs O2 Saturation was 95% on room air and nail beds indicated adequate oxygenation. Ativan .25mg was administered by Nurse #1 to the Resident at 10:27am as a prophylactic calming agent and in addition to the O2 was effective in relieving anxiety. Nurse #1 was immediately interviewed by the DNS as to rationale for lack of response to residentMs needs as had been instructed and trained per facility policies and procedures. Due to failure to follow facility policy and protocol, the nurse was terminated on 09/04/14 by the DNS. Corrective Action #2 - The DNS and administrative nursing staff reviewed all residents receiving Oxygen therapy, whether via concentrator or on portable O2 canisters, to ascertain canisters and concentrators were within normal operating ranges (9/04/14). All residents reviewed were found to have proper operating canisters and concentrators. Corrective Action # 3 - The facility DNS in serviced all licensed staff on 9/5/14 with regards to the following issues: (1) Treatment/Management of residents with COPD/Respiratory Compromise M Using COPD Clinical Protocol, 2) Oxygen (O2) Administration M Using Oxygen Administration Protocol, 3) Abuse and Neglect M Using Abuse/Neglect Protocol, and 4) Change in residents condition/status MUsing Change in Resident Condition Status Change	

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F 224	Continued From page 2 of the resident's wheelchair was observed "empty" of oxygen. Upon looking for someone on the 500 unit where the resident was located, to help the resident, there was no staff member physically in sight. At 10:08 am NA (Nursing Assistant) #1 was observed and notified the resident oxygen cylinder was empty and she complained to Nurse #1 of shortness of breath/difficult breathing and needed immediate medical attention. NA (Nursing Assistant) #1 asked Resident #1 was she okay and the resident explained to her she could not breathe, no air was coming from her oxygen tank and that she had told Nurse #1 who instructed her to go back to her room. NA #1 immediately looked at the oxygen gauge, removed the oxygen cylinder in its entirety from the holder on the back of the wheelchair, then accompanied by the activities director, the resident was escorted in her wheelchair to the 300/400 hall nurses station to get another oxygen cylinder. At 10:13 am, the resident's oxygen saturation was assessed by the medication aide at 95% on room air; however the resident continued with shortness of breath, deep breathing, anxiety and flushed in color. At 10:14 am, oxygen per a new oxygen cylinder at 2 liters per minutes was applied by nasal cannula and Nurse #1 arrived and adjusted the nasal cannula for proper fit and then asked Resident #40 "Are you okay?" The resident did not respond to her. At 10:15 am, the resident stated "I feel much better now and I'm not as frustrated" with no labored (difficultly) breathing observed. A review of the MAR revealed Nurse #1 on 9/4/14 at 10:27 am administered Ativan 0.25 mg (one tablet) by mouth for anxiety/agitation. Per follow up at 11:27 am, Nurse #1 documented the medication was effective.	F 224	Protocol. Portable O2 canisters have been added to the Medication Administration Record (MAR) with a new procedure, developed by the DNS, of changing out portable O2 canisters if less than 500 pounds per square inch (PSI) and document such in the ResidentMs medical record. Licensed staff were in serviced on how to respond to residents who are experiencing difficulty breathing. Staff re-educated to the airway, breathing and circulation assessment and its priority to other general nursing duties. Staff reeducated to insure that residents in respiratory distress are thoroughly and completely assessed. This includes that the ordered O2 is on and functioning; O2 saturation levels have been checked; vitals signs taken; lungs have been auscultated for wheezing, crackling or any abnormal breaths sounds. Staff are to assess for irregular labored breathing, nail beds to be monitored for cyanosis. Any licensed nurse not attending the in-service will not be placed on the schedule until the DNS, or appropriate designee, has reviewed all in-service material with said nurse. Any resident on portable O2 canisters will have the use of portable O2 canisters added to the applicable residents MAR to ensure residentsM canisters have been physically checked every shift by licensed personnel while the resident is up and using the O2 portable canister. If the resident is in bed or in room and the portable canister is not needed, it will be turned off and the resident placed on the provided O2 concentrator set at the	

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Continued From page 3

On 9/4/14 at 10:30 am, Nurse #1 in the presence of the Director of Nursing, acknowledged she was Resident #1's primary nurse. She stated she was aware the resident was ordered to have continuous oxygen. She indicated she instructed the resident to go to her room because she was in the middle of her medication pass when the resident stopped her in route from the med room. Nurse #1 stated there was no other emergency concern she was attending to when Resident #40 informed her she was short of breath and could not breathe. She further acknowledged Resident #40's concerns should have been her priority at the time the resident informed her she was short of breath and could not breathe, however she felt the resident was capable of going back to her room independently, as she instructed her and placing herself on the oxygen concentrator; until she had an opportunity to get to her because the resident was alert and capable of doing such a task independently. Nurse #1 acknowledged her response was inappropriate when the resident requested help from her and she continued with her med pass. She concluded she did not check to ensure the oxygen cylinder located on the back of the resident's wheelchair had sufficient oxygen, since taking over care of the resident on her shift at 7:00 am.

