	-	ID HUMAN SERVICES				FORM APPF	ROVED
		MEDICAID SERVICES				OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	Y
		345277	B. WING			C 11/17/201	16
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		<u> </u>
WOODLAN	ND HILL CENTER			400 VISION DRIVE			
				ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIA CIENCY)	COMP	X5) PLETION ATE
F 000	INITIAL COMMENTS	3	F 00	00			
		e cited as a result of the ion 11/17/16 Event ID# in deletion of E 371					
F 278 SS=D	483.20(g) - (j) ASSE		F 21	78		12/9/*	16
	The assessment mus resident's status.	accurately reflect the					
	A registered nurse m each assessment wit participation of health						
	A registered nurse m assessment is compl	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreemen material and false sta	t does not constitute a atement.					
	This REQUIREMENT	is not met as evidenced					
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DAT	<sup>™</sup> /2016

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.

				IPLE CONSTRUCTION		<u>10. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDI	NG		С
		345277	B. WING			1/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/1//2010
				400 VISION DRIVE	-	
WOODLA	ND HILL CENTER			ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 278	Continued From page	e 1	E,	278		
. 2.0	by:					
		ecord review and staff		Those affected: Director of		
		failed to accurately code the		Nursing/Management Nurse to	o complete	
	Minimum Data Set (N	MDS) assessment in the		modifications to the Minimum	Data Set for	
	areas of active diagn			residents #58, #83, and #63 b	y 12/9/16.	
		t #83), and dental status		T		
		of 15 sampled residents.		Those potentially affected: Di		
	The findings included	1:		Nursing/Management Nurse to audit for section I and section		
	1. Resident #58 was	admitted to the facility on		accuracy by 12/9/16 for the m		
		ed to the facility on 10/21/16		Minimum Data Set for each re		
	with multiple diagnos			There were 23 inaccurate Min	imum Data	
	schizophrenia, depre	ession, anxiety, and insomnia.		Sets that had modifications ma Director of Nursing/Manageme	•	
		ated 10/21/16 indicated		the time of the audit. Director		
		nedication) 7.5 milligrams		Nursing/Management Nurse to		
		hrs) as needed (PRN) for		audit for section L accuracy by		
	anxiety for Resident	#58.		the most recent Minimum Data each resident. There were 18		
	A review of Resident	#58's October 2016		Minimum Data Sets that had	inaccurate	
	Medication Administr			modifications made by the Dire	ector of	
		ministered Valium for anxiety		Nursing/Management Nurse a		
		nce on 10/23/16, three times nes on 10/25/16, twice on		the audit.		
	10/26/16, once on 10			Systemic changes: All nursing		
	10/28/16.			in-serviced on accurate coding		
	·			completion of the User Data A		
	The annual Minimum	· · · · ·		and Minimum Data Set coding		
	#58 had moderate co	0/28/16 indicated Resident		accuracy by 12/9/16. Two lice on Leave. Both will be in-servi		
		dicated to have received		their return.		
		on on 7 of 7 days during the				
		v period. Section I, the Active		Monitoring and Performance		
	Diagnoses section, w	vas not coded for anxiety		Improvement: Audits will be c	-	
	(Question I5700).			Director of Nursing/Manageme		
				on 5 Minimum Data Set per we		
	-	ordinator was not available		month, then bi-weekly for two		
	unable to be reached	was on vacation and was		then monthly for three months Nursing/Management Nurse w		

Facility ID: 923365

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	-	D HUMAN SERVICES				FORM	): 01/17/2017 APPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345277	B. WING		_		C 17/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	00 VISION DRIVE			
WOODLA	ND HILL CENTER		4	ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	2	F 278		to the Performance	9	
	MDS Coordinator on Section I, the Active II 10/28/16 MDS for Res with the Traveling MD physician's order for A PRN for anxiety was n MDS Coordinator. The Resident #58 that ind administered on 7 of 3 back period was reviee Coordinator. She rep why anxiety was not i diagnosis on the 10/2 An interview was come Nursing on 11/17/16 a indicated her expecta accurate. 2. Resident #83 was 7/21/16. Cumulative dementia without beh major depressive disc A Quarterly Minimum 11/1/16 indicated Res impaired in cognition. during the seven day the following: antian days. Physician orders for C revealed an order for medication) 0.5 millign hours as needed for a	Diagnoses section, of the sident #58 was reviewed S Coordinator. The /alium 7.5mg every 8hrs reviewed with the Traveling he October 2016 MAR for icated Valium was 7 days during the MDS look ewed with Traveling MDS orted she was unable to say indicated to be an active 8/16 MDS for Resident #58. ducted with the Director of at 10:14 AM. The DON tion was for the MDS to be admitted to the facility diagnoses included avioral disturbance and order. Data Set (MDS) dated ident #83 was severely Medications administered look back period included xiety medication six (6) Dctober and November 2016 Lorazepam (antianxiety rams by mouth every six (6)		results of the audits Improvement meeti		•	

Facility ID: 923365

If continuation sheet Page 3 of 53

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345277	B. WING				C / <b>17/2016</b>
NAME OF PF	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLAI	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 278 F 279 SS=D	received antianxiety r 10/26/16, 10/27/16, 1 10/31/16-a total of five On 11/16/16 at 12:450 conducted with the Di she expected the MD On 11/17/16 at 10:53, conducted with the tra who stated she mistor initials and Resident # antianxiety medication 3. Resident # 63 was 11/27/13 with multiple vascular dementia. T Set (MDS) assessme that Resident #62 had impairment and he was The medical records of reviewed. The records #63 was seen by the notes indicated that R edentulous. On 11/15/16 at 9:07 A observed. He was ob On 11/17/16 at 10:15 MDS Nurse was inter expected MDS assess On 11/17/16 at 10:20 (DON) was interviewed she expected MDS as	day look-back period ealed that Resident #83 nedication (Lorazepam) on 0/28/16, 10/30/16 and e (5) days. PM, an interview was rector of Nursing who stated S to be accurate. AM, an interview was aveling MDS Coordinator ok one of the entries as #83 received 5 days of n. admitted to the facility on e diagnoses including the annual Minimum Data nt dated 10/3/16 indicated d severe cognitive as not edentulous. of Resident #63 were s indicated that Resident dentist on 4/6/16. The dental Resident #63 was overved to be edentulous. AM, the facility's traveling viewed. She stated that she sments to be accurate. AM, the Director of Nursing ed. The DON indicated that sessments to be accurate. AM, the Director of Nursing ed. The DON indicated that sessments to be accurate. 1) DEVELOP		278			12/9/16

If continuation sheet Page 4 of 53

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345277	B. WING				C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
WOODLA	ND HILL CENTER				100 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	A facility must use the to develop, review an comprehensive plan of The facility must deve plan for each resident objectives and timeta medical, nursing, and needs that are identifi assessment. The care plan must d to be furnished to atta highest practicable pf psychosocial well-bei §483.25; and any ser be required under §48 due to the resident's of §483.10, including the under §483.10(b)(4).	e results of the assessment d revise the resident's of care. elop a comprehensive care t that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's hysical, mental, and ng as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment	F	279			
	by: Based on medical re interview, the facility f comprehensive plans antipsychotic medicat reviewed for unneces #58 and #117). The f 1. Resident #58 was 6/13/15 and readmitte with multiple diagnose schizophrenia, depres Resident #58's compr included, in part, the f	ailed to develop of care related to the use of tions for 2 of 7 residents sary medications (Residents findings included: admitted to the facility on ed to the facility on 10/21/16			Those affected: Director of Nursing/Management Nurse to complet a modification to the Care Plan for Residents #58 and #117 by 12/9/16 to include diagnosis or the use of antipsychotic medications related to th diagnosis. Those potentially affected: Care Plans residents receiving antipsychotic medications to be reviewed by Directo Nursing/Management Nurse for accura by 12/9/16. There were 83 Care Plans found not addressing the use of psychotropic medications and/or the	e s for r of acy	

