DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			ON	1B NO.	0938-0391
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (E SURVEY PLETED
		345481	B. WING			09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODI				40	00 PELT DRIVE		
WOODL	ANDS NURSING & RE	EHABILITATION CENTER		F	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 224 SS=G	483.13(c) PROHIB MISTREATMENT/N The facility must de policies and proced mistreatment, negle and misappropriation This REQUIREMEN by: Based on record re interviews, the facil immediately to the who verbalized diffi breath and an emp resulted in anxiety,	IT NEGLECT/MISAPPROPRIATN evelop and implement written lures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced eview, observation and staff ity failed to respond emergent need of a resident cultly breathing, shortness of ty oxygen cylinder, which panic and frustration for 1 of 4 at on supplemental oxygen	F 2	224		tion ed the the rect with	9/29/14
	8/29/14. Diagnoses Airway Obstruction Dependent, Anxiety Minimum Data Set completed. The FL tool) dated 8/6/14 r orientation was con time. Ambulation an supervision. Specia continuous oxygen plan dated 8/29/14 Pulmonary Disease Oxygen therapy wa be used with care. A review of the Phy	admitted into the facility on a include Bronchitis, Chronic , Supplemental Oxygen y and Atrial Fibrillation. The was in process of being 2 (a level of care screening evealed Resident #40's mental listant to person, place and nd transfers required al treatment included therapy. The admission care listed Chronic Obstructive e (COPD) as a diagnosis. Is indicated as an approach to resician orders for August 2014 -			allegation of compliance. Corrective Action #1 - Resident #40 taken to the 300/400 hall nurses stat NA#1 and the activities director to be assessed by the nursing staff. O2 saturation was measured at 95% on air by the Med Aide. O2 canister was changed and reset to 2 liters/nasal cannula by the Medication Aide. The resident was then taken to her room nurse # 1 where an assessment was completed by the unit manager with assistance from the Director Nursing Services (DNS) as per facility protoc O2 Saturation; Lung assessment (crackles, wheezes, diminished lung sounds); oxygenation of nail beds; L	tion by e i room s i by s g col:	(X6) DATE

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.

09/26/2014

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED
		345481	B. WING			09/04/2014	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	ANDS NURSING & RE	HABILITATION CENTER			00 PELT DRIVE AYETTEVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 224	Continued From pa	ige 1	F 2	24			
1 224	September 2014 re oxygen at 2 liters pr continuous every da A review of a discip Nurse #1 on 9/4/14 incompetent work, resident with respir On 9/4/14 at 10:07 Nurse #1 exited the to the medication c Resident #40 at the wheelchair as the m room. The resident breath and can not get air, there's no a tank on the back of frustrated right now resident was obser of accessory muscl intercostal muscles include neck and sl shortness of breath your room, I'll be th away without asses concerns and conti resident was obser from her room, whi hallway and to the r sight of Nurse #1. F "Somebody please listening to me, I an	evealed a physician order for er minute via nasal cannula ay. linary action notice signed by in part read "unsatisfactory or failed to properly assess	F2	24	of consciousness. Based on the assessment, it was determined that the residentMs O2 Saturation was 95% on room air a beds indicated adequate oxygenat Ativan .25mg was administered by #1 to the Resident at 10:27am as a prophylactic calming agent and in to the O2 was effective in relieving anxiety. Nurse #1 was immediately intervie the DNS as to rationale for lack of response to residentMs needs as f been instructed and trained per fac policies and procedures. Due to fa follow facility policy and protocol, th nurse was terminated on 09/04/14 DNS. Corrective Action #2 - The DNS ar administrative nursing staff reviews residents receiving Oxygen therap whether via concentrator or on por O2 canisters, to ascertain canister concentrators were within normal operating ranges (9/04/14). All res reviewed were found to have propo operating canisters and concentrator Corrective Action # 3 - The facility serviced all licensed staff on 9/5/14 regards to the following issues: (1) Treatment/Management of resider COPD/Respiratory Compromise M COPD Clinical Protocol, 2) Oxyger	nd nail ion. Nurse a addition wed by mad cility ailure to ne by the nd ed all y, table s and idents er tors. DNS in 4 with hts with 1 Using	
	The resident was o there was no other voiced her concern began to panic as s	bserved to be frustrated and staff present at the time she s to Nurse #1 - the resident she looked for someone to en cylinder gauge on the back			Administration Protocol, 3) Abuse Neglect M Using Abuse/Neglect Pr and 4) Change in residents condition/status MUsing Change in Resident Condition Status Change	rotocol, n	

