	-	ID HUMAN SERVICES			FORI	M APPROVED
		MEDICAID SERVICES				D. 0938-0391
		. ,		(X3) DATE SURVEY COMPLETED		
		345349	B. WING			C / 01/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER		2	778 COUNTRY CLUB DRIVE		
MOODDO			F	IAMPSTEAD, NC 28443		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	complaint investigation 10/28/19 through 11/0 in compliance with the	ertification survey and on survey was conducted on 01/19. The facility was found e requirement CFR 483.73, ness. Event ID # PPDO11.	F 000			
		complaint investigation d from 10/18/19 - 11/01/19,				
	4 of the 4 complaint a substantiated.	Illegations were not				
F 640 SS=D		g Resident Assessments (4)	F 640			11/21/19
	a facility completes a facility must encode t each resident in the fa (i) Admission assess (ii) Annual assessment (iii) Significant change (iv) Quarterly review a (v) A subset of items reentry, discharge, ar	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. sheet) information, if there				
	after a facility comple a facility must be cap CMS System informa contained in the MDS	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to uts and data dictionaries,				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					11/21/2019

Electronically Signed

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED //B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
3		345349	B. WING			C 11/01/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
WOODDU				2778 COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	INC		HAMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 640	and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, an the CMS System, incl (i)Admission assessm (ii) Annual assessmer (iii) Significant change (iv) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, an (viii) Background (fact initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record revi facility failed to compl facility tracker Minimu assessments within th of 25 residents review	A WELLNESS CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 and that passes standardized edits defined by CMS and the State. 4483.20(f)(3) Transmittal requirements. Within 4 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: i)Admission assessment. ii) Annual assessment. iii) Significant change in status assessment. iv) Significant correction of prior full assessment. iv) Significant correction of prior quarterly assessment. vi) Quarterly review. vi) Quarterly review. vii) A subset of items upon a resident's transfer, eentry, discharge, and death. viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that loes not have an admission assessment. 4483.20(f)(4) Data format. The facility must ransmit data in the format specified by CMS or, or a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced		640 Preparation and submis of correction is in respon Form 2567 from the 10/2 does not constitute an ag admission by Woodbury of the truth of the facts a correctness of the conclu- the statement of deficien reserves all rights to con deficiencies, findings, co actions of the Agency. T	ase to the CMS 28/2019 survey. I greement or Wellness Center lleged or of the usions stated on acy. The facility test the unclusions and		

Event ID: PPDO11

Facility ID: 923206

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345349	B. WING		C 11/01/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•
WOODBU	RY WELLNESS CENTER	RINC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	
(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 T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 640	Continued From page	e 2	F 6	40	
		Ilitus II, Peripheral Artery		Correction (and the attac	ched documents)
		essive and Chronic Kidney		also functions as the fac allegation of compliance	ility s credible
	Record review revea completed was a qua 05/15/19.	led that the last assessment arterly MDS dated on		# 1 - Address how correct accomplished for those in have been affected by the practice;	residents found to
	Record review revea 07/18/19 in his room.	led that resident expired on		" For Resident #1, #2	
		led that the facility did not facility Minimum Data Set f1.		Coordinators completed Death In Facility MDS by 2019. " MDS Coordinators a	y November 6, and Social
	Coordinator (MDS) o revealed that it was t responsibility to comp death in the facility. stated that the Social	plete the assessment for The MDS Coordinator further I Worker and Business Office y together on the facility		Services Designee inser November 4, 2019 by Di on MDS Transmittal Rec the guidelines of Encodi Resident Assessments a Assessment Instrument Death in Facility MDS co transmission requiremen	irector of Nursing quirements, as per ng/Transmitting and the Resident Manual to include ompletion and
	10/30/19 at 4:05 PM responsible for comp assessment within 7 reviewed the dash bo health records daily t facility assessment n Social Worker further	with the Social Worker on revealed that she was leting the death in the facility days. She stated that she bard in the facility electronic o determine if a death in the eeded to be completed. The r stated that she did not ment due to an oversight.		 # - 2 Address how the far other residents having the affected by the same details of the same details with a date of the construction of the same details with a date of the construction of the same details with a date of the same details withe date of the same details with a date of the same details with	ne potential to be ficient practice; to audit all death January 1, required Death in eted and
	on 10/31/19 at 10:25	vith the Director of Nursing AM revealed that it would be		Audit was completed by Coordinators on October " MDS Coordinators r	MDS r 30, 2019.
	the death in facility a	the Social Worker completes ssessment within 7 days and		audit with Director of Nu	rsing and
	the MDS coordinator	transmit the assessment		Administrator on Octobe	er 30, 2019. No