Facility ID: 923365

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TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
					с
		345277			11/17/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET
F 279	Continued From page	e 5	F 279		
	drugs for the diagnos	is of Depressive Disorder. ndicated to most recently be		diagnoses related to the psychol medications. All were revised by Director of Nursing/Managemen	the
rev thr he tho de Th	through 10/21/16 for health admission for thoughts. Chief com	spitalized on 10/12/16 an involuntary behavioral depression and delusional blaints were indicated to be , and delusional thoughts. ary, dated 10/21/16,		Systemic changes: All nursing si in-serviced on the need for Care accuracy to include diagnosis or of antipsychotic medications rela diagnosis by 12/9/16. Two licens on Leave. Both will be in-service their return.	Plan the use ted to the sed staff
	#58 had moderate co had delusions during Resident #58 was inc behaviors or rejection period. She was addi received antipsychoti medication, and antic of 7 days during the M Care Area Assessme was triggered for Psy Resident #58 was inc multiple psychoactive Latuda (antipsychotic (antianxiety medicatio (antidepressant medi	<ul> <li>W28/16 indicated Resident</li> <li>ignitive impairment and she</li> <li>the MDS review period.</li> <li>licated to have had no</li> <li>of care during the review</li> <li>tionally indicated to have</li> <li>c medication, antianxiety</li> <li>lepressant medication on 7</li> <li>MDS review period. The</li> <li>nt (CAA) for Resident #58</li> <li>chotropic Drug Use.</li> <li>licated to have received</li> <li>medications that included</li> <li>medication), Valium</li> <li>on), and Cymbalta</li> <li>cation). Resident #58 had a</li> <li>amenia and was indicated to</li> </ul>		Improvement: Audits will be com Director of Nursing/Management on 5 Care Plans for diagnosis/us antipsychotic medication related diagnosis weekly for one month, bi-weekly for two months, then n three months. Director of Nursing/Management Nurse will results of the audits to the Perfor Improvement meetings.	t Nurse be of to the then nonthly for bring the
		· ·			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	SURVEY
		245277	B. WING	<u> </u>			С
	ROVIDER OR SUPPLIER	345277	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	/17/2016
NAME OF P	ROVIDER OR SUPPLIER				400 VISION DRIVE		
WOODLA	ND HILL CENTER				ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 279	indicated she was far She reported Resider behaviors that include paranoia. She indica recent mental health behaviors and delusio Resident #58 seemed improvement since th but she continued wit An interview was con 11/15/16 at 4:00 PM. familiar with Resident Resident #58 had fre An interview was con MDS Coordinator on plan of care for Resid diagnosis of schizoph antipsychotics was re MDS Coordinator. Si take a closer look at I An interview was con Nursing on 11/17/16 at indicated her expecta be accurate and upda On 11/17/16 at 12:10 Coordinator provided Resident #58. The ca area of: "Disruption ir Resident [#58] exhibit times." This focus ar been revised on 11/1	5/16 at 3:40 PM. She niliar with Resident #58. ht #58 had number of ed delusions, anxiety, and ted Resident #58 had a hospitalization related to her ons. The SW reported d to have had some is inpatient hospitalization, h delusions and anxiety. ducted with Nurse #3 on She indicated she was t #58. She reported quent delusions and anxiety. ducted with the Traveling 11/17/16 at 10:10 AM. The lent #58 as well as the menia and usage of eviewed with the Traveling the reported she needed to Resident #58's plan of care. ducted with the Director of at 10:14 AM. The DON tion was for plans of care to ated as needed. PM the Traveling MDS an updated care plan for are plan indicated a focus in cognition, Schizophrenia. ts delusional thinking at ea was indicated to have	F	279			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/17/2017 // APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING					C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP	CODE		
WOODLA	ND HILL CENTER				00 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 279	cumulative diagnoses The admission Minim 9/19/16 indicated sev and extensive assista activities of daily living A review of the medic included Seroquel (ar milligrams (mg) to be Resident #117 ' s card include a care plan fo medication to include potential side effects of behaviors to warrant the antipsychotic medicat In an observation on Resident #117 was sin nursing station when ambulate unassisted. In an interview on 11/ Assistant (NA) # 1 star resisted care and had while ambulating in the In an interview on 11/ stated Resident #117 especially as the day become more confust #117 had been observa- ambulating inside his In another observation Resident #117 was of chair at the nursing sta- cooperative but confust	<ul> <li>a of dementia and psychosis.</li> <li>a um Data Set (MDS) dated ere cognitive impairment ance with most of his g.</li> <li>b attons ordered on admission antipsychotic) 25 given every evening.</li> <li>b e plan dated 9/21/16 did not or the use of an antipsychotic the monitoring of the targeted the continued use of an antipsychotic.</li> <li>11/14/16 at 4:00 PM, itting in a wheelchair at the he stood and attempted to He was easily redirected.</li> <li>(16/16 at 2:45 PM, Nursing ated Resident #117 often d been observed disrobed he hall on occasion.</li> <li>(16/16 at 2:50 PM, NA #2 required close observation went on when he seemed to ed. NA #2 stated Resident ved disrobed but only room.</li> <li>n on 11/16/16 at 3:00 PM, bserved sitting in a wheel</li> </ul>	F	279				

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-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/17/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345277	B. WING		_		C 17/2016
NAME OF PROVIDER OR S	UPPLIER	I		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				400 VISION DRIVE			
	NIER			ASHEBORO, NC 27203	}		
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 Continued be.	From page	98	F 27	79			
traveling N that a care the time of actively pr behavior m evaluation side effectIn an inter Administra resident 's and that a on Reside possible d side effectF 280 SS=EF 280 SS=EF 280 DARTICIPThe reside incompete incapacita participate changes in A comprehe interdiscip physician, for the res disciplines and, to the the reside	IDS Coordi e plan would f admission escribed Se nonitoring, and obser s. view on 11/ ator voiced s prescribed care plan v nt #117 to e ose reducti s related hi 3), 483.10( ATE PLANI ent has the ent or otherview ted under the in planning n care and f nensive care ays after the nsive assess linary team a registere ident, and of extent pra ant, the resides esentative; a	<ul> <li>17/16 at 10:00 AM, the inator stated her expectation d have been completed at since Resident #117 was eroquel and would require gradual dose reduction vation for possible adverse</li> <li>17/16 at 11:27 AM, the the importance of monitoring d antipsychotic medications would have been expected ensure behavior monitoring, on and potential adverse s Seroquel.</li> <li>k)(2) RIGHT TO NING CARE-REVISE CP</li> <li>right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment.</li> <li>e plan must be developed e completion of the ssment; prepared by an , that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, cticable, the participation of dent's family or the resident's needs, and periodically reviewed n of qualified persons after</li> </ul>	F 28	80			12/9/16

Facility ID: 923365

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	ED
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345277	B. WING		C 11/17/2016	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		1
F 280	Continued From page each assessment.	9 9	F 280			
	by: Based on medical re interview, the facility f related to behavior m reviewed for unneces #58, #63, #67, #83). 1. Resident #67 was	Failed to revise plans of care onitoring for 4 of 7 residents sary medications (Residents The findings included: initially admitted to the d most recently readmitted inoses that included		Those affected: Care Plans for resider #67, #58, #63 and #83 will be reviewed and revised by the Director of Nursing/Management Nurse by 12/9/1 state the Behavior Monitoring Tool will used to reflect the residents □ behavior Behavior monitoring tool will be implemented for the affected residents 12/9/16 by the Director of Nursing/Management Nurse.	d 6 to be r. by	
	included, in part, the f complications related drugs. This focus are recently be updated of Resident #67 to recei- effective dose of psyc without side effects. completion of the beh for Resident #67. The annual Minimum assessment dated 11 #67's cognition was s had no delusions, no and no rejection of ca indicated to have reco	chotropic medications The interventions included aavior monitoring flow sheet Data Set (MDS) /5/16 indicated Resident ignificantly impaired, she hallucinations, no behaviors, are. Resident #67 was eived antipsychotic epressant medication on 7		<ul> <li>a behavior care plan will be reviewed the 12/9/16 by the Director of Nursing/Management Nurse. There were that care plans that did not address behaviors and the behavior monitoring tool. The Director of Nursing/Management Nurse revised those care plans to inclus the behaviors and the behavior monitor tool. Behavior monitoring tool will be implemented for all appropriate resident by 12/9/16 by the Director of Nursing/Management Nurse.</li> <li>Systemic Changes: All nursing staff wi in-serviced on adding the Behavior Monitoring Tool to the Care Plan for residents with behaviors or receiving antipsychotic medications by 12/9/16. licensed staff on Leave. Both will be in-serviced upon their return.</li> </ul>	by ere nent ude ring nts	

Event ID: 307L11

Facility ID: 923365

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	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	ECONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			C
		345277	B. WING		1	1/17/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
WOODLA	ND HILL CENTER			100 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From page	e 10	F 280			
	<ul> <li>Continued From page 10</li> <li>A review of the medical record revealed the most recent behavior monitoring flow sheet for resident #67 was completed in May 2016.</li> <li>An interview was conducted with the Social Worker (SW) on 11/15/16 at 3:40 PM. She reported that nurses documented behaviors in their progress notes. She indicated that in the past, the nurses had documented behaviors on hard copy behavior flow sheets. She stated that she thought the hard copy flow sheets were no longer utilized, but she was unsure. She indicated she thought the change may have happened when the facility began utilizing electronic Medication Administration Records (eMARs). The SW was unsure when the eMARs were implemented. She suggested speaking to the nursing staff.</li> </ul>			Monitoring and Performance Improvement: Audits will be control the Director of Nursing/Manag Nurse on 5 Care Plans that the Monitoring Tool is addressed of Plan for residents with behavior antipsychotic medications. Aud done weekly for one month, th bi-weekly for two months, and monthly for three months. The Nursing/Management Nurse w results of the Care Plan audits Performance Improvement me	ement e Behavior on the Care ors or on dits will be en then Director of vill bring the to the	
	11/15/16 at 3:58 PM. were documented in t Record (E MR). She to utilize hard copy be sheets, but these were indicated she thought behavior monitoring of to be completed each was not sure if every eMAR. She indicated nurse if the behavior all residents' eMARs. The interview with Nu #3 was included in the 11/15/16 at 4:00 PM.	ducted with Nurse #2 on She reported that behaviors the Electronic Medical stated that the nurses used ehavior monitoring flow re no longer in use. She is some residents had on their eMAR that needed is shift by the nurse, but she resident had it on their d she needed to ask another monitoring was included on urse #2 continued and Nurse is portion of the interview on Nurse #3 indicated that mented on nursing progress				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345277	B. WING				C 17/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	future. An interview was con Manager (UM) on 11/ indicated that behavior nursing progress note had previously utilized monitoring flow sheet out when the facility b May of 2016. The UM behavior monitoring fl transition to eMAR. An interview was con Nursing (DON) on 11/ DON reported that eM May 23, 2016. She s out the hard copy bef when eMAR was imp indicated there was a when the facility trans MARs to eMARs. Sh dropped" and the card revised to indicate that flow sheets were no b indicated the complet monitoring flow sheet removed from the card her expectation was f and revised as neede 2. Resident #58 was facility on 6/13/15 and the facility on 10/21/1 that included schizopt insomnia.	b be implemented in the ducted with the Unit 16/16 at 11:44 AM. She prs were documented in es. She reported the facility d a hard copy behavior , but this had been phased began eMAR sometime in A indicated there were no low sheets utilized after the ducted with the Director of (17/16 at 10:14 AM. The MAR was implemented on tated that the facility phased havior monitoring flow sheets lemented. The DON huge adjustment period bitioned from hard copy e revealed, "The ball got e plans had not been at the behavior monitoring conger utilized. She ion of the behavior s should have been e plans. The DON reported or care plans to be accurate	F	280			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/17/2017 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345277	B. WING		_	( 11/*	C 17/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	complications related drugs. This focus area recently be updated o Resident #58 to receiv effective dose of psyc without side effects. completion of the beh for Resident #58. The annual Minimum assessment dated 10. #58 had moderate con had delusions during Resident #58 was ind behaviors or rejection period. She was addit received antipsychotic medication, and antid of 7 days during the M A review of the medic recent behavior monit Resident #58 was con Morker (SW) on 11/18 reported that nurses of their progress notes. past, the nurses had of hard copy behavior flo she thought the hard longer utilized, but she indicated she thought happened when the fa electronic Medication (eMARs). The SW was	Tocus area of the risk for to the use of psychotropic a was indicated to most in 8/5/16. The goal was for ve the smallest most chotropic medications The interventions included avior monitoring flow sheet Data Set (MDS) /28/16 indicated Resident gnitive impairment and she the MDS review period. icated to have had no of care during the review tionally indicated to have c medication, antianxiety epressant medication on 7 MDS review period. al record revealed the most toring flow sheet for mpleted in May 2016. ducted with the Social 5/16 at 3:40 PM. She documented behaviors in She indicated that in the documented behaviors on ow sheets. She stated that copy flow sheets were no e was unsure. She the change may have	F 280				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/17/2017 APPROVED ). 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345277	B. WING		_	C 11/17/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 280	Continued From page	e 13	F 280					
	11/15/16 at 3:58 PM. were documented in the Record (E MR). She to utilize hard copy be sheets, but these were indicated she thought behavior monitoring of to be completed each was not sure if every eMAR. She indicated nurse if the behavior mail residents' eMARs. The interview with Nut #3 was included in the 11/15/16 at 4:00 PM. behaviors were docur notes. She reported the monitoring on the eM. yet, but it was going the future. An interview was commonitoring flow sheet out when the facility behavior monitoring flow sheet out when the facility behavior monit	stated that the nurses used ehavior monitoring flow e no longer in use. She some residents had on their eMAR that needed shift by the nurse, but she resident had it on their d she needed to ask another monitoring was included on  rse #2 continued and Nurse is portion of the interview on Nurse #3 indicated that mented on nursing progress that the electronic behavior AR had not been utilized o be implemented in the						

