STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	03/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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, staff interviews, and record review, the facility failed to follow up with wound clinic for orders for 1 (Resident #38) of 2 reviewed residents. Findings included: Resident # 38 was admitted to the facility on 2/21/2018 from an acute care hospital. Cumulative diagnosis included unstageable pressure ulcer of left heel, unstageable pressure ulcer of sacral region, osteoarthritis, venous insufficiency, chronic obstructive pulmonary disease, and unspecified dementia. A review of admission MDS (Minimum Data Set) assessment dated 2/28/2018 revealed that resident was rarely/never understood and dependent on staff for all Activities of Daily Living (ADLs). The MDS assessment indicated was always incontinent of bowel and bladder.	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to follow up with wound clinic for orders for 1 (resident #38) of 2	4/4/18

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

Electronically Signed | 03/31/2018

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F 686	Continued From page 1 A review of medical record revealed careplans in place for pressure ulcer to coccyx and left heel, difficulty making own decisions related to dementia, and ADL care deficit. Observation of wound dressing changes to sacrum on 3/08/2018 at 10:00 AM revealed sacral wound with moist, pink and yellow wound bed, no odor noted, and minimal drainage. Dressing was changed as ordered on Treatment Administration Record (TAR) with no breaks in infection control. Interview with treatment aide and Nurse #1 immediately after dressing change, stated resident was followed by wound clinic and was scheduled to have wound vac placed next week. Review of medical record did not reveal wound care clinic notes or documentation of visits. Discussed with Nurse #1 who stated she would contact clinic. Review of wound clinic notes dated 2/27/2018 with Nurse #1 on 3/8/2018 at 11:15 stated stage IV sacral decubitus. Cultures taken. Review of medical record did not reveal culture results. Discussed with Nurse #1 who stated she would contact lab. Review of culture results revealed final report results were verified 3/1/2018 showing heavy growth Escherichia coli with heavy growth enterococcus faecalis and moderate growth normal skin flora isolated. Discussed culture results with Nurse #1 who stated that they were unaware of these results or the culture being obtained at the wound clinic visit. During phone interview with RN at wound clinic on 3/8/2018 at 1:30 PM stated that the facility	F 686	reviewed residents. On 03/08/2018, the unit manager contacted the Wound Clinic regarding resident #38 for follow up of a wound culture completed during a visit on 02/27/2018. New orders were received for antibiotic and new orders were put in place by unit manager on 03/08/2018. All current residents who have had a MD consult or ER visit in the past 30 days were reviewed by the nurse managers for consult paperwork and any new orders received to verify that the orders were put in place. This will be completed by 04/04/2018. 2. Procedure for implementing the acceptable plan of correction. On 03/29/2018, an in-service education was provided to full time, part time, and as needed nurses, nurse managers, Med Tech's, and Med Aides by the Nurse Mangers Topics included: • Use of the office visit report of consultation form for appointments out of facility • Ensuring the office visit report of consultation or ER visit documentation is received back when the resident arrives from the appointment or ER and orders are initiated if indicated. • What to do if the office visit report of consultation or ER paper work is not received back. In-service education for the above	

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F 686	Continued From page 2 (Woodlands) was notified on 3/2/2018 at 4:15 PM of culture results and verbal order was given for ampicillin 5mg by mouth three times daily for 10 days to nurse caring for resident at that time. Unable to state name of nurse that order was verbal order was given to. No order was faxed to facility. Interview with Nurse #2, who was caring for Resident #38 on 3/2/2018 evening shift, on 3/8/2018 at 3:00 PM stated that she did not receive a verbal order for an antibiotic for Resident #38 on that date. Interview with Director of Nursing (DON) 3/8/2018 at 3:10 PM stated that her expectation when a resident goes out of the facility for an appointment is that upon the resident's return to facility if they do not have paperwork from the visit that the nurse would call to the place of appointment to obtain clinic notes of visit. Stated that education would take place to nurses of expectations. Interview with Administrator on 3/9/2018 at 11:30 AM stated that her expectation is that anytime a resident goes out of the facility for an appointment that they should return with notes from visit and if they do not, the nurse is responsible for calling to obtain the notes.	F 686	identified positions will be completed by 04/04/2018. This information has been integrated into the standard orientation training and in the required in-service refresher courses for the above named staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Nurse Manager will monitor the receipt of consult paperwork for implementation of any new orders by using the Consult Quality Assurance tool weekly times 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for	

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F 686	Continued From page 3	F 686	implementation and completion of the acceptable plan of correction.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		4/4/18

