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WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #38FZ11.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		8/25/17

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

Electronically Signed | 08/23/2017

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(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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F 280	Continued From page 2 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update the care plan when a new pressure ulcer was found for 1 of 3 residents (Resident #30) reviewed for pressure ulcers. Findings included: Record review revealed Resident #30 was admitted to the facility on 08/17/16. Her documented diagnoses included left hand pressure ulcer, adult failure to thrive, and anemia, and Alzheimer dementia. A 03/31/17 progress note documented, "...found blood in left hand while washing. Noted new area (pressure ulcer) to webbing of left thumb." A 03/31/17 skin assessment documented Resident #30 had a pressure ulcer measuring 2.5 x 1.5 x 0.1 centimeters (cm) with a small amount of serosanguinous in the webbing of her left thumb. A 05/02/17 skin assessment documented this ulcer had healed. A 07/11/17 progress note documented, " (Nursing assistant) had removed palm guards to bathe and had noticed that the left interior thumb that had healed had re-opened....Received (family member's) permission to discontinue palm guards and to use rolled washcloths instead in bilateral palms for protection....This AM wound at	F 280	1. The wound had healed at the time of the survey, but was overlooked by the care plan team. Notification to the team for new wounds was by word of mouth or phone messages to the MDS office. 2. All wounds in the facility have been assessed to make sure they are on the care plans. A new process in place is the care plan team members make rounds every morning on each nursing unit and checks the treatment books for new skin alterations to ensure every area is on the care plan and none are missed. 3. This has been added to the quality improvement program to be monitored weekly times 4 weeks, then monthly if 100% compliance is achieved. 4. The Director of Nursing, Barbara Collins RN, MSN/ed, MHA, is responsible for implementing the acceptable plan of correction and ensuring a sustainable compliance.	

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left hand, base of thumb interior aspect between thumb and index finger, measured 1.7 cm x 1.5 cm x 0.2 cm, serous exudate with small areas of yellow slough, pungent odor. Wound resulting from protective palm guard."

Weekly Skin/Wound Notes on 07/19/17, 07/26/17, and 08/02/17 documented Resident #30's re-opened left thumb pressure ulcer was healing.

Review of Resident #30's care plan on 08/09/17 revealed the only pressure ulcer addressed was a stage II ulcer to the resident's sacrum.

At 4:52 PM on 08/09/17 the Minimum Data Set (MDS) Coordinator stated the MDS department was not aware that Resident #30's pressure ulcer to the left thumb had re-opened on 07/11/17. She reported the paperwork associated with the resident's most recent MDS assessment, a quarterly assessment completed on 05/18/17, documented the resident had only one pressure ulcer which was a healing stage II wound to the sacrum. She commented the hall nurses were supposed to verbally notify the MDS department when new wounds were found or wounds re-opened. According to the coordinator, one or two weeks ago she recalled the Treatment Nurse mentioning that Resident #30's left thumb wound had re-opened. The MDS Coordinator stated it was the responsibility of the MDS department to update resident care plans as soon as new or re-opened pressure ulcers were identified.

At 11:58 AM on 08/10/17 the Director of Nursing stated her expectation was for direct care staff to call or verbally inform members of the MDS team about new or re-opened pressure ulcers as soon

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F 280	Continued From page 4 as they were found. She reported resident pressure ulcer care plans were supposed to be updated the same day the MDS team was informed about the change in skin integrity.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to identify a re-opened pressure ulcer, which was once again caused by the application of a palm guard, until there was yellow slough, pungent odor, and serous drainage in the wound for 1 of 3 sample residents (Resident #30) with pressure ulcers. Findings included: Record review revealed Resident #30 was admitted to the facility on 08/17/16. Her documented diagnoses included left hand	F 314	1. The plan of correcting the deficiency is to ensure that the skin integrity under all splints is checked daily by a licensed nurse. In the past, a weekly body audit has been performed by a nurse, and the splint was being removed daily by the Nursing Assistant to perform bathing and range of motion. 2. The splints will be added to the treatment sheets for the nurses to document daily that they have removed the splint and observed the skin	8/25/17

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pressure ulcer, adult failure to thrive, and anemia, and Alzheimer dementia.

Bilateral palm guards were recommended and put in place for Resident #30 during a 02/16/17 Contracture Screen.

A 02/27/17 physician order clarified Resident #30 was to wear bilateral palm guards "at all times, only off for hygiene and cleaning."

A 03/31/17 progress note documented, "...found blood in left hand while washing. Noted new area (pressure ulcer) to webbing of left thumb."