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/17/2017 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345277	B. WING		_	( 11/ <sup>,</sup>	) 17/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	out the hard copy berwhen eMAR was implindicated there was a when the facility trans MARs to eMARs. She dropped" and the care revised to indicate tha flow sheets were noted indicated the completed monitoring flow sheets removed from the care her expectation was fand revised as needed 3. Resident #63 was a 11/27/13 with multiple psychosis, anxiety, de stress disorder. The a (MDS) assessment dia Resident #63 had sev and had received antia antidepressant for the assessment also indic not displayed hallucind behavioral symptoms. The care plan of Resi The care plan problem for complications rela psychotropic drugs ar hallucinations and paresident should have dose without side effect less incidents of behavioral symptoms.	havior monitoring flow sheets lemented. The DON huge adjustment period sitioned from hard copy e revealed, "The ball got e plans had not been at the behavior monitoring onger utilized. She ion of the behavior s should have been re plans. The DON reported for care plans to be accurate additted to the facility on e diagnoses including epression and posttraumatic annual Minimum Data Set ated 10/3/16 indicated that vere cognitive impairment ipsychotic, antianxiety, and e last 7 days. The cated that Resident #63 had vations, delusions or any in the last 7 days. dent #63 was reviewed. ms included resident at risk ted to the use of nd resident has delusions, ranoia. The goals were the smallest most effective acts and resident will have wiors through next review. ided to complete behavior and to document delusions its.	F 24				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/17/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345277	B. WING			( 11/*	) 17/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE	,	
			40	00 VISION DRIVE			
WOODLA	ND HILL CENTER		A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 280	On 11/17/16 at 10:13 MDS Nurse was inter care plan should have monitoring when the f behavior monitoring fl An interview was com Nursing (DON) on 11/ DON reported that eM May 23, 2016. She s out the hard copy ber when eMAR was implindicated there was a when the facility trans MARs to eMARs. Sh dropped" and the care revised to indicate that flow sheets were no lo indicated the complet monitoring flow sheet removed from the car her expectation was f and revised as needed 4. Resident #83 was 7/21/16. Cumulative dementia without beh major depressive disc Minimum Data Set (M 11/1/16 indicated Res impaired in cognition. Resident #83 stated s energy never or one of indicated during the as Medications administer	As did not contain any low sheets since May 2016. AM, the facility's traveling viewed. She stated that the e been revised for behavior facility stopped using the low sheets. ducted with the Director of (17/16 at 10:14 AM. The MAR was implemented on tated that the facility phased navior monitoring flow sheets lemented. The DON huge adjustment period sitioned from hard copy e revealed, "The ball got e plans had not been at the behavior monitoring onger utilized. She ion of the behavior s should have been e plans. The DON reported for care plans to be accurate ed. admitted to the facility diagnoses included: avioral disturbance and order. The Quarterly IDS) assessment dated sident #83 was severely Mood state indicated she was tired or had little day. No behaviors were	F 280				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277 NAME OF PROVIDER OR SUPPLIER WOODLAND HILL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			A. BUILDING B. WING S	TREET ADDRESS, CITY, ST. 00 VISION DRIVE	- ATE, ZIP CODE	FORM OMB NO (X3) DATE COMP	LETED
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	antidepressant medic A care plan dated 8/1 was at risk for complic psychotropic drugs. I complete behavior mo The medical records f reviewed. The record behavior monitoring fl admission on 7/21/16 An interview was cond 11/16/16 at 11:44 AM behaviors were docur notes. She reported fu utilized a hard copy be sheet, but this had be facility began eMAR ( administration record) The UM indicated the monitoring flow sheets to eMAR. An interview was cond Nursing (DON) on 11/ DON reported that eM May 23, 2016. She s out the hard copy beh when eMAR was impli indicated there was a when the facility trans MARs to eMARs. Shi dropped" and the care	<ul> <li>) days of antianxiety and ation.</li> <li>/16 indicated Resident #83 cations related to the use of interventions included to onitoring flow sheet.</li> <li>For Resident #83 were is did not contain any ow sheets since resident 's</li> <li>ducted with the UM on She indicated that nented in nursing progress he facility had previously ehavior monitoring flow en phased out when the electronic medication sometime in May of 2016. The were no behavior situilized after the transition</li> <li>ducted with the Director of 17/16 at 10:14 AM. The MAR was implemented on tated that the facility phased avior monitoring flow sheets emented. The DON huge adjustment period itioned from hard copy e revealed "The ball got e plans had not been at the behavior monitoring progress is the behavior monitoring progress is provide the provided that the facility phased provided that the fa</li></ul>	F 280				

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
					С		
		345277	B. WING		11/17/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI		
F 280	Continued From page	e 17	F 28	0			
	her expectation was f	e plans. The DON reported or care plans to be accurate					
F 329 SS=E			F 32	9	12/9/16		
	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.						
	by: Based on medical re interview, the facility f	failed to consistently monitor iors to support a clinical		Those affected: Behavior Monitorin to be implemented by Director of Nursing/Management Nurse for resi #63, #67, #94 and #117 by 12/9/201	dents		

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If continuation sheet Page 18 of 53

<u>CENTER</u>	<u>S FOR MEDICARE &amp;</u>	MEDICAID SERVICES			<u>OMB</u> N	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
						С
		345277	B. WING		1	1/17/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 18	F 3	29		
	<ul> <li>F 329 Continued From page 18 <ul> <li>increase in dosage of psychotropic medication</li> <li>(Residents #63, #67, #94, and #117) and failed to</li> <li>identify a duplicate order for antihistamine</li> <li>medication resulting in a duplication of therapy</li> <li>(Resident #103) for 5 of 7 residents reviewed for</li> <li>unnecessary medications. The findings included:</li> </ul> </li> <li>1. Resident #94 was initially admitted to the</li> <li>facility on 10/25/15 and readmitted on 11/13/15</li> <li>with multiple diagnoses that included dementia,</li> <li>anxiety, and depression.</li> <li>Resident #94's comprehensive plan of care</li> <li>included, in part, the focus area of the risk for</li> <li>complications related to the use of psychotropic</li> <li>drugs. This focus area was indicated to most</li> <li>recently be updated on 9/13/16. The goal was for</li> <li>Resident #94 to receive the smallest most</li> <li>effective dose of psychotropic medications</li> <li>without side effects. The interventions included</li> <li>Resident #94 being monitored for the continued</li> <li>need of medication and monitored for side effects</li> </ul>			Those potentially affected: Resi receiving antipsychotic or antiar medications will have a Behavio Monitoring Tool put into place b by the Director of Nursing/Mana Nurse. Newly admitted residen medications will be reviewed du clinical meeting by the Director Nursing/Management Nurse for of a Behavior Monitoring Tool. O medications are reviewed, the D Nursing/Management Nurse will implement the behavior monitor appropriate. The behavior monitor will be implemented for any resi placed on a medication that req behavior monitoring tool by the Nursing/Management Nurse. Those affected: Director of Nursing/Management Nurse to	nxiety or y 12/9/16 agement t s uring our of the need Director of l conce the Director of l toring tool as toring tool dent uires the Director of	
of medication. Resident #94 had an initial psychiatric evaluation on 5/12/16. The chief complaint/nature of presenting problem was indicated to be "dementia, depression, anxiety". Resident #94 was indicated to be referred for evaluation due to a noted decline in her kidney function and a concern of the Nurse Practitioner (NP) with Resident #94's existing psychotropic medications. The psychiatric evaluation reported Resident #94 stated, "I'm always anxious". Resident #94 denied depression, auditory and visual hallucinations, and distress with side effects from existing psychotropic medications. The Psychiatric Mental Health Nurse Practitioner (PMHNP) indicated Resident #94's presentation			<ul> <li>Resident #103 □ s medication for duplication by 12/9/16. Residen 1 duplicate medication order. The attending Physician was notified clarified the order.</li> <li>Those Potentially Affected: Phy orders were reviewed for accurate duplication therapy for all other by Director of Nursing/Manager Nurse. There were 2 residents I duplication of therapy. Physicial notified and any changes to the medication orders were comple</li> <li>Systemic Changes: All nursing in-serviced by 12/9/16 in regard</li> </ul>	t 103 had he d and sician acy and residents nent had hs were ted. staff will be		