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F 756	Continued From page 4 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, Pharmacy Consultant and staff interviews, facility failed to document the rationale in the resident's medical records if not in agreement with the Pharmacy Consultant's recommendation or if there was no change in the medication for 3 of 5 sampled residents reviewed for unnecessary medications (Residents # 29, Resident # 11, Resident # 27). Findings included: 1. Resident # 29 was admitted to the facility on 11/17/2017 with multiple diagnoses including anxiety and psychosis. The quarterly Minimum Data Set (MDS) assessment dated 11/24/2017 indicated that Resident #29's cognition was intact and she did not have behavioral symptoms indicated. Resident #29's physician's orders were reviewed. He had a physician's order for Ativan tablet 0.5 milligrams (mgs.) 1 tablet by mouth every 6 hours as needed for anxiety. On 1/24/2018 and 2/28/2018, the Pharmacy Consultant had recommended to the physician to "document rationale in chart & indicate a duration of as needed (PRN) order of Ativan tablet 0.5 milligrams (mgs)." During the review of the resident's medical records, there was no rationale documented in the medical records of Resident #29 or in the	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to document the rationale in the resident's medical records if not in agreement with the Pharmacy Consultant's recommendation or if there was no change in the medication for 3 of 5 sampled residents (Resident #29, Resident # 1, Resident #27). On 03/05/2018 resident #29 was discharged home. On 03/29/2018, the Pharmacy Consultant recommendations for residents #1 and 27 were audited for response from the MD, NP, or PA by the nurse manager. For resident #1, the MD	

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F 756	Continued From page 5 Consultant Pharmacist Communication to Physician form. On 3/7/17 at 11:32 AM, the Pharmacy Consultant was interviewed. He stated that he expected the Physician to respond to his recommendations and if he didn't agree or didn't want to change the medication to document the rationale in the resident's medical record or on the communication form. On 3/8/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to respond to the Pharmacist recommendations and he or she if didn't want to change or didn't agree, to document the rationale in the medical records or in the communication form. She further indicated she will change the method of communication to the physician in the facility. 2. Resident # 1 was admitted to the facility on 8/11/2017 with multiple diagnoses including Anxiety, Depression, restlessness and insomnia. The quarterly Minimum Data Set (MDS) assessment dated 11/18/2017 indicated that Resident # 1's cognition was intact and she did not have behavioral symptoms indicated. Resident # 1's physician's orders were reviewed. He had a physician's order for Ativan tablet 1 milligrams (mgs.) 1 tablet by mouth every 12 hours as needed for anxiety. On 11/28/2017,1/24/2018 and 2/28/2018, the Pharmacy Consultant had recommended to the physician to "document rationale in chart & to indicate a duration of as needed (PRN) order of	F 756	discontinued the PRN Ativan. For resident #27, the practitioner decreased Trazadone and placed a stop date for the PRN Ativan. Pharmacy recommendations for all current residents for February 2018 were audited to ensure response was received from the MD or practitioner. This was completed by 04/04/2018 by the nurse managers. 2. Procedure for implementing the acceptable plan of correction. An in-service education was provided to the Facility Physicians, Nurse Practitioner, Physician Assistant, on the completion of Pharmacy Consultant Recommendations. Topics included: Education provided to ensure that when pharmacy recommendations or irregularities are reviewed by the physician, Nurse Practitioner, or Physician Assistant, that the provider must document in the resident's medical record (on the consult form is acceptable) that the identified recommendation or irregularity has been reviewed and what, if any action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record or consult form. An in-service education was provided to the Director of Nursing (DON) and the two	

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F 756	Continued From page 6 Ativan tablet 0.5 milligrams (mgs), Zoloft 25 mg QD(once for per day) for Depression." During the review of the resident's medical records, there was no rationale documented in the medical records of Resident #29 or in the Consultant Pharmacist Communication to Physician form. On 3/7/17 at 11:32 AM, the Pharmacy Consultant was interviewed. He stated that he expected the Physician to respond to his recommendations and if he didn't agree or didn't want to change the medication to document the rationale in the resident's medical record or on the communication form. On 3/8/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to respond to the Pharmacist recommendations and he or she if they didn't want to change or didn't agree, to document the rationale in the medical records or in the communication form. She further indicated she will change the method of communication to the physician in the facility. 3. Resident # 27 was admitted to the facility on 8/11/2017 with multiple diagnoses including Dementia, Anxiety and Depression. The quarterly Minimum Data Set (MDS) assessment dated 12/28/2017 indicated that Resident # 27's cognition was intact and she did not have behavioral symptoms indicated. Resident # 27's physician's orders were reviewed. He had a physician's order for Ativan tablet 1 milligrams (mgs.) Every 24 hours 1 tablet by mouth as needed for anxiety, Cymbalta 30 mg	F 756	Nurse Mangers by the Nurse Consultant on the completion of Pharmacy Consultant Recommendations. Topics included: • Upon receipt of the Pharmacist Recommendations, the, DON or Nurse Manager as assigned will deliver the Pharmacist Recommendation either in person, via email, or via fax to the attending Physician, Nurse Practitioner, or Physician Assistant for review within 5 days of receipt of the Pharmacist Recommendations. • The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If no changes are made then the rationale should be documented by the attending physician. This should be completed within 7 days of the receipt of the report. • If the attending Physician, Nurse Practitioner, or Physician Assistant has not responded within 7 days, the DON will make a second contact with the provider for immediate response to the recommendations. • If the pharmacist identifies an irregularity that requires urgent action, the Director of Nursing or Nurse Manger must be notified immediately. They will call the attending physician for order changes. In-service education for the above identified positions will be completed by 04/04/2018.	