Facility ID: 923206

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/201 MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345349				(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED C
		B. WING				01/2019	
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODDU				27	778 COUNTRY CLUB DRIVE		
WOODBO	RY WELLNESS CENTER			H.	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 640	Continued From page	2		640			
1 040		5	Г	040			
	after it is completed.				additional residents were identified or		
	During on interview	with the Advance interaction and			audit without the required Death in Fa	•	
		vith the Administrator on			MDS completed and transmitted with	IN	
	her expectation that t				the required timeframe		
	-	eted timely and accurately.					
	assessment is compl				# -3 Address what measures will be p	nut	
	2 Resident #2 was a	admitted to the facility on			into place or systemic changes made		
		sis of Alzheimer's Disease,			ensure that the deficient practice will		
		Depressive Disorder, Heart			recur;		
		Kidney Disease Stage 4.					
	Record review revealed that the last assessment				" MDS Coordinators and Social		
	completed was a qua	rterly MDS dated on			Services Designee educated on		
	06/04/19.				November 4, 2019 by Director of Nur	-	
					on MDS Transmittal Requirements, a		
		ed that resident expired on			the guidelines of Encoding/Transmitti	-	
	07/06/19 in her room				Resident Assessments and the Resid		
	D · · · · ·				Assessment Instrument Manual to inc		
		vith the Minimum Data Set			Death in Facility MDS completion and		
	. ,	n 10/30/19 at 3:30 PM			transmission requirements.	h	
	revealed that it was the	blete the assessment for			 Weekly Audits to be completed MDS Coordinators beginning week or 		
		The MDS Coordinator further			November 4, 2019 of Death in Facility		
	•	Worker and Business Office			MDS completion and transmission tin	•	
		y together on the facility			weeks. Weekly audits will be reviewe		
	census and this was				weekly by the Administrator/Designed		
		-			monitor for compliance with education		
	During an interview w	vith the Social Worker on			training.		
	10/30/19 at 4:05 PM	revealed that she was					
		leting the death in the facility					
		days. She stated that she			# - 4 Indicate how the facility plans to		
		pard in the facility electronic			monitor its performance to make sure		
		o determine if a death in the			solutions are sustained; and Include		
	-	eeded to be completed. The			when corrective action will be comple	eted.	
		stated that she did not					
	complete this assess	ment due to an oversight.			" Audit tool developed by Director		
	During on intervie	with the Director of Number			Nursing on November 4, 2019. Educa		
	During an interview w	vith the Director of Nursing			was provided at this time by the Direc	CIOF	

Facility ID: 923206

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/03/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345349	B. WING				C / 01/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER			27	778 COUNTRY CLUB DRIVE		
WOODBO	RI WELLNESS CENTER			H.	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 640	 on 10/31/19 at 10:25 her expectation that t the death in facility as the MDS coordinator after it is completed. During an interview w 11/01/19 at 11:33 AM her expectation that t assessment is completed. 2. Resident #54 was 05/02/19 with diagnost dementia, congestive stenosis and chronic A record review reveat 10/05/19. A record review reveat complete the Minimur Assessment, Death in During an interview w 10/30/19 at 3:50 p.m. Social Worker (SW) f completing the MDS of Facility. The MDS nu Facility assessment f secondary to human During an interview w 4:06 p.m., the SW state 	AM revealed that it would be the Social Worker completes seessment within 7 days and transmit the assessment with the Administrator on I revealed that it would be the death in facility eted timely and accurately.	F	640	of Nursing to MDS Coordinators on A tool with implementation the week of November 4,2019 "Audit to be completed weekly tim weeks by MDS Coordinators to ensur that all resident deaths in facility have the Death In Facility MDS completed transmitted within the required timefra Any discrepancies revealed from aud be addressed and corrected at that tii "Results of weekly audits will be reviewed by Administrator/Designee weekly. "Results of the weekly audits will reviewed and discussed in the next scheduled monthly Quality Assurance Performance Improvement Committe meeting thru completion of 8 week au period. The Quality Assurance Committee will assess and modify the action plan at as needed to ensure continued compliance.	es 8 e had and ame. it will me. be e e idit	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345349	B. WING				_ 01/2019	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CIT	Y, STATE, ZIP CODE			
WOODBU	RY WELLNESS CENTER	RINC		2778 COUNTRY CLUB HAMPSTEAD, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 640	During an interview w (DON) on 11/1/19 at it was her expectatior	e 5 with the Director of Nursing 10:25 a.m., the DON stated in the MDS Assessment, completed within 7 days by	F	640				

Facility ID: 923206

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