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If continuation sheet Page 19 of 53

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(V2) DAT	E SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,			E SURVET IPLETED		
						С		
		345277	B. WING		11	/17/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	PCODE			
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE		
F 329	Continued From page	e 19	F 32	9				
		ety than depression. The		Behavior Monitoring Tool	and the			
	PMHNP indicated he	r plan was to implement a		documentation of behavi	ors on the tool.			
		on (GDR) of Resident #94's		Two licensed staff on Lea				
	antidepressant and in (antianxiety medication	nitiate an alternate anxiolytic		in-serviced upon their ret staff will be in-serviced by				
		511).		regards to duplication of	•			
	Resident #94's psych	iatric medications at the		when receiving orders to				
		sychiatric evaluation were:		order is a duplicate order				
		edication) 0.5 milligrams		and to notify the attendin				
		nxiety, Ativan 0.5mg every 8		duplication. Two licensed				
		d (PRN) for anxiety, Paxil		Both will be in-serviced u	ipon their return.			
	depression, and Rem	cation) 10mg once daily for		Monitoring and Performa	ince			
	medication) 7.5mg or	· ·		Improvement: Audits of t				
	depression and appe			Monitoring Tool will be co Director of Nursing/Mana	onducted by the			
		ated 5/12/16 indicated the		weekly for one month, bi-				
		ntianxiety medication)		months, and then monthl				
	7.5mg twice daily and 10mg once daily for F	d a discontinuation of Paxil Resident #94.		month. All new orders will weekly for one month and for three months for dupl	d then monthly			
	The guarterly MDS da	ated 5/18/16 indicated		The Director of Nursing/N				
		gnitively intact, had no		Nurse will bring the resul				
		nations, no behaviors, and no		the Performance Improve	ement meetings.			
	-	was indicated to have						
	received antianxiety r							
	the MDS review period	ation on 7 of 7 days during od.						
		ote dated 6/27/16 indicated reased anxiety, agitation, orning.						
		ated 7/14/16 indicated an ency of routine Ativan 0.5mg						
	to twice daily (from or frequency of Ativan 0	nce daily), a decrease in the .5mg PRN to every 12 hrs rs), an increase in Buspar to						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/17/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345277	B. WING			C 11/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER				00 VISION DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	Continued From page	20	F	329			
	increase in the freque to every 6 hrs (from two of PRN Ativan, and a 7.5mg twice daily (fro A nursing progress no Resident #94 continue and repetitive question A follow up psychiatric for Resident #94 by the note indicated staff has had confusion, incomes sleep accompanied b episodes and increase reported during the ex- falling asleep, decrease energy, and depressing anxiety, hallucinationse indicated Resident #92 inconsistent with her plan wa antianxiety and antide additionally indicated mood stabilizer if nee #94's response. A physician's order da increase in Remeron 7.5mg once daily), an 15mg twice daily (fror Resident #94. Nursing progress note 8/5/16, and 8/6/16 income	c evaluation was conducted ne PMHNP on 7/26/16. The ad reported Resident #94 sistent complaints of poor y sleeping all day, tearful ed anxiety. Resident #94 valuation she had difficulty sed appetite, decreased on. Resident #94 denied s, or distress. The PMHNP 4's denial of anxiety was presentation. The PMHNP s to increase Resident #94's epressant medication. She she was considering a ded based on Resident ated 7/27/16 indicated an to 15mg once daily (from d an increase in Buspar to n 7.5mg twice daily) for es dated 8/3/16, 8/4/16, licated Resident #94 had					
	(8/3, 8/4), and agitatic	3, 8/4, 8/5, 8/6), restlessness on (8/5).					

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	-					FORM	): 01/17/2017 1 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345277	B. WING		_	( 11/	C 17/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				400 VISION DRIVE			
WOODLA	ND HILL CENTER			ASHEBORO, NC 27203	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	21	F 329				
	A nursing progress no Resident #94 had deo	ote dated 8/7/16 indicated creased anxiety.					
	decrease in the frequ to three times daily (fi initiation of Risperdal 0.5mg twice daily, and	ated 8/8/16 indicated a ency of routine Ativan 0.5mg rom every 6 hrs), the (antipsychotic medication) d the initiation of Depakote mg once daily for Resident					
	increase in frequency twice daily (from once	ated 8/12/16 indicated an of Depakote 125mg to e daily) and a decrease in twice daily (from 0.5mg) for					
	Resident #94 was cou delusions, no hallucin rejection of care. She received antipsychotic	ated 8/18/16 indicated gnitively intact, had no nations, no behaviors, and no was indicated to have c medication, antianxiety lepressant medication on 7 MDS review period.					
	for Resident #94 by the note indicated staff re- continued confusion, presentation of anxiet to family, and a decre- sleep. Resident #94 had improved sleep, a Resident #94 addition depression and anxie Resident #94 denied The PMHNP indicated						

Facility ID: 923365

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345277	B. WING				C 17/2016
NAME OF P	ROVIDER OR SUPPLIER	L		\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 329	Continued From page	22	F	329	9		
	adjustments were rec	commended at that time.					
	dated 8/29/16 indicate decrease the frequen once daily (from twice goal of discontinuatio was addressed on 11 declined the recomme Resident #94 struggle unsafe, exhibiting bet A physician's order da decrease in Remeron 15mg), a decrease in 125mg to once daily (	ated 9/1/16 indicated a to 7.5mg once daily (from frequency of Depakote (from twice daily), and the mood stabilizer) 25mg once					
	delusions, no hallucin rejection of care. She received antipsychotic	gnitively intact, had no lations, no behaviors, and no was indicated to have c medication, antianxiety lepressant medication on 7					
		ated 10/4/16 indicated the pakote 125mg once daily for					
	A nursing progress no Resident #94 had a d	ote dated 10/5/16 indicated lecrease in anxiety.					
	dated 10/31/16 indica recommendation to d Risperdal 0.25mg to d	tion report for Resident #94 ated the repeated ecrease the frequency of once daily (from twice daily) I of discontinuation. At the					

Facility ID: 923365

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	): 01/17/2017 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING		_	C 11/17/2016	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WOODLA	ND HILL CENTER			00 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	had not been address recommendation was the PMHNP. She dec for Resident #94 indic reduction was delayed alternate medication the A follow up psychiatric for Resident #94 by the note indicated staff re- behavior or function, it somatic complaints, the for Resident #94. She she had good sleep, a She additionally repor- depression and anxied that time. Resident # hallucinations or distri- Resident #94 was tole (Lamictal) and had a and restlessness. The plan was to increase from once daily. A note included in the 11/1/16 indicated Resi exhibit mood instabilit A physician's order da increase in the frequent twice daily (from once The review of the mean Resident #94 had door nursing progress note 5/12/16 through 11/1/	ndation the previous Resident #94, dated 8/29/16, sed by the physician. This addressed on 11/15/16 by clined the recommendation cating a Risperdal dose d due to efforts initiating an to buffer/replace it. It evaluation was conducted the PMHNP on 11/1/16. The ported no complaints of noting decreased confusion, earful episodes, and anxiety e reported to the PMHNP appetite, and fair energy. rted she had some ty that was manageable at 94 indicated she had no ess. The PMHNP indicated erating the mood stabilizer reduction of mood instability e PMHNP indicated her Lamictal 25mg to twice daily e physician's orders dated ident #94 continued to by and distress.	F 329				

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	MENT OF HEALTH AN					FORM	): 01/17/2017 1 APPROVED
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE	0. 0938-0391 SURVEY LETED
		345277	B. WING			(	C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	/	1772010
				400 VISION DRIVE			
WOODLA	ND HILL CENTER			ASHEBORO, NC 27203	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	initiation of an antianx an antipsychotic medi distinct mood stabilized of 11/1/16 Resident # medications included Buspar, and Remeror An interview was cone Worker (SW) on 11/18 reported that nurses of their progress notes. past, nurses had door copy behavior monito that she thought the h no longer utilized, but indicated she thought happened when the fa electronic Medication (eMARs). The SW wa eMARs were implement speaking to the nursin An interview was cone 11/15/16 at 3:58 PM. were documented in t Record (E MR). She to utilize hard copy be sheets, but these were indicated she thought behavior monitoring of to be completed each was not sure if every the MAR. She indicated nurse if the behavior r all residents' eMARs. The interview with Nu #3 was included in thi	iety medication (5/12/16), cation (8/8/16) and two ers (8/8/16 and 9/1/16). As 94's psychotropic Risperdal, Lamictal, Ativan, n. ducted with the Social 5/16 at 3:40 PM. She locumented behaviors in She indicated that in the umented behaviors on hard ring flow sheets. She stated ard copy flow sheets were she was unsure. She the change may have acility began utilizing Administration Records as also unsure when the ented. She suggested ng staff. ducted with Nurse #2 on She reported that behaviors he Electronic Medical stated that the nurses used thavior monitoring flow e no longer in use. She some residents had n their eMAR that needed shift by the nurse, but she resident had it on their she needed to ask another nonitoring was included on	F 32	9			