Facility ID: 923402

If continuation sheet Page 2 of 12

							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345481	B. WING _			09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	ANDS NURSING & RE	EHABILITATION CENTER			00 PELT DRIVE AYETTEVILLE, NC 28301		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 224	Continued From pa	age 2	F 22	24			
1 224	of the resident's wh "empty" of oxygen. the 500 unit where help the resident, th physically in sight. Assistant) #1 was of resident oxygen cyl complained to Nurse breath/difficult breat medical attention. It asked Resident #1 explained to her sh was coming from h had told Nurse #1 w to her room. NA #1 oxygen gauge, rem entirety from the ho wheelchair, then ac director, the resident wheelchair to the 3 get another oxygen resident's oxygen s medication aide at resident continued breathing, anxiety a am, oxygen per a r per minutes was ap Nurse #1 arrived an for proper fit and th you okay?" The resident better now and I'm labored (difficultly) A review of the MA at 10:27 am admin	heelchair was observed Upon looking for someone on the resident was located, to here was no staff member At 10:08 am NA (Nursing observed and notified the linder was empty and she se #1 of shortness of athing and needed immediate NA (Nursing Assistant) #1 was she okay and the resident he could not breathe, no air er oxygen tank and that she who instructed her to go back immediately looked at the noved the oxygen cylinder in its older on the back of the companied by the activities int was escorted in her 00/400 hall nurses station to n cylinder. At 10:13 am, the saturation was assessed by the 95% on room air; however the with shortness of breath, deep and flushed in color. At 10:14 new oxygen cylinder at 2 liters oplied by nasal cannula and nd adjusted the nasal cannula en asked Resident #40 "Are sident did not respond to her. esident stated "I feel much not as frustrated" with no breathing observed. R revealed Nurse #1 on 9/4/14 istered Ativan 0.25 mg (one		24	Protocol. Portable O2 canisters have been at the Medication Administration Rec. (MAR) with a new procedure, develop by the DNS, of changing out portal canisters if less than 500 pounds p square inch (PSI) and document s the ResidentMs medical record. Lie staff were in serviced on how to re to residents who are experiencing difficulty breathing. Staff re-educat the airway, breathing and circulation assessment and its priority to othe general nursing duties. Staff reedu to insure that residents in respirator distress are thoroughly and comple assessed. This includes that the of O2 is on and functioning; O2 satur levels have been checked; vitals st taken; lungs have been auscultate wheezing, crackling or any abnorm breaths sounds. Staff are to asses irregular labored breathing, nail be monitored for cyanosis. Any licens nurse not attending the in-service of be placed on the schedule until the or appropriate designee, has revie in-service material with said nurse. Any resident on portable O2 canist have the use of portable O2 canist added to the applicable residents for ensure residentsM canisters have physically checked every shift by li- personnel while the resident is up a using the O2 portable canister. If the resident is in bed or in room and the	ord eloped ble O2 ber uch in censed spond ed to on r cated ory etely rdered ation gns d for hal s for ds to be ed will not ed NS, wed all ers will ers will ers dAR to been censed and he he	
OPM CMS-22	labored (difficultly) A review of the MA at 10:27 am admin tablet) by mouth for	breathing observed. R revealed Nurse #1 on 9/4/14 istered Ativan 0.25 mg (one r anxiety/agitation. Per follow irse #1 documented the ective.	1	Fac	physically checked every shift by lip personnel while the resident is up a using the O2 portable canister. If the resident is in bed or in room and the portable canister is not needed, it we turned off and the resident placed provided O2 concentrator set at the	censed and he ie will be on the	Pag

Facility ID: 923402

If continuation sheet Page 3 of 12

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI T				0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		345481	B. WING			09/0	04/2014
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
NOODL	ANDS NURSING & RE	EHABILITATION CENTER			00 PELT DRIVE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 224	Continued From pa	age 3	F 2	24			
	of the Director of N Resident #1's prima aware the resident continuous oxygen the resident to go to in the middle of her resident stopped he Nurse #1 stated the concern she was a informed her she w not breathe. She fu #40's concerns sho the time the residen of breath and could the resident was ca room independently placing herself on to she had an opportu- resident was alert a task independently response was inap requested help from her med pass. She to ensure the oxyge of the resident's who	am, Nurse #1 in the presence ursing, acknowledged she was ary nurse. She stated she was was ordered to have . She indicated she instructed o her room because she was medication pass when the er in route from the med room. ere was no other emergency ttending to when Resident #40 vas short of breath and could inther acknowledged Resident ould have been her priority at in informed her she was short and breathe, however she felt apable of going back to her y, as she instructed her and he oxygen concentrator; until unity to get to her because the and capable of doing such a . Nurse #1 acknowledged her propriate when the resident in her and she continued with concluded she did not check en cylinder located on the back beelchair had sufficient oxygen, are of the resident on her shift			ordered settings and delivered as ordered. O2 saturation levels will b every shift for residents with orders continuous O2 and documented of Upon examination of the canister b licensed personnel, or appropriate designee, any canister found to be than 500PSI will be exchanged for canister and documented as such residentMs medical record. Continuing with facility policy, proto guidelines, the licensed staff will co to document every shift on the MA resident receiving Oxygen Therapy saturation levels will also continue checked, each shift, on all residen receiving Oxygen Therapy, whether concentrator or portable O2 canist All licensed nursing will be re-in set by the DNS, or appropriate design on/before 9/29/14 on facility policy regarding the definition of abuse, r misappropriation of resident proper facility expectations regarding kee residents safe from abuse, neglec misappropriation of resident proper licensed nurse will be allowed to w re-in serviced on care of a residen oxygen.	s for n MAR. by e less a full in the bocol and bontinue R any y. O2 to be ts er by ers. erviced ee neglect, rty, and ping all t and rty. No ork until	
	On 9/4/14 at 10:35 (DON) stated she e	am, the Director of Nursing			All newly hired nurses will be in-se during orientation by the DNS, or appropriate designee of the facility		