A 03/31/17 skin assessment documented Resident #30 had a pressure ulcer measuring 2.5 x 1.5 x 0.1 centimeters (cm) with a small amount of serosanguinous in the webbing of her left thumb.

A 05/02/17 skin assessment documented this ulcer had healed.

A 05/03/17 Contracture Screen recommended and put in place bilateral palm guards for Resident #30.

Resident #30's 05/18/17 quarterly minimum data set (MDS) documented her short and long term memory were not assessed, she was severely impaired in her decision making, she exhibited no mood or behavior problems including resistance to provision of care, she was dependent on the staff for her activities of daily living (ADLs), and she had one stage II pressure ulcer (to the sacrum).

A 07/10/17 body audit documented Resident #30

underneath it.
3. This has been added to the facility's quality assurance program to be monitored weekly times four weeks, then monthly if 100% compliance is achieved.
4. The Director of Nursing, Barbara Collins RN, MSN/ed, MHA is responsible for implementing and the sustaining of the acceptable plan of correction.

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had no new skin integrity issues.

A 07/11/17 progress note documented, " (Nursing assistant) had removed palm guards to bathe and had noticed that the left interior thumb that had healed had re-opened....Received (family member's) permission to discontinue palm guards and to use rolled washcloths instead in bilateral palms for protection....This AM wound at left hand, base of thumb interior aspect between thumb and index finger, measured 1.7 cm x 1.5 cm x 0.2 cm, serous exudate with small areas of yellow slough, pungent odor. Wound resulting from protective palm guard."

Weekly Skin/Wound Notes on 07/19/17, 07/26/17, and 08/02/17 documented Resident #30's re-opened left thumb pressure ulcer was healing.

Review of Resident #30's care plan on 08/09/17 revealed the only pressure ulcer addressed was a stage II ulcer to the resident's sacrum.

At 1:23 PM on 08/09/17 nursing assistant (NA) #1, who found the re-opened ulcer to Resident #30's left thumb on 07/11/17, stated she was removing the resident's geri-sleeve because food had been spilled on it. The NA commented the sleeve caught on the Velcro of the left palm guard and partially removed it also. She reported a very foul odor was coming from the resident's left hand. According to NA #1 the last time Resident #30 was on her assignment was a week and half ago. She stated at that time she had removed the resident's palm guards during her bed bath, and there was no skin breakdown or odor. She reported she thought handwashing since then might have been an issue because of the

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malodorous condition of the left thumb on 07/11/17.

At 2:08 PM on 08/09/17 Nurse #2, who assessed Resident #30's left thumb on 07/11/17, stated the webbing was bloody and there was a very foul odor. She also commented she thought there was pus mixed in with the drainage. She reported considering the size of the ulcer, the drainage, and the strong odor she had her doubts about the palm guards being removed daily during bed baths so the hands could be washed.

At 1:57 PM on 08/09/17 NA #2 stated in order to prevent skin breakdown NAs were instructed to remove all appliances from the hands during the bathing process and to wash fingers and between fingers.

At 2:32 PM on 08/09/17 the facility's Treatment Nurse stated the left thumb ulcers developed because Resident #30 clenched her hands, putting a lot of pressure on the palm guards which dug into the resident's skin. Considering how the re-opened ulcer presented on 07/11/17, the Treatment Nurse reported she did not think the wound developed in a matter of just 24 hours.

At 2:49 PM on 08/09/17 during an observation with the Treatment Nurse the webbing between the resident's left thumb and index finger was intact with a small amount of scar tissue present.

At 8:40 AM on 08/10/17 Resident #30's primary physician stated the left thumb pressure ulcer found on 07/11/17 probably formed in 48 hours to five or six days depending on the degree of pressure from the palm guard and the cleanliness of the webbing. He reported if pressure was

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F 314	Continued From page 8 going to be reapplied to an area where skin breakdown had already occurred then you had to monitor the area very frequently because it was more prone to skin integrity problems. At 9:32 AM on 08/10/17 Nurse #3, who completed Resident #30's 07/10/17 body audit, stated she was "pretty sure" she removed the resident's palm guards during the assessment. She reported the body audits involving inspecting resident skin from head to toe, and all nurses had been instructed to remove any appliances and devices so all skin was visible. At 9:48 AM on 08/10/17 Occupational Therapist (OT) #1 stated she was not aware that Resident #30 had experienced previous skin breakdown when she recommended reapplying palm guards to the resident on 05/03/17. However, she reported the palm guards applied on 05/03/17 fit differently from the ones which were used starting on 02/16/17. She explained the palm guards which were applied to Resident #30 on 02/16/17 had a Velcro closure which came up between the thumb and forefinger while those applied on 05/03/17 only had Velcro closures at the base of the hands. At 11:58 AM on 08/10/17 the Director of Nursing stated Resident #30 had very delicate, thin skin which was prone to skin tears and breakdown. She reported she was not aware that there was foul odor, yellow slough, and purulent drainage when the left thumb wound re-opened on 07/11/17.	F 314		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		8/25/17