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	MENT OF HEALTH AN						FORM	): 01/17/2017 // APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING			-		C 17/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 329	behaviors were docur notes. She reported to monitoring on the eM. yet, but it was going to future. An interview was com Manager (UM) on 11/ procedure for pharmat recommendations wa She indicated that pha- related to psychotropi reviewed by the PMH responsible for putting recommendation she at the facility for the P reported the PMHNP The UM indicated her pharmacy consultatio addressed by the PM pharmacy consultatio Resident #94 dated 8 by the PMHNP on 11/ UM. She indicated the when the facility NP a the process of decidir responsible for addrea- recommendations rela- medications. The UM recommendation may time when a decision that may have been w until over two months A second interview wa on 11/16/16 at 11:44. behaviors were docur notes. She reported to	mented on nursing progress that the electronic behavior AR had not been utilized o be implemented in the ducted with the Unit 16/16 at 9:45 AM. The icy consultation s reviewed with the UM. armacy recommendations ic medications were NP. She indicated she was g the pharmacy consultation ets in a folder that was kept MHNP to review. She came to the facility weekly. Texpectation was for the n recommendations to be HNP in about 3-4 days. The n recommendation for /29/16 that was addressed (1/16 was reviewed with the ere was a period of time and the PMHNP had been in ng who was going to be ssing pharmacy consultation ated to psychotropic 1 indicated she thought this of have come in during the had not been made and why it was not addressed	F	329				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
		345277	B. WING		11	/17/2016
NAME OF P	ROVIDER OR SUPPLIER	•	- <b>·</b>	STREET ADDRESS, CITY, STATE, ZIP CC	DE	
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 329	Continued From page	26	F 329			
1 020	-	een phased out when the	F 523			
		sometime in May of 2016.				
		ere were no hard copy				
		low sheets utilized after the				
	transition to eMAR.					
	The interview with the	- IM continued She				
		r understanding, when a				
		psychotropic medication the				
	-	s supposed to automatically				
		required the nurse to				
	resident had any side	t had behaviors and if the				
	-	ion. The UM reported that				
		(11/15/16) one of the nurses				
		behavior monitoring in the				
		I after she was asked this				
		taff she looked into the ed these questions had not				
		iggered. The UM stated she				
		of this before yesterday				
		ted she then went through				
		R who was on a psychotropic				
		added two questions to the ired to be answered every				
		The first question asked if				
		avior free and the second				
	question asked if the	resident was free from side				
		ic medications. The UM				
		the behavior monitoring				
		R, the only way for nurses to was in the nursing progress				
	notes.	· · · · · · · · · · · · · · · · · · ·				
	A follow up interview	was conducted with the UM				
		M. She revealed she was				
	now aware that the h	nedical records had not				
		documentation that was				

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If continuation sheet Page 27 of 53

		D HUMAN SERVICES //EDICAID SERVICES					FORM	): 01/17/2017 APPROVED ). 0938-0391
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING _					C 17/2016
NAME OF PROV	IDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLAND	HILL CENTER				00 VISION DRIVE ISHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE		(X5) COMPLETION DATE
ma cu Ar Nu DO Ma ou wh rev be 11 wa ex be tha sh on be for do Th rej ps wc ps an for go ma for go ma for stor to to to to to to to to to to to to to	Interview was conc ursing (DON) on 11/ ON reported that eM ay 23, 2016. She st ut the hard copy beh hen eMAR was impl- vealed she became ehavior monitoring d (/15/16. She indicate as a problem previous opectation was for nue ehaviors each time th at if they occurred m he expected them to nee daily. The DON is ehaviors to be docum r initiation, continuat beage of psychotropic me interview with the ported the facility was sychotropic medication to a plan to me sychotropic medication to a concern bal of decreasing the edications. The DON et with both their Me WHNP to discuss the ough that over the p een a significant dec sage, but she was av decrease their usage	icated the facility was a way to solve this problem. Aucted with the Director of 17/16 at 10:14 AM. The IAR was implemented on ated that the facility phased avior monitoring flow sheets emented. The DON aware of the lack of ocumentation as of ed she was not aware this usly. She reported her ursing staff to document hey occurred. She stated bultiple times during the day be documented at least indicated she expected nented to support the need ion, and/or increase in the ic medications. DON continued. She as aware their use of ons was high and they were educe the use of ons, specifically dicated the facility began to around July 2016 with the eir use antipsychotic N reported that the facility edical Director and the in goal. She revealed she past few months there had rease in their antipsychotic ware there was still a need	F 3	329				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/17/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345277	B. WING			_		C 17/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	on 12/24/15 with diag schizophrenia, anxiety dementia. Resident #67's comp included, in part, the f complications related drugs. This focus area recently be updated of Resident #67 to receir effective dose of psych without side effects. Resident #67 being m need of medication, n medication, and docu monitoring flow sheet Resident #67 had a for evaluation on 2/18/16 complaint/nature of the indicated to be "depre- indicated to have no r reported, she had red depressive symptoms psychiatrist's evaluation mania or psychosis and thought content or pro- psychiatric medication (antidepressant medication (antidepressant medication thours as needed (PR indicated Resident #6 and he indicated he w	d most recently readmitted inoses that included y, depression, and brehensive plan of care focus area of the risk for to the use of psychotropic a was indicated to most on 8/12/16. The goal was for ve the smallest most chotropic medications The interventions included nonitored for the continued nonitored for side effects of imentation on the behavior c. bllow up psychiatric by a psychiatrist. The chief he presenting problem was easion". Resident #67 was hew behavioral issues luced crying spells, and her s were stable. The on revealed no evidence of nd no evidence of abnormal bcess. Her current ns were Seroquel ation) 50 milligrams (mg) in mg at night, Celexa cation) 30mg at night, and edication) 1mg every 6 N). The psychiatrist 57's psychosis was stable vould consider a gradual ) of Seroquel if further	F	329				

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MED						FORM	): 01/17/2017 APPROVED ). 0938-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345277	B. WING _			_	( 11/	C 17/2016
NAME OF PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WOODLAND HILL CENTER				00 VISION DRIVE SHEBORO, NC 27203			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>F 329 Continued From page 29 A physician's order dated decrease in Celexa to 20 for Resident #67.</li> <li>Resident #67 had a follow evaluation on 3/31/16 by Health Nurse Practitioner reported Resident #67 ha behavior or function. Res good sleep, fair appetite a distress with auditory or v she denied mania. Resid some depression and anx current psychiatric medica 50mg in the morning and 20mg at night, and Xanax PRN. The PMHNP recon changes.</li> <li>The quarterly MDS dated Resident #67 had signification impairment, had no delus no behaviors, and no reje</li> <li>A physician's order dated decrease in Celexa to 10 for 7 days, a discontinuation (antidepressant medication for Resident #67.</li> <li>The quarterly MDS dated Resident #67.</li> </ul>	ng at night (from 30mg) v up psychiatric the Psychiatric Mental (PMHNP). Staff d no complaints of sident #67 endorsed and adequate energy, no isual hallucinations, and ent #67 had reported sidety at times. Her ations were Seroquel 100mg at night, Celexa at mg every 6 hours mended no medication 4/1/16 indicated ant cognitive ions, no hallucinations, ction of care. 4/20/16 indicated a mg at night (from 20mg) ion of Celexa on of Effexor on) 37.5mg once daily 4/22/16 indicated ant cognitive ions, no hallucinations, ction of care. 4/28/16 indicated an ng once daily (from	F	329				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
				NG _			C
		345277	B. WING			11/	17/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		E ATE	(X5) COMPLETION DATE	
F 329	Continued From page	2 30	F	329			
	reported Resident #6 behavior or function, I of crying and depress indicated she had sor had fair appetite and distress with auditory she denied mania. R some depression and current psychiatric me 50mg in the morning 75mg once daily, and PRN. The PMHNP re changes due to the et upcoming anniversary The quarterly MDS da Resident #67 had sig impairment, had no d no behaviors, and no A pharmacy consultat indicated the recomm Seroquel 100mg to 75 was addressed on 6/S declined the recomm #67 was guardedly st breakthrough delusion hallucinations. The quarterly MDS da Resident #67 had sig impairment, had no d no behaviors, and no Resident #67 had sig	by the PMHNP. Staff 7 had no complaints of but there were some periods ion noted. Resident #67 me difficulty falling asleep, adequate energy, no or visual hallucinations, and esident #67 had reported anxiety at times. Her edications were Seroquel and 100mg at night, Effexor Xanax 1mg every 6 hours ecommended no medication xacerbation of grief with the y of her spouse 's death. ated 5/9/16 indicated nificant cognitive elusions, no hallucinations, rejection of care. tion report dated 5/30/16 tendation to decrease 5mg. This recommendation 9/16 by the PMHNP. She endation indicating Resident able and reported ns/auditory visual ated 8/9/16 indicated nificant cognitive elusions, no hallucinations, rejection of care.					