On 9/4/14 at 10:35 am, the Director of Nursing (DON) stated she expected Nurse #1 to have immediately stopped her med pass and assessed the resident, situation and provided immediate care to Resident #40.

On 9/4/14 at 10:53 am, the DON indicated she discussed in conference with Nurse #1 regarding the concern of not responding immediately to

F 224

ordered settings and delivered as ordered. O2 saturation levels will be taken every shift for residents with orders for continuous O2 and documented on MAR. Upon examination of the canister by licensed personnel, or appropriate designee, any canister found to be less than 500PSI will be exchanged for a full canister and documented as such in the residentMs medical record.
Continuing with facility policy, protocol and guidelines, the licensed staff will continue to document every shift on the MAR any resident receiving Oxygen Therapy. O2 saturation levels will also continue to be checked, each shift, on all residents receiving Oxygen Therapy, whether by concentrator or portable O2 canisters.
All licensed nursing will be re-in serviced by the DNS, or appropriate designee on/before 9/29/14 on facility policy regarding the definition of abuse, neglect, misappropriation of resident property, and facility expectations regarding keeping all residents safe from abuse, neglect and misappropriation of resident property. No licensed nurse will be allowed to work until re-in serviced on care of a resident on oxygen.

All newly hired nurses will be in-serviced during orientation by the DNS, or appropriate designee of the facility policy regarding abuse, neglect, misappropriation of resident funds, the facility expectations for following facility policy and protocol regarding keeping all residentMs safe from abuse, neglect, misappropriation of resident property and

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F 224	Continued From page 4 Resident #40's complaint of shortness of breath and difficultly breathing. The DON added she explained to Nurse #1 she failed to assess Resident #40's respiratory status; however during the discussion Nurse #1 responded she did not feel the concern was a priority, therefore, Nurse #1 was no longer employed at the facility effective immediately.	F 224	care of resident on oxygen, and evaluation of portable O2 canisters. Corrective Action #4 - Mobile residents dependent on portable O2 canisters will be monitored for respiratory status using Oxygen Monitoring Tool by the DNS, or appropriate designee 5 X week for 2 weeks; followed by 2 X week for 2 weeks; followed by weekly X 4 weeks, followed by monthly X 1 months; followed by quarterly X 3 quarters; and as needed. 10% of residents will be randomly selected by the facility administrator to be interviewed by the Social Service Director, or appropriate designee, with regards to resident rights as it pertains to the right to be free of abuse, neglect, and misappropriation of property and the facilityMs expectations of providing appropriate assessment and treatment. The random 10% of residents will be interviewed weekly times 8 weeks, followed by monthly X 4 months; followed by quarterly X 2 quarters, and as needed. Results of the monitoring for compliance with portable O2 canisters and the 10% random audit of residents will be brought to the morning administrations meeting by the DNS, Social Service Director, or appropriate designee weekly X 8 weeks. The results will be reviewed and discussed and appropriate follow up action implemented as needed. Following this 8 week period, the DNS, Social Service Director, or appropriate designee	

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F 224	Continued From page 5	F 224	will bring compliance with monitoring to the facility monthly Quality Assessment and Assurance Committee Meeting monthly X 4 months, then the facility QAA meeting quarterly X 2 quarters for discussion by the QAA team. Any non-compliance will be reviewed by the team with regards to the root cause of non-compliance and the QAA team will revise the plan as needed to ascertain compliance. All discussions by the QAA team will be documented in the QAA meeting minutes. Any revisions to the plan will be documented in the QAA meeting minutes and appropriate staff will be in serviced by the DNS, Social Service Director, or appropriate designee as applicable with regards to changes in the plan. Any change in the plan for monitoring portable O2 canisters or for interviewing random 10% of residents will require the monitoring outlined above to begin again.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/29/14