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F 371	Continued From page 9 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degree Fahrenheit during operation of the trayline. The facility also failed to remove dust from a fan blowing across sanitized kitchenware at the three-compartment sink, and failed to air dry kitchenware before stacking it in storage and serving food on it. Findings included: 1. At 5:50 PM on 08/07/17 dietary employees were observed preparing resident meals from the kitchen's trayline. Interview with dietary staff	F 371	1. The chicken salad was made prior to it being served. It was placed in ice on the tray line but the ice had melted in the container. All fans had been removed from the facility, but an employee had placed another one in the kitchen. The pots were stacked in a way that did not allow them to fully dry. These areas have been corrected. 2. Staff education is being done. The fan was immediately removed from the facility. Cold plates will be made ahead of time to allow them to reach the proper	

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F 371	Continued From page 10 preparing resident meals revealed they had three more carts left to fill with resident supper trays. At 5:52 PM on 08/07/17 a calibrated thermometer used to check the temperature of potato salad being stored and served at the trayline for the remainder of these supper trays registered 62.2 to 62.6 degrees Fahrenheit. The clear plastic cups of potato salad were in tubs where ice had melted into room temperature water. At 5:55 PM on 08/07/17 chicken salad on a salad plate being stored and served at the trayline for the remainder of the supper trays registered 55.1 degrees Fahrenheit when checked with a calibrated thermometer. No chilling method was being utilized to keep the salad on the plate cold. The chicken salad and the potato salad on salad plates being stored in reserve in the reach-in refrigerator registered 53.9 and 55.7 degrees Fahrenheit respectively. At 6:00 PM on 08/07/17 cups of puree chicken and potato salad being stored and served at the trayline for the remainder of the supper trays registered 62.2 and 58.7 degrees Fahrenheit respectively. No chilling method was being utilized to keep the cups of the puree salad cold. At 6:03 PM on 08/07/17 the Dietary Manager (DM) stated cold salads should remain at 41 degrees Fahrenheit or below during the operation of the trayline. The dietary employee who prepared the salads stated she finished assembling them between 2:00 and 2:30 PM on 08/07/17. She reported she then transferred them in bowls/cups or on plates into the walk-in refrigerator where they remained until the trayline started up. This employee commented the potato	F 371	temperatures before serving. Monthly education will be done with the dietary staff by the Dietary Manager covering kitchen sanitation and proper food storage and serving. 3. This will be added to the facility Quality assurance Program to be monitored weekly times four weeks then monthly if 100% compliance has been achieved. 4. The Director of Nursing Barbara Collins will be responsible for implementing the plan of correction and ensuring ongoing compliance.	

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salad she made contained potatoes, mayonnaise, boiled eggs, pickles, mustard, salt, and pepper, and the chicken salad which she made contained chicken, mayonnaise, pickles, salt, and pepper.

At 1:47 PM on 08/10/17 the DM stated dietary employees were in-serviced to keep cold salads on or in pans of ice during the operation of the trayline. She reported the preferred method was to prepare salads made with mayonnaise the day before they were served so they could chill down appropriately in the walk-in refrigerator. However, on 08/06/17 the DM commented the staff did not have all the ingredients they needed to prepare the chicken and potato salads so the salads had to be prepared and served on 08/07/17. According to the DM, salads containing mayonnaise needed to be kept at 41 degrees Fahrenheit or below so the mayonnaise would not spoil and make residents sick.

At 2:04 PM on 08/10/17 a dietary employee who was responsible for various kitchen/food preparation tasks stated dietary employees were trained to make salads containing mayonnaise the day before they were served, and these salads were to be stored on ice at the trayline. She reported not following these procedures could allow bacteria to form in foods which could make an already compromised population very sick.

2. During initial tour of the kitchen, beginning at 12:45 PM on 08/07/17, a fan with a dusty face was sitting on a shelf above the three-compartment sink. The fan was not running at that time.