Facility ID: 923365

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345277	B. WING	-			C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
					400 VISION DRIVE		
WOODLA	ND HILL CENTER		ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 329	behavior or function. good sleep, fair apper denied depression, an with auditory or visua #67 had reported som times. Her current ps Seroquel 50mg in the night, Effexor 75mg of every 6 hours PRN. no medication change "guardedly stable at of The annual MDS date Resident #67 had sig impairment, had no d no behaviors, and no A review of the medic #67 had no behaviors progress notes from Resident #67's medic antipsychotic that had over one year despite consulting pharmacis An interview was con Worker (SW) on 11/12 reported that nurses of their progress notes. past, the nurses had hard copy behavior fle she thought the hard longer utilized, but sh indicated she thought happened when the fi electronic Medication (eMARs). The SW w	7 had no complaints of Resident #67 endorsed tite and adequate energy, nxiety, mania, and distress I hallucinations. Resident ne depression and anxiety at cychiatric medications were morning and 100mg at nce daily, and Xanax 1mg The PMHNP recommended es as Resident #67 was current doses". ed 11/5/16 indicated nificant cognitive elusions, no hallucinations, rejection of care. al record revealed Resident a documented in the nursing 1/1/16 through 11/1/16. cation included an d no dosage adjustment in e a recommendation by the t (5/30/16). ducted with the Social 5/16 at 3:40 PM. She documented behaviors in She indicated that in the documented behaviors on ow sheets. She stated that copy flow sheets were no e was unsure. She t the change may have	F	329			

If continuation sheet Page 32 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		345277	B. WING				C / <b>17/2016</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODLA	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	the nursing staff. An interview was con 11/15/16 at 3:58 PM. were documented in f Record (E MR). She to utilize hard copy be sheets, but these wer indicated she thought behavior monitoring of to be completed each was not sure if every eMAR. She indicated nurse if the behavior all residents' eMARs. The interview with Nu #3 was included in thi 11/15/16 at 4:00 PM. behaviors were docur notes. She reported f monitoring on the eM	ducted with Nurse #2 on She reported that behaviors the Electronic Medical stated that the nurses used ehavior monitoring flow re no longer in use. She	F	329	9		
	indicated that behavior nursing progress note had previously utilized monitoring flow sheet out when the facility b May of 2016. The UN hard copy behavior m after the transition to The interview with the reported that from her	16/16 at 11:44 AM. She prs were documented in es. She reported the facility d a hard copy behavior began eMAR sometime in M indicated there were no nonitoring flow sheets utilized eMAR.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/17/2017 // APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING			-		C 17/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
WOODLA	ND HILL CENTER				00 VISION DRIVE SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 329	electronic system was trigger questions that indicate if the residen resident had any side psychotropic medicat yesterday afternoon ( had asked her about eMAR. She revealed question by nursing s eMARs and discovere been automatically tri had not been aware of afternoon. She repor each resident's eMAF medication and she a eMAR that were requishift by nursing staff. the resident was beha question asked if the effects of psychotropi reported that without included on the eMAF document behaviors notes. A follow up interview on 11/17/16 at 9:36 A now aware that the m contained behavioral needed to support the medications. She ind currently looking into An interview was con Nursing (DON) on 11/ DON reported that eM May 23, 2016. She s	a supposed to automatically required the nurse to t had behaviors and if the effects from the ion. The UM reported that 11/15/16) one of the nurses behavior monitoring in the after she was asked this taff she looked into the ed these questions had not ggered. The UM stated she of this before yesterday ted she then went through 8 who was on a psychotropic dded two questions to the ired to be answered every The first question asked if avior free and the second resident was free from side c medications. The UM the behavior monitoring 8, the only way for nurses to was conducted with the UM M. She revealed she was edical records had not documentation that was a use of psychotropic icated the facility was a way to solve this problem.	F	329				

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY	
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED	
		345277	B. WING			С	
	ROVIDER OR SUPPLIER	545211		STREET ADDRESS, CITY, STATE, ZIP CODE	<b>11/17/2016</b>		
				400 VISION DRIVE			
WOODLA	ND HILL CENTER			ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 329	revealed she became behavior monitoring of 11/15/16. She indica was a problem previo expectation was for m behaviors each time that if they occurred m she expected them to once daily. The DON behaviors to be docu for initiation, continua dosage of psychotrop The interview with the reported the facility w psychotropic medicat working on a plan to psychotropic medicat antipsychotics. She in	e aware of the lack of documentation as of ted she was not aware this ously. She reported her nursing staff to document they occurred. She stated multiple times during the day o be documented at least l indicated she expected mented to support the need ation, and/or increase in the oic medications. e DON continued. She yas aware their use of tions was high and they were reduce the use of tions, specifically indicated the facility began to a around July 2016 with the	F 32	9			
	met with both their M PMHNP to discuss the thought that over the been a significant deu usage, but she was a to decrease their usa 3. Resident #103 was 8/31/16 with multiple The admission Minim assessment dated 9/ #103 had severe cog The admission physic #103 dated 8/31/16 v included Claritin (anti (mgs.) by mouth in the	s admitted to the facility on diagnoses including Allergy. num Data Set (MDS) 7/16 indicated that Resident nitive impairment. cian's orders for Resident vere reviewed. The orders histamine) 10 milligram the afternoon for Allergy. as an order for Claritin 10					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	PLE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							с
		345277	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2010
					400 VISION DRIVE		
WOODLAI	ND HILL CENTER				ASHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	1	DEFICIENCY)	11E	
			-				
F 329	Continued From page	35	F	32			
1 020		ember 2016 Medication		52	.9		
		ds (MARs) of Resident #103					
		MARs indicated that the					
		I Claritin 10 mgs. twice a day					
		ugh November 15, 2016.					
	On 11/15/16 at 4:30 F						
		ted that she would call the					
		ue one of the orders for					
	Claritin due to duplica						
	On 11/16/16 at 3:10 F						
	interviewed. She stat	ted that she was the nurse					
	who wrote the order f	or Claritin on 10/25/16.					
	Nurse #6 indicated th	at she didn't realize that					
	Resident #103 was a	Iready on Claritin.					
		AM, the Director of Nursing					
		ed. The DON stated that					
	she expected the med						
	for duplicate medicati	nd the pharmacist to check					
		on orders.					
	4 Resident #63 was	originally admitted to the					
		ith multiple diagnoses					
	•	anxiety, depression and					
	posttraumatic stress of						
		IDS) assessment dated					
		Resident #63 had severe					
	cognitive impairment	and had received					
	antipsychotic, antianx	tiety and antidepressant in					
	the last 7 days. The a						
	indicated that the resi						
	hallucination, delusion	n or any behavioral					
	symptoms.						
		ident #63 dated 10/10/16					
		of the problems was resident					
		tions related to the use of					
		The goal was resident					
		lest most effective dose					
	without side effects th	rough next review. One of					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	FED: 01/17/201 RM APPROVED NO. 0938-039	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION		ATE SURVEY DMPLETED	
		345277	B. WING			11/17/2016		
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	I		
	ND HILL CENTER			400	VISION DRIVE			
WOODLAI	ND HILL GENTER			AS	HEBORO, NC 27203			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFI) TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 329	Continued From page	e 36	É E	329				
		to complete behavior						
	monitoring flow sheet							
	The medical records	of Resident #63 were						
		2016 behavior monitoring						
		nk indicating that the resident						
	had no behaviors.	hale. Assessed Orantematica						
		July, August, September, r 2016 behavior monitoring						
		the records for Resident #63.						
		ceiving psychiatric services						
		lication management.						
		rs of Resident #63 were						
		s revealed that Resident #63						
		pressant drug), Zoloft						
		), Xanax (antianxiety drug),						
	Buspar (antianxiety d	Irug) and Seroquel						
	(antipsychotic drug).	g progress notes were						
	reviewed. There were							
		to support the continued						
	need of the psychotro							
		that Resident #63 was on						
	Elavil 50 milligrams (i	mgs) at bedtime since						
		there was a doctor's order to						
		100 mgs at bedtime. There						
		umentation found in the						
	On 2/19/16, there wa	port the increase in dosage.						
		.5 mgs every 6 hours from						
	every 8 hours. There							
	-	e was no behavior						
	documentation in the	e was no behavior nurse's notes to support the						
	increase in dosage.	nurse's notes to support the						
	increase in dosage. On 6/29/16, there wa	nurse's notes to support the s a doctor's order to						
	increase in dosage. On 6/29/16, there wa increase Seroquel to	nurse's notes to support the s a doctor's order to 150 mgs twice a day from						
	increase in dosage. On 6/29/16, there wa increase Seroquel to 100 mgs in AM and 1	nurse's notes to support the s a doctor's order to 150 mgs twice a day from 50 mgs at bedtime. There						
	increase in dosage. On 6/29/16, there wa increase Seroquel to 100 mgs in AM and 1 was no behavior doct	nurse's notes to support the s a doctor's order to 150 mgs twice a day from 50 mgs at bedtime. There umentation in the nurse's						
	increase in dosage. On 6/29/16, there wa increase Seroquel to 100 mgs in AM and 1 was no behavior doct notes to support the i	nurse's notes to support the s a doctor's order to 150 mgs twice a day from 50 mgs at bedtime. There umentation in the nurse's						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE		
		345277	B. WING				C 17/2016
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	400 VISION DRIVE		
WOODLA	ND HILL CENTER			A	ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	was declined. On 8/29/16, the pharm gradual dose reduction was declined. An interview was com- Worker (SW) on 11/19 reported that nurses of their progress notes. past, nurses had door copy behavior monito that she thought the h no longer utilized, but indicated she thought happened when the fa- electronic Medication (eMARs). The SW we eMARs were implement speaking to the nursin An interview was com- 11/15/16 at 3:58 PM. were documented in the Record (E MR). She to utilize hard copy be sheets, but these were indicated she thought behavior monitoring of to be completed each was not sure if every eMAR. She indicated nurse if the behavior of all residents' eMARs. The interview with Nur #3 was included this p 11/15/16 at 4:00 PM. behaviors were docur	on for Elavil but the request macist had requested for on for Xanax but the request ducted with the Social 5/16 at 3:40 PM. She documented behaviors in She indicated that in the umented behaviors on hard ring flow sheets. She stated hard copy flow sheets were she was unsure. She the change may have acility began utilizing Administration Records as also unsure when the ented. She suggested hig staff. ducted with Nurse #2 on She reported that behaviors the Electronic Medical stated that the nurses used ehavior monitoring flow the no longer in use. She is some residents had on their eMAR that needed to shift by the nurse, but she resident had it on their d she needed to ask another monitoring was included on	F	329			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/17/2017 APPROVED D. 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	INCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING			-		C 17/2016
NAME OF PROVIDER O	R SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
WOODLAND HILL (	CENTER				400 VISION DRIVE ASHEBORO, NC 27203			
	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
monitor yet, but future. A secor on 11/1 behavio notes. utilized sheet, b facility b The UN behavio transitio A follow on 11/1 now aw contain needed medicai current An inter Nursing DON re May 23 out the when el reveale behavio 11/15/1 was a p expecta behavio that if th she exp once da	t it was going to and interview wa 6/16 at 11:44 / ors were docur She reported to a hard copy be but this had be began eMAR so / indicated the or monitoring fl on to eMAR. vup interview was 7/16 at 9:36 A vare that the m ed behavioral to support the tions. She ind ly looking into a view was cond g (DON) on 11/ eported that eM 5, 2016. She si hard copy beh MAR was impled she became or monitoring d 6. She indicat problem previo ation was for m ors each time to ally. The DON	AR had not been utilized o be implemented in the as conducted with the UM AM. She indicated that mented in nursing progress the facility had previously ehavior monitoring flow ben phased out when the sometime in May of 2016. re were no hard copy low sheets utilized after the was conducted with the UM M. She revealed she was redical records had not documentation that was a use of psychotropic licated the facility was a way to solve this problem. ducted with the Director of (17/16 at 10:14 AM. The MAR was implemented on tated that the facility phased navior monitoring flow sheets lemented. The DON a ware of the lack of locumentation as of ted she was not aware this usly. She reported her ursing staff to document hey occurred. She stated nultiple times during the day be documented at least indicated she expected mented to support the need	F	329				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		345277	B. WING				C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1//2010
WOODLA	ND HILL CENTER				400 VISION DRIVE		
					ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 329	dosage of psychotrop added that the family did not want changes medications. The interview with the reported the facility w psychotropic medicat working on a plan to r psychotropic medicat antipsychotics. She ir focus on this concern goal of decreasing the medications. The DO met with both their Me psychiatric services to revealed she thought months there had bee their antipsychotic us there was still a need 5. Resident #117 was cumulative diagnoses The admission Minim 9/19/16 indicated sev and coded with no be A review of the medic behavior monitoring in 10/3/16 at 5:34 PM, 1 at 11:41 AM and on 1 these nursing notes, in	tion, and/or increase in the bic medications. The DON member of Resident #63 to the resident's a DON continued. She as aware their use of ions was high and they were reduce the use of ions, specifically ndicated the facility began to around July 2016 with the eir use antipsychotic N reported that the facility edical Director and the o discuss their goal. She that over the past few en a significant decrease in age, but she was aware to decrease their usage. admitted 9/12/16 with s of dementia and psychosis. um Data Set (MDS) dated ere cognitive impairment shaviors. tations ordered on admission n antipsychotic) 25 given every evening. al record only included n a nursing note dated 0/4/16 at 1:34 PM, 10/5/16 0/6/16 at 1:58 PM. In all of it was documented that nstrated on-going wandering	F	329			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED	
		345277	B. WING		C 11/17/2016		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (			
	ND HILL CENTER			400 VISION DRIVE			
WOODLA				ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 40	F 32	9			
	Director of Nursing (I (UM) stated it was the behaviors by exceptive Behaviors: Managerr as revised 3/15/16 in was indicated for psy The DON stated prior electronic Medication (MAR), the nurses we written behaviors monitor electronic MAR. The	/16/16 at 2:00 PM the DON) and the Unit Manager eir policy to only document on. A copy of a policy titled " nent of Challenging " dated dicated behavior monitoring vchotherapeutic medication. r to starting to use the n Administration Record ere charting behaviors on nitoring sheet. Last Spring, wing was added to the DON and UM stated for d previously unnoticed, the had dropped on the					
F 385 SS=D	stated she was not a behaviors on Resider antipsychotic medica aware of what behav look for in Resident # In an interview on 11 stated she would exp any behaviors to sup an antipsychotic med 483.40(a) RESIDENT A PHYSICIAN	/17/16 at 10:45 AM, the DON beet the staff to document port the continued need for dication for Resident #117. TS' CARE SUPERVISED BY rsonally approve in writing a t an individual be admitted to	F 38	95		12/9/16	