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to immediately assess and provide care to a resident who verbalized difficultly breathing and shortness of breath for 1 of 4 residents, who was dependent on supplemental oxygen (Resident #40). Findings included: Resident #40 was admitted into the facility on 8/29/14. Diagnoses include Bronchitis, Chronic Airway Obstruction, Supplemental Oxygen Dependent, Anxiety and Atrial Fibrillation. The Minimum Data Set was in process of being completed. The FL2 (a level of care screening tool) dated 8/6/14 revealed Resident #40's mental orientation was constant to person, place and time. Ambulation and transfers required supervision. Special treatment included continuous oxygen therapy. The admission care plan dated 8/29/14 listed Chronic Obstructive Pulmonary Disease (COPD) as a diagnosis. Oxygen therapy was indicated as an approach to be used with care. A review of the Physician orders for August 2014 - September 2014 revealed the following medications ordered for respiratory treatment: 1. Combivent inhalant spray one puff (inhalation) four times a day as needed for shortness of breath. Combivent is used in persons with COPD to prevent sudden bronshospams (constriction) of the muscles in the bronchiole (passageway by which air passage through the nose and mouth to the lungs). 2. Oxygen at 2 liters per minute via nasal cannula continuous every day.	F 309	Woodlands Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposed the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. Corrective Action #1 - Resident #40 was taken to the 300/400 hall nurses station by NA#1 and the activities director to be assessed by the nursing staff. O2 saturation was measured at 95% on room air by the Med Aide. O2 canister was changed and reset to 2 liters/nasal cannula by the Medication Aide. The resident was then taken to her room by nurse # 1 where an assessment was completed by the unit manager with assistance from the Director Nursing Services (DNS) as per facility protocol: O2 Saturation; Lung assessment (crackles, wheezes, diminished lung sounds); oxygenation of nail beds; Level of consciousness. Based on the assessment, it was determined that the residentMs O2 Saturation was 95% on room air and nail beds indicated adequate oxygenation. Ativan .25mg was administered by Nurse #1 to the Resident at 10:27am as a prophylactic calming agent and in addition to the O2 was effective in relieving anxiety. Nurse #1 was immediately interviewed by	

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F 309	Continued From page 7 3. Montelukast 10 milligram (mg) one tablet by mouth every day for shortness breath. Montelukast prevent shortness of breath, wheezing and asthma attacks. A review if the medication administration record (MAR) revealed Montelukast 10 mg was last administered on 9/4/14 at 8:00 am, as ordered by Nurse #1. On 9/4/14 at 10:07 am, an observation revealed Nurse #1 exited the med room on her way back to the medication cart and was stopped by Resident #40 at the nurse's station in her wheelchair as the nurse exited from the med room. The resident stated to her "I am short of breath and can not breathe, it is hard for me to get air, there's no air coming from my oxygen tank on the back of my wheelchair, I'm so frustrated right now, I need your help." The resident was observed with deep breathing, use of accessory muscles (internal and external intercostal muscles to aide in breathing which include neck and shoulders) with breathing and shortness of breath. Nurse #1 responded "Go to your room, I'll be there after a while" and walked a way without assessing the resident's voiced concerns and continued with her med pass. The resident was observed to be 50 feet or greater from her room, which was located down the hallway and to the right in the corner and out of sight of Nurse #1. Resident #40 yelled "Somebody please help me, she (Nurse #1) is not listening to me, I am short of breath and can't breathe and I need someone to help me now. The resident was observed to be frustrated and there was no other staff present at the time she voiced her concerns to Nurse #1 - the resident began to panic as she looked for someone to	F 309	the DNS as to rationale for lack of response to residentMs needs as had been instructed and trained per facility policies and procedures. Due to failure to follow facility policy and protocol, the nurse was terminated on 09/04/14 by the DNS. Corrective Action #2 - The DNS and administrative nursing staff reviewed all residents receiving Oxygen therapy, whether via concentrator or on portable O2 canisters, to ascertain canisters and concentrators were within normal operating ranges (9/04/14). All residents reviewed were found to have proper operating canisters and concentrators. Corrective Action # 3 - The facility DNS in serviced all licensed staff on 9/5/14 with regards to the following issues: (1) Treatment/Management of residents with COPD/Respiratory Compromise M Using COPD Clinical Protocol, 2) Oxygen (O2) Administration M Using Oxygen Administration Protocol, 3) Abuse and Neglect M Using Abuse/Neglect Protocol, and 4) Change in residents condition/status MUsing Change in Resident Condition Status Change Protocol. Portable O2 canisters have been added to the Medication Administration Record (MAR) with a new procedure, developed by the DNS, of changing out portable O2 canisters if less than 500 pounds per square inch (PSI) and document such in the ResidentMs medical record. Licensed staff were in serviced on how to respond to residents who are experiencing difficulty breathing. Staff re-educated to	