At 9:20 AM on 08/09/17 there were utensils and

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tray pans air drying on the draining board of the three-compartment sink after being run through the sanitizing compartment. The fan with the dusty face was blowing directly across the sanitized kitchenware. There was a coating of dust on the center of the fan grill, and there were strands of dust which had adhered to the face of the fan.

At 1:47 PM on 08/10/17 the Dietary Manager (DM) stated it was against facility policy to run fans in the kitchen. She also reported fans with dusty faces were especially a problem because the dust could cross-contaminate kitchenware and food and make residents sick.

At 2:04 PM on 08/10/17 a dietary employee who was responsible for various kitchen/food preparation tasks stated fans were not supposed to be used in the kitchen because keeping them free from dust and dirt was such a problem. She reported dusty fans could blow dirt and germs onto kitchenware and into food which could jeopardize the health of residents.

3. During initial tour of the kitchen, beginning at 12:45 PM on 08/07/17, 8 of 14 tray pans stacked on top of one another on a storage rack were wet inside. In addition, 26 of 26 tray pans stacked on top of one another on a rack designated for air drying also had moisture trapped inside of them. 2 of 5 tray pans stacked under a food preparation table were also wet inside.

At 11:12 AM and 11:14 AM on 08/09/17 food was placed in sectional plates in which water was still pooled in the corners. The trayline was still in operation, and 8 of 10 sectional plates stored in the plate warmer at the trayline were also wet in

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	345054	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 the corners. At 1:47 PM on 08/10/17 the Dietary Manager (DM) stated all kitchenware was supposed to completely air dried before placing it in storage or serving food on it. She reported the prolonged presence of moisture in kitchenware could contaminate the food placed in it and make resident sick. At 2:04 PM on 08/10/17 a dietary employee who was responsible for various kitchen/food preparation tasks stated moisture on kitchenware promoted the growth of mold and bacteria which could jeopardize the health of residents.	F 371		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to	F 520		8/25/17

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F 520	Continued From page 14 coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance performance improvement (QAPI) process failed to prevent the reoccurrence of deficient practive related to kitchen sanitation which resulted in a repeat deficiency at F371. The re-citing of F371 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross-referenced to: F371: Kitchen Sanitation: Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degree Fahrenheit during operation of the	F 520	1. We feel we have a good quality program in place that has allowed us to put processes in place for great improvements. The deficient areas were in the dietary area but were not areas that have repeatedly been cited. The areas cited were due to staff failing to follow guidelines in place to ensure the regulations were being followed. 2. The quality committee will continue to monitor the kitchen for deficient areas and the committee will also monitor to ensure the dietary manager is completing her quality assessments and education on a monthly basis; as well as, the dietary Director. 3. This is a huge part of our ongoing quality monitoring and will be completed	

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F 520	Continued From page 15 trayline. The facility also failed to remove dust from a fan blowing across sanitized kitchenware at the three-compartment sink, and failed to air dry kitchenware before stacking it in storage and serving food on it. Review of the facility's survey history revealed F371 was cited during the facility's 08/19/16 annual recertification/complaint investigation survey. During this survey the facility failed to label and date opened food items, failed to store thawed meat properly, and failed to discard expired products. F371 was re-cited during the 08/10/17 on-site recertification/complaint investigation survey. During this survey the facility failed to keep cold salads in a safe temperature range, failed to clean a fan blowing in the kitchen, and failed to air dry kitchenware before stacking in storage and placing food on it. At 4:00 PM on 08/10/17 the Director of Nursing (DON) stated the facility's F371 citation from the 08/19/16 survey concerned failure to date and label opened food items, store thawed meat properly, and failure to discard expired products. F371 was re-cited during the 08/10/17 on-site recertification/complaint investigation survey. During this survey the facility failed to keep cold salads in a safe temperature range, failed to clean a fan blowing in the kitchen, and failed to air dry kitchenware before stacking in storage and placing food on it. The DON reported the dietary manager and registered dietitian did periodic audits in the kitchen which required them to look at all areas of kitchen sanitation, and apparently they had not previously observed problems with the storage of kitchenware, the presence of fans in the kitchen, and cold salad temperatures. She explained that even though the facility received	F 520	monthly and an action plan will be done to correct and prevent further issues noted during the audits. 4. The Director of Nursing, Barbara Collins, is responsible for implementing the plan of correction and the sustainability of the plan of correction.	

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F 520	Continued From page 16 citations about kitchen sanitation in both 2017 and 2017 the specific problems which were identified during the two years were very different.	F 520		