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F 756	Continued From page 7 twice in a day for depression and pain, Depakote 250 mg three times in a day, Trazodone 50 mg once a day for increased agitation. On 9/25/2017, 11/28/2017, 12/28/2017 and 1/24/2018, the Pharmacy Consultant had recommended to the physician to "document rationale in chart & to indicate a duration of as Ativan tablet 1 milligrams (mgs) every 24 hours 1 tablet by mouth as needed for anxiety, Cymbalta 30 mg twice in a day for depression and pain, Depakote 250 mg three times in a day, Trazodone 50 mg once a day for increased agitation." During the review of the resident's medical records, there was no rationale documented in the medical records of Resident #27 or in the Consultant Pharmacist Communication to Physician form. On 3/7/17 at 11:32 AM, the Pharmacy Consultant was interviewed. He stated that he expected the Physician to respond to his recommendations and if he didn't agree or didn't want to change the medication to document the rationale in the resident's medical record or on the communication form. On 3/8/17 at 3:15 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to respond to the Pharmacist recommendations and he or she if didn't want to change or didn't agree, to document the rationale in the medical records or in the communication form. She further indicated she will change the method of communication to the physician in the facility.	F 756	This information has been integrated into the standard orientation training and in the required in-service refresher courses for Facility Physicians, Nurse Practitioner, Physician Assistant, Director of Nursing (DON) and the Nurse Mangers and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing will monitor the completion of Pharmacy Recommendations using the Pharmacy Recommendation Quality Assurance tool monthly for 3 months. Monitoring will include auditing all Pharmacy Recommendations for completion according to the above guidelines. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction.	

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F 756	Continued From page 8	F 756	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired medications in 2 of 3 medication room fridges on 400 and 500 halls.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	4/4/18

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F 761	Continued From page 9 Findings included: 1a. During observation of medication room refrigerator on 400 hall on 3/6/2018, medication fridge revealed 3 insulin pens, 1 multi-dose bottle of insulin, 2 bags of Invanz, 1 bottle of lanaprost, and 3 bottles of hepatitis B vaccine to be past their expiration dates. 1b. During continued observation of the medication room refrigerator on the 500 hall, 1 insulin pen was noted with past expiration date. Interview with Nurse #1 on 3/8/2018 at 10:30 PM stated that medication expiration dates are to be noted prior to administration but any expired meds should also be removed from storage areas. Interview with Director of Nursing on 3/9/2018 at 11:30 AM stated that her expectation is not to have any expired medications in storage areas and would be putting into place a monthly audit of medication storage. Interview with Administrator on 3/9/2018 at 11:40 AM stated that her expectation is that there is not expired medications in storage areas.	F 761	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 761 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to remove expired medications in 2 of 3 medication room fridges on 400 and 500 halls. On 03/06/2018 the hall nurses disposed of the 400 hall medication room 3 insulin pens, 1 multi-dose bottle of insulin, 2 bags of Invanz, 1 bottle of lanaprost, and 3 bottles of hepatitis B vaccine that were past their expiration dates. On 03/06/2018 the hall nurse disposed of the 500 hall medication room 1 insulin pen that was past the expiration date. On 03/29/2018 the Nurse Consultant audited 100% of the following • All medication rooms for expired medications This audit was completed on 03/29/2018 with the following findings no expired medications. 2. Procedure for implementing the	

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F 761	Continued From page 10	F 761	acceptable plan of correction. On 03/29/2018 the Nurse Managers began in servicing all FT, PT, and PRN RN's, LPN's, and Med Tech's on the following procedures: • When opening multi-use medications such as insulin vials and insulin pens, the date opened must immediately be written on the medication label by the nurse or Med Tech opening the vial or the nurse or Med Tech placing the insulin pen on the medication cart. Each nurse and Med Tech is responsible for looking at the date opened on the insulin pen to determine when to discard the pen. This is to be completed prior to using the insulin pen. Insulin vials are discarded according to the "Recommended Maximum Storage for Insulin and Other Selected Injectables". Prior to using the insulin vial, the nurse or Med Tech must check the date opened to determine if the insulin is expired. Discard immediately if expiration is noted. The recommended maximum storage guidelines are posted in each medication room and in front of each narcotic book on each medication cart. • When obtaining supplies from the medication room, the nurse or Med Tech obtaining the supplies are to check for the expiration date of the product you are getting. If the product is expired notify the Supply Clerk and dispose of the expired product. • The hall nurse will audit each medication room for expired medications	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11	F 761		

or undated multi-dose vials every Tuesday.

Any in-house staff member who did not receive in-service training by 04/04/2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Nurse Manger will audit medication rooms weekly for four weeks then monthly for two months for expired medications and to ensure open multi-use medications are dated with the date opened. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

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F 761	Continued From page 12	F 761	4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	