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F 309	Continued From page 8 help her. The oxygen cylinder gauge on the back of the resident's wheelchair was observed "empty" of oxygen. Upon looking for someone on the 500 unit where the resident was located, to help the resident, there was no staff member physically in sight. At 10:08 am NA (Nursing Assistant) #1 was observed and notified the resident oxygen cylinder was empty and she complained to Nurse #1 of shortness of breath/difficult breathing and needed immediate medical attention. NA (Nursing Assistant) #1 asked Resident #1 was she okay and the resident explained to her she could not breathe, no air was coming from her oxygen tank and that she had told Nurse #1 who instructed her to go back to her room. NA #1 immediately looked at the oxygen gauge, removed the oxygen cylinder in its entirety from the holder on the back of the wheelchair, then accompanied by the activities director, the resident was escorted in her wheelchair to the 300/400 hall nurses station to get another oxygen cylinder. At 10:13 am, the resident's oxygen saturation was assessed by the medication aide at 95% on room air; however the resident continued with shortness of breath, deep breathing and anxiety and flushed in color. At 10:14 am, oxygen per a new oxygen cylinder at 2 liters per minutes was applied by nasal cannula and Nurse #1 arrived and adjusted the nasal cannula for proper fit and then asked Resident #40 "Are you okay?" The resident did not respond to her. At 10:15 am, the resident stated "I feel much better now and I'm not as frustrated" with no labored (difficultly) breathing observed. A review of the MAR revealed Nurse #1 on 9/4/14 at 10:27 am administered Ativan 0.25 mg (one tablet) by mouth for anxiety/agitation. Per follow up at 11:27 am, Nurse #1 documented the	F 309	the airway, breathing and circulation assessment and its priority to other general nursing duties. Staff reeducated to insure that residents in respiratory distress are thoroughly and completely assessed. This includes that the ordered O2 is on and functioning; O2 saturation levels have been checked; vitals signs taken; lungs have been auscultated for wheezing, crackling or any abnormal breaths sounds. Staff are to assess for irregular labored breathing, nail beds to be monitored for cyanosis. Any licensed nurse not attending the in-service will not be placed on the schedule until the DNS, or appropriate designee, has reviewed all in-service material with said nurse. Any resident on portable O2 canisters will have the use of portable O2 canisters added to the applicable residents MAR to ensure residentsM canisters have been physically checked every shift by licensed personnel while the resident is up and using the O2 portable canister. If the resident is in bed or in room and the portable canister is not needed, it will be turned off and the resident placed on the provided O2 concentrator set at the ordered settings and delivered as ordered. O2 saturation levels will be taken every shift for residents with orders for continuous O2 and documented on MAR. Upon examination of the canister by licensed personnel, or appropriate designee, any canister found to be less than 500PSI will be exchanged for a full canister and documented as such in the residentMs medical record. Continuing with facility policy, protocol and	

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medication was effective.

On 9/4/14 at 10:30 am, Nurse #1 in the presence of the director of nursing, acknowledged she was Resident #1's primary nurse. She stated she was aware the resident was ordered to have continuous oxygen. She indicated she instructed the resident to go to her room because she was in the middle of her medication pass when the resident stopped her in route from the med room. Nurse #1 stated there was no other emergency concern she was attending to when Resident #40 informed her she was short of breath and could not breathe. She further acknowledged Resident #40's concerns should have been her priority at the time the resident informed her she was short of breath and could not breathe; however she felt the resident was capable of going back to her room independently, as she instructed her and placing herself on the oxygen concentrator; until she had an opportunity to get to her because the resident was alert and capable of doing such a task independently. Nurse #1 acknowledged her response was inappropriate when the resident requested help from her and she continued with her med pass. She concluded she did not check to ensure the oxygen cylinder located on the back of the resident's wheelchair had sufficient oxygen, since taking over care of the resident on her shift at 7:00 am.

