STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	**2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443**

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E 000	Initial Comments An unannounced recertification survey and complaint investigation survey was conducted on 10/28/19 through 11/01/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # PPDO11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/18/19 - 11/01/19, Event PPDO11. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		11/21/19

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

Electronically Signed | 11/21/2019

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F 640	Continued From page 1 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 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. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for 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 by: Based on record review and staff interviews, the facility failed to complete and transmit 3 death facility tracker Minimum Data Set (MDS) assessments within the required time frame for 3 of 25 residents reviewed for submission of MDS assessments (Resident #1, #2 and #50). The findings included: 1. Resident #1 was admitted to the facility on 01/14/17 with diagnosis of Congestive Heart	F 640	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 10/28/2019 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of	

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F 640	Continued From page 2 Failure, Diabetes Mellitus II, Peripheral Artery Disease, Major Depressive and Chronic Kidney Disease Stage 3. Record review revealed that the last assessment completed was a quarterly MDS dated on 05/15/19. Record review revealed that resident expired on 07/18/19 in his room. Record review revealed that the facility did not complete a death in facility Minimum Data Set (MDS) for Resident #1. During an interview with the Minimum Data Set Coordinator (MDS) on 10/30/19 at 3:30 PM revealed that it was the Social Worker responsibility to complete the assessment for death in the facility. The MDS Coordinator further stated that the Social Worker and Business Office Manager work closely together on the facility census and this was an oversight. During an interview with the Social Worker on 10/30/19 at 4:05 PM revealed that she was responsible for completing the death in the facility assessment within 7 days. She stated that she reviewed the dash board in the facility electronic health records daily to determine if a death in the facility assessment needed to be completed. The Social Worker further stated that she did not complete this assessment due to an oversight. During an interview with the Director of Nursing on 10/31/19 at 10:25 AM revealed that it would be her expectation that the Social Worker completes the death in facility assessment within 7 days and the MDS coordinator transmit the assessment	F 640	Correction (and the attached documents) also functions as the facility□s credible allegation of compliance # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " For Resident #1, #2, and #54 MDS Coordinators completed and transmitted a Death In Facility MDS by November 6, 2019. " MDS Coordinators and Social Services Designee inserviced on November 4, 2019 by Director of Nursing on MDS Transmittal Requirements, as per the guidelines of Encoding/Transmitting Resident Assessments and the Resident Assessment Instrument Manual to include Death in Facility MDS completion and transmission requirements. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " MDS Coordinators to audit all residents with a date of death January 1, 2019 to ensure that the required Death in Facility MDS was completed and transmitted within the required timeframe. Audit was completed by MDS Coordinators on October 30, 2019. " MDS Coordinators reviewed results of audit with Director of Nursing and Administrator on October 30, 2019. No	

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F 640	Continued From page 3 after it is completed. During an interview with the Administrator on 11/01/19 at 11:33 AM revealed that it would be her expectation that the death in facility assessment is completed timely and accurately. 2. Resident #2 was admitted to the facility on 01/09/19 with diagnosis of Alzheimer's Disease, Hypertension, Major Depressive Disorder, Heart Failure and Chronic Kidney Disease Stage 4. Record review revealed that the last assessment completed was a quarterly MDS dated on 06/04/19. Record review revealed that resident expired on 07/06/19 in her room. During an interview with the Minimum Data Set Coordinator (MDS) on 10/30/19 at 3:30 PM revealed that it was the Social Worker responsibility to complete the assessment for death in the facility. The MDS Coordinator further stated that the Social Worker and Business Office Manager work closely together on the facility census and this was an oversight. During an interview with the Social Worker on 10/30/19 at 4:05 PM revealed that she was responsible for completing the death in the facility assessment within 7 days. She stated that she reviewed the dash board in the facility electronic health records daily to determine if a death in the facility assessment needed to be completed. The Social Worker further stated that she did not complete this assessment due to an oversight. During an interview with the Director of Nursing	F 640	additional residents were identified on audit without the required Death in Facility MDS completed and transmitted within the required timeframe # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; " MDS Coordinators and Social Services Designee educated on November 4, 2019 by Director of Nursing on MDS Transmittal Requirements, as per the guidelines of Encoding/Transmitting Resident Assessments and the Resident Assessment Instrument Manual to include Death in Facility MDS completion and transmission requirements. " Weekly Audits to be completed by MDS Coordinators beginning week of November 4, 2019 of Death in Facility MDS completion and transmission times 8 weeks. Weekly audits will be reviewed weekly by the Administrator/Designee to monitor for compliance with educational training. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. " Audit tool developed by Director of Nursing on November 4, 2019. Education was provided at this time by the Director	

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F 640	Continued From page 4 on 10/31/19 at 10:25 AM revealed that it would be her expectation that the Social Worker completes the death in facility assessment within 7 days and the MDS coordinator transmit the assessment after it is completed. During an interview with the Administrator on 11/01/19 at 11:33 AM revealed that it would be her expectation that the death in facility assessment is completed timely and accurately. 2. Resident #54 was admitted to the facility on 05/02/19 with diagnoses which included dementia, congestive heart failure, aortic valve stenosis and chronic kidney disease stage 3. A record review revealed the resident expired on 10/05/19. A record review revealed the facility did not complete the Minimum Data Set (MDS) Assessment, Death in Facility, for resident #54. During an interview with the MDS nurses on 10/30/19 at 3:50 p.m., the MDS nurses stated the Social Worker (SW) had been responsible for completing the MDS Assessment, Death in Facility. The MDS nurses stated the Death in Facility assessment had not been completed secondary to human error. During an interview with the SW on 10/30/19 at 4:06 p.m., the SW stated she did not complete Resident #54's MDS Assessment, Death in Facility, secondary to an oversight.	F 640	of Nursing to MDS Coordinators on Audit tool with implementation the week of November 4,2019 " Audit to be completed weekly times 8 weeks by MDS Coordinators to ensure that all resident deaths in facility have had the Death In Facility MDS completed and transmitted within the required timeframe. Any discrepancies revealed from audit will be addressed and corrected at that time. " Results of weekly audits will be reviewed by Administrator/Designee weekly. " Results of the weekly audits will be reviewed and discussed in the next scheduled monthly Quality Assurance Performance Improvement Committee meeting thru completion of 8 week audit period. The Quality Assurance Committee will assess and modify the action plan at as needed to ensure continued compliance.	

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F 640	Continued From page 5 During an interview with the Director of Nursing (DON) on 11/1/19 at 10:25 a.m., the DON stated it was her expectation the MDS Assessment, Death in Faciilty, be completed within 7 days by the SW.	F 640		