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			0.00	TIP: -			0.0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COMP	SURVEY LETED	
						(	C	
		345277	B. WING			11/	17/2016	
NAME OF P	ROVIDER OR SUPPLIER	·		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	ND HILL CENTER				100 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE	
F 385	Continued From page	e 41	E F	385				
	each resident is supe another physician su	ervised by a physician; and pervises the medical care of attending physician is						
	This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, pharmacist and physician interview, the facility failed to maintain physician services to meet the needs of a resident who required a prescription for an antianxiety medication resulting in delayed obtainment of the medication and the omission of the medication for seven doses for 1 of 5 residents (Resident #83). The findings included: Resident #83 was admitted to the facility 7/21/16. Cumulative diagnoses included: dementia without behavioral disturbance and major depressive disorder.				Those Affected: Director of Nursing/Management Nurse audited controlled medications requiring a writt prescription on 11/17/16 for resident #8 and ensured that adequate supply was available. Those Potentially Affected: Audit to be completed by Director of Nursing/Management Nurse by 12/9/16 for controlled medications requiring a written prescription for all residents, an to ensure adequate supply was available	33, 5 6 d		
	A Quarterly Minimum 11/1/16 indicated Res impaired in cognition during the assessme antipsychotic, antiany medication. Physician orders wer order dated 8/1/16 fo used to treat anxiety) mouth at bedtime for A review of the Septe			Systemic Changes: All nursing staff will in-serviced by 12/9/16 regarding the process of obtaining a written prescript for controlled medications. Two license staff on Leave. Both will be in-serviced upon their return. The Administrator/Director of Nursing met v Physicians and Physician Extenders regarding the need for prompt action when notified of written prescriptions needed. If there is any delay in receipt written prescription, the Director of Nursing will be notified. The Director of	ion ed vith of			
	Administration Recor following: 9/26/16 9:02PM clone	d (MAR) revealed the azepam 0.5 mg by mouth at isorder, med not in facility.			Nursing will then contact the Medical Director of the need for written prescription.			

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		MEDICAID SERVICES			OMB NO. 0938-0		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345277	B. WING		C 11/17/2016		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLE		
F 385	9/27/16 8:22PM clona bedtime for anxiety di 9/28/16 8:34PM clona by mouth at bedtime for in facility. 9/29/16 8:38 PM clona by mouth at bedtime for in facility. A review of the Nover following: 11/1/16 7:09 clonazep mouth at bedtime for facility 11/2/16 (time not note mouth at bedtime for have any in narcotic b 11/3/16 8:58 clonazep bedtime for anxiety di in facility. On 11/16/16 at 318PM conducted with Nurse administer the clonaz 11/3/16 because the r from the pharmacy ar hard script (written pro pharmacy. She state physician. On 11/16/2016 at 4:09 conducted via phone physician. He stated administer medication was available for staff a hard script for the m	Azepam 0.5 mg by mouth at sorder. Med not in facility. Azepam 0.5 mg give 0.5 mg for anxiety disorder. Med not azepam 0.5 mg give 0.5 mg for anxiety disorder. Med not mber MAR revealed the bam 0.5 mg give 0.5 mg by anxiety disorder. Med not in ed) clonazepam 0.5 mg by anxiety disorder. Did not box. bam 0.5 mg by mouth at sorder. Resident had none M, an interview was e #8. She stated she did not epam on 11/2/16 and medication had not arrived ad they were waiting for a escription) from the d she did not notify the DPM, an interview was	F 38		or one onths, ien riate. The t Nurse it to the		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/17/2017 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345277	B. WING				C / <b>17/2016</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLAI	ND HILL CENTER				400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 385	nurse practitioner. He vacation this week. He and had noted that sh behind on things and writing the scripts. On 11/16/2016 at 5:34 conducted with Nurse clonazepam was not 9/27/16, 9/28/16, 9/28 stated she usually cal control medication (cl medication cart and w nursing shift that a ha medication. If the me available the next nig the physician and lear the next shift that the Nurse #9 stated she c was not available on tw as not in the facility. A telephone interview pharmacist on 11/17/7 the facility sent a reor sheet of paper, it woul had expired, needed a pharmacy would auto for a hard script. He m records and said he c	bet was that he had a new e stated she was on the had reviewed her charts he might have been a little she might have delayed in 8PM, an interview was e #9. She said the in the facility on 9/26/16, 0/16 and 11/1/16. She lled the pharmacy first if a onazepam) was not in the vould also notify the next and script was needed for the edication was still not ht, she said she would notify ve a voice mail and report to medication was needed. did now why the medication the days she documented it r was conducted with the 16 at 9:28AM. He stated if der for the clonazepam on a and indicate that the script a hard script and the matically fax the physician eviewed the pharmacy	F	385			
F 425 SS=D	483.60(a),(b) PHARM ACCURATE PROCEI		F	425	5		12/9/16
	The facility must prov	ide routine and emergency					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345277	B. WING _			( 11/	C 17/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER				00 VISION DRIVE SHEBORO, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	drugs and biologicals them under an agreen §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licens A facility must provide (including procedures acquiring, receiving, of administering of all dr the needs of each res The facility must emp	to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. e pharmaceutical services that assure the accurate dispensing, and ugs and biologicals) to meet sident.	F	125			
	by: Based on record revi physician interview, th medications were ava physician for two of so unnecessary medicat #117). The findings in 1. Resident #83 was 7/21/16. Cumulative dementia without beh major depressive disc A Quarterly Minimum 11/1/16 indicated Res	admitted to the facility diagnoses included: avioral disturbance and order. Data Set (MDS) dated ident #83 was severely Medications administered			Those Affected: Director of Nursing/Management Nurse will audit medications for sufficient supply for residents #83 and #117 by 12/9/16 to ensure that adequate supply was available. Those Potentially Affected: Director of Nursing/Management Nurse to comple audit by 12/9/16 for all residents to ens adequate supply of medication. Systemic Changes: All nursing staff will in-serviced by 12/9/16 regarding the process of obtaining medications if unavailable. Two licensed staff on Leav	ure I be	