On 9/4/14 at 10:35 am, the Director of Nursing (DON) stated "Every nurse should know if a resident is having trouble breathing, the nurse should immediately address the issue." The DON further stated she expected Nurse #1 to have immediately stopped her med pass and assessed the resident, situation and provided immediate care to Resident #40.

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guidelines, the licensed staff will continue to document every shift on the MAR any resident receiving Oxygen Therapy. O2 saturation levels will also continue to be checked, each shift, on all residents receiving Oxygen Therapy, whether by concentrator or portable O2 canisters. All licensed nursing will be re-in serviced by the DNS, or appropriate designee on/before 9/29/14 on facility policy regarding the definition of abuse, neglect, misappropriation of resident property, and facility expectations regarding keeping all residents safe from abuse, neglect and misappropriation of resident property. No licensed nurse will be allowed to work until re-in serviced on care of a resident on oxygen.

All newly hired nurses will be in-serviced during orientation by the DNS, or appropriate designee of the facility policy regarding abuse, neglect, misappropriation of resident funds, the facility expectations for following facility policy and protocol regarding keeping all residentMs safe from abuse, neglect, misappropriation of resident property and care of resident on oxygen, and evaluation of portable O2 canisters.

Corrective Action #4 - Mobile residents dependent on portable O2 canisters will be monitored for respiratory status using Oxygen Monitoring Tool by the DNS, or appropriate designee 5 X week for 2 weeks; followed by 2 X week for 2 weeks; followed by weekly X 4 weeks, followed by monthly X 1 months; followed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING ______ B. WING ______	09/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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On 9/4/14 at 11:00 am, Nurse #2 stated supply oxygen cylinders are kept on the 300/400 (one unit) medication room only for backup cylinder oxygen.

On 9/4/14 at 11:05 am, in an attempt to interview Resident #40, the DON and Nurse #2 were observed by the resident's bedside talking to the resident in her room, while she rested in the bed. Upon their exit and entering the room the resident stated "I am okay now, I don't want to cause any trouble for anyone here." Resident #40 would not elaborate further concerning her previous complaint to Nurse #1 or the respiratory episode she experienced.

On 9/4/14 at 11:20 am, NA #1 stated she worked with Resident #40 regularly and she had never seen the resident act the way she did. She added she believed the resident was short of breath and could not breathe properly when she informed her. NA #1 added the resident was alert and was capable of making her needs known to the staff.

On 9/4/14 at 11:26 am, the Activity Director stated when she heard Resident #40 state she needed help and was having difficulties breathing, she escorted the resident behind NA #1 who had the oxygen cylinder to the next nurses station because she wanted to ensure the resident received oxygen.

On 9/4/14 at 12:30 pm, the administrator provided a copy of the MAR. The MAR did not reflect combivent inhalant one puff as needed for shortness of breath was administered on 9/4/14 during the time of the respiratory event or immediately following.

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quarterly X 3 quarters; and as needed.

10% of residents will be randomly selected by the facility administrator to be interviewed by the Social Service Director, or appropriate designee, with regards to resident rights as it pertains to the right to be free of abuse, neglect, and misappropriation of property and the facilityMs expectations of providing appropriate assessment and treatment.

The random 10% of residents will be interviewed weekly times 8 weeks, followed by monthly X 4 months; followed by quarterly X 2 quarters, and as needed.

Results of the monitoring for compliance with portable O2 canisters and the 10% random audit of residents will be brought to the morning administrations meeting by the DNS, Social Service Director, or appropriate designee weekly X 8 weeks. The results will be reviewed and discussed and appropriate follow up action implemented as needed. Following this 8 week period, the DNS, Social Service Director, or appropriate designee will bring compliance with monitoring to the facility monthly Quality Assessment and Assurance Committee Meeting monthly X 4 months, then the facility QAA meeting quarterly X 2 quarters for discussion by the QAA team.

Any non-compliance will be reviewed by the team with regards to the root cause of non-compliance and the QAA team will revise the plan as needed to ascertain

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	345481	A. BUILDING ______ B. WING ______	**09/04/2014**

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

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F 309	Continued From page 11	F 309	compliance. All discussions by the QAA team will be documented in the QAA meeting minutes. Any revisions to the plan will be documented in the QAA meeting minutes and appropriate staff will be in serviced by the DNS, Social Service Director, or appropriate designee as applicable with regards to changes in the plan. Any change in the plan for monitoring portable O2 canisters or for interviewing random 10% of residents will require the monitoring outlined above to begin again.	