Facility ID: 923365

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	i î		COMPLETED		
					С		
		345277			11/17/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET		
F 425	Continued From page	e 45	F 425	5			
-		kiety and antidepressant	1 120	Both will be in-serviced upon their r	eturn.		
	medication.	, ,		If there is any delay in receipt of wr	itten		
				prescription, the Director of Nursing be notified. The Director of Nursing			
		e reviewed and revealed an r clonazepam (medication		then contact the Medical Director of			
		0.5 milligrams (mg) by		need for written prescription.			
				Monitoring and Performance			
	A review of the Septe Administration Record			Improvement: Director of Nursing/Management Nurse will au	dit		
	following:			medications for sufficient supply we			
		azepam 0.5 mg by mouth at		for one month, then monthly for three			
		isorder, med not in facility. azepam 0.5 mg by mouth at		months. Director of Nursing/Manag Nurse will bring results of each aud			
		isorder. Med not in facility.		the Performance Improvement mee			
		azepam 0.5 mg give 0.5 mg					
	by mouth at bedtime in facility.	for anxiety disorder. Med not					
		azepam 0.5 mg give 0.5 mg					
		for anxiety disorder. Med not					
	A review of the Nover following:	mber MAR revealed the					
	11/1/16 7:09 clonaze mouth at bedtime for	pam 0.5 mg give 0.5 mg by anxiety disorder. Med not in					
	facility	ed) clonazepam 0.5 mg by					
		anxiety disorder. Did not					
	have any in narcotic t	DOX.					
		pam 0.5 mg by mouth at isorder. Resident had none					
	On 11/16/16 at 11:15	AM, an interview was irector of Nursing who stated					
		e potential for 4 deliveries e delivery times were					

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	2: 01/17/2017 1 APPROVED 2: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING		_	( 11/ <sup>,</sup>	; 17/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	8:00PM-10:00PM in th 2:00AM3:00AM in th 5:00AM-7:00AM. The for re-ordering medicat the bar code from the placed the bar code o faxed the re-order to t of Nursing stated her medication to be deliv hours. If the medicati facility in 24 hours, sh the pharmacy and refa pharmacy. On 11/16/16 at 318PM conducted with Nurse administer the clonaze 11/3/16 because the r from the pharmacy an hard script (written pre pharmacy. She stated pharmacy. She stated physician. He stated administer medication was available for staff a hard script for the m physician stated the h facility on 9/28/16 and said the only explanat sending the hard scrip nurse practitioner. He vacation this week. H and had noted that sh	he evening, he morning and between e Director of Nursing stated, ation, nursing staff removed bottom of the medication, on a piece of paper and the pharmacy. The Director expectation was for the vered at the facility within 24 on was not delivered to the he expected the nurse to call ax the order to the #8. She stated she did not epam on 11/2/16 and medication had not arrived at they were waiting for a escription) from the d she did not notify the PPM, an interview was with Resident #83 ' s he expected nursing staff to he as ordered. He said he f to notify him if they needed hedication. Resident #83 ' s hard script was sent to the d on 11/2/16. The physician tion for the lateness of by was that he had a new	F 425	5			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/17/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		DNSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345277	B. WING					C 17/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP	CODE	•	
WOODLA	ND HILL CENTER				VISION DRIVE HEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BI		(X5) COMPLETION DATE
F 425	conducted with Nurse clonazepam was not 9/27/16, 9/28/16, 9/29 stated she usually cal control medication (cl medication cart and w nursing shift that a ha medication. If the me available the next nig the physician and lea the next shift that the Nurse #9 stated she c	8PM, an interview was e #9. She said the in the facility on 9/26/16, 0/16 and 11/1/16. She lled the pharmacy first if a onazepam) was not in the vould also notify the next and script was needed for the edication was still not ht, she said she would notify ve a voice mail and report to medication was needed. did now why the medication the days she documented it	F 42	25				
	cumulative diagnoses The admission Minim 9/19/16 indicated sev and extensive assista activities of daily living A review of the Nover ordered included Sero milligrams (mg) to be review of the Novemb Administration Record evening of 11/2/16 and did not receive his pre- nursing note dated 11 the medication was un nursing note dated 11 the medication was applied	g. mber 2016 medications oquel (an antipsychotic) 25 given every evening. A ber 2016 Medication d (MAR) indicated on the id 11/3/16, Resident #117 escribed Seroquel. The I/2/16 at 9:29 PM indicated navailable. In another I/3/16 at 8:51 PM, indicated						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/17/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345277	B. WING		-	C 11/17/2016		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
WOODLAI	ND HILL CENTER							
				A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
	Continued From page 48 stated she did not give Resident #117 his prescribed Seroquel on the evening of 11/2/16 or the evening of 11/3/16 because it was not available with his other prescribed medications. Nurse #1 stated she was not aware she should have called the pharmacy and had it sent by the backup pharmacy. The Unit Manager (UM) stated that was her expectation. The UM stated that as a nurse, if any prescribed medication was not available, the physician should be notified or pharmacy be notified in order to have the medication sent using the backup pharmacy In a telephone interview on 11/16/16 at 4:07 PM, the Medical Director stated he would have expected the facility to have called the backup pharmacy and obtained the Seroquel as ordered for Resident #117. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS			425				12/9/16
	a licensed pharmacist of records of receipt a controlled drugs in sur accurate reconciliation records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable.	fficient detail to enable an n; and determines that drug nd that an account of all aintained and periodically used in the facility must be with currently accepted s, and include the y and cautionary						

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUIT	PLE CONSTRUCTION		10. 0938-039 TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
				с			
345277			B. WING		1 <sup>,</sup>	11/17/2016	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILL CENTER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
				400 VISION DRIVE ASHEBORO, NC 27203			
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(¥5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 431	Continued From page	e 49	F 4	31			
		drugs and biologicals in					
		s under proper temperature					
		only authorized personnel to					
	have access to the ke	eys.					
		vide separately locked,					
		compartments for storage of d in Schedule II of the					
		Abuse Prevention and					
		ind other drugs subject to					
		the facility uses single unit					
	package drug distribu	ution systems in which the					
		nimal and a missing dose can					
	be readily detected.						
	This REQUIREMENT	「 is not met as evidenced					
	by:						
		iew, observation and staff		Those Affected: Director			
	-	failed to discard expired		Nursing/Management Nu			
	medications and faile	ened on 3 (100/300/400)		audit of affected 100, 300 medication carts by 12/9/			
		4 medication carts observed.		the audit showed that no			
	Findings included:			were expired or opened a			
				the affected medication ca			
		n medication storage dated					
		was reviewed. The policy		Those Potentially Affected			
		e dose vials for injection		Nursing/Management Nu			
		n opened and should be ter opening. The policy also		audit of all medication car The result of the audit sho	•		
		og insulin (used to treat		medications were expired			
		ould be discarded 28 days		undated for the affected n	-		
		mulin R (used to treat					
		sulin should be discarded 31		Systemic Changes: All nu	irsing staff will be		
		he policy further indicated		in-serviced by 12/9/16 reg	arding the		
		to treat Asthma) inhalation		process of dating medical			
	should be discarded foil envelope.	2 weeks after opening the		opened, checking the exp prior to administration, an			
			1	i prior to administration on	a propor	1	

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		D HUMAN SERVICES			FORM	D: 01/17/2017
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING _	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345277	B. WING			C 1 <b>7/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILL CENTER			00 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431			F 431	disposal. Two licensed staff on Leave Both will be in-serviced upon their re- Monitoring and Performance Improvement: Director of Nursing/Management Nurse will aud medication carts monthly for one year ensure all opened medications are disposed of. Director of Nursing/Management Nurse will brin results of each audit to the Performa Improvement meetings.	turn. t r to ated,	

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	-	ID HUMAN SERVICES				FORM	): 01/17/2017 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345277	B. WING		_	( 11/ <sup>-</sup>	C 17/2016
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WOODLAND HILL CENTER				00 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	9 51	F 431				
	(300/400) was observ	D PM, medication cart #2 red. There were 4 ampules iside an opened envelope ng.					
	be dated when opene	ed that Budesonide should d. Nurse 4 observed the l acknowledged that the					
	(DON) was interviewed expected the nurses to when opened and to of the medication before	PM, the Director of Nursing ed. She stated that she to date the medications check the expiration date of administration. The DON the pharmacy also had on carts regularly.					
	medication cart for 10 ipratropium albuterol	5PM, an observation of the 10 hall revealed 2 vials of lying in the medication box. moved from the foil pouch					
	Manufacturer's instruct indicated the vials sho pouch.	ctions on medication box ould be kept in the foil					
		M, an interview with Nurse Is should have been in a foil en took both vials and					
	pharmacy checked th	AM, an interview was rector of Nursing who stated e medication carts when ity. She said she also					

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		D HUMAN SERVICES MEDICAID SERVICES				RINTED: 01/17/2017 FORM APPROVED MB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345277			B. WING			C 11/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
WOODLA	ND HILL CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 431		f to check the medications , date medications when	F 43				

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