Facility ID: 923402

If continuation sheet Page 4 of 12

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		345481	B. WING	G		09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WOODL	ANDS NURSING & RE	EHABILITATION 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 224	and difficultly breat explained to Nurse Resident #40's res the discussion Nurs feel the concern wa	age 4 nplaint of shortness of breath hing. The DON added she #1 she failed to assess piratory status; however during se #1 responded she did not as a priority, therefore, Nurse employed at the facility effective	F 2	24	care of resident on oxygen, and evaluation of portable O2 canisters Corrective Action #4 - Mobile reside dependent on portable O2 canister be monitored for respiratory status Oxygen Monitoring Tool by the DNS appropriate designee 5 X week for weeks; followed by 2 X week for 2 followed by weekly X 4 weeks, follo monthly X 1 months; followed by quarterly X 3 quarters; and as need 10% of residents will be randomly selected by the facility administrato interviewed by the Social Service D or appropriate designee, with regar resident rights as it pertains to the be free of abuse, neglect, and misappropriation of property and th facilityMs expectations of providing appropriate assessment and treatm The random 10% of residents will b interviewed weekly times 8 weeks, followed by monthly X 4 months; for by quarterly X 2 quarters, and as n Results of the monitoring for comp with portable O2 canisters and the random audit of residents will be br to the morning administrations meet the DNS, Social Service Director, of appropriate designee weekly X 8 w The results will be reviewed and discussed and appropriate follow u action implemented as needed. For this 8 week period, the DNS, Social Service Director, or appropriate designee weekly X 8 w	ents s will using S, or 2 weeks; weeks; weed by ded. or to be Director, rds to right to nent. De bllowed eeded. liance 10% rought eting by or reeks. p Dillowing l	

Event ID: WR3711

Facility ID: 923402

If continuation sheet Page 5 of 12

		AND HUMAN SERVICES			F	ORM	10/06/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:		E SURVEY PLETED
		345481	B. WING			09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	ANDS NURSING & RE	EHABILITATION CENTER			00 PELT DRIVE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 224 F 309 SS=G	483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	CARE/SERVICES FOR	F 2		 will bring compliance with monitoring the facility monthly Quality Assessment and Assurance Committee Meeting monthly X 4 months, then the facility of meeting quarterly X 2 quarters for discussion by the QAA team. Any non-compliance will be reviewed the team with regards to the root cause non-compliance and the QAA team will be documented in the QAA meeting minuted and appropriate staff will be in service the DNS, Social Service Director, or appropriate designee as applicable wiregards to changes in the plan. Any change in the plan for monitoring portable O2 canisters or for interviewir andom 10% of residents will require the monitoring outlined above to begin age. 	nt QAA by se of ill n oe utes. utes ed by ith ing the gain.	9/29/14

Facility ID: 923402

If continuation sheet Page 6 of 12

	OF DEFICIENCIES	& MEDICAID SERVICES			LE CONSTRUCTION (SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		COM	PLETED
		345481	B. WING	i		09/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	ANDS NURSING & RE	HABILITATION CENTER			100 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 6	F 3	309			
		NT is not met as evidenced					
	Based on record re interviews, the facili assess and provide verbalized difficultly breath for 1 of 4 res on supplemental ox included: Resident #40 was a 8/29/14. Diagnoses Airway Obstruction, Dependent, Anxiety Minimum Data Set completed. The FL2 tool) dated 8/6/14 re orientation was con time. Ambulation ar supervision. Specia continuous oxygen plan dated 8/29/14	eview, observation and staff ity failed to immediately a care to a resident who y breathing and shortness of sidents, who was dependent tygen (Resident #40). Findings admitted into the facility on a include Bronchitis, Chronic , Supplemental Oxygen y and Atrial Fibrillation. The was in process of being 2 (a level of care screening evealed Resident #40's mental astant to person, place and nd transfers required al treatment included therapy. The admission care listed Chronic Obstructive (CORD) as a diagnosia			Woodlands Nursing and Rehabilitat Center acknowledges receipt of the Statement of Deficiency and propos plan of correction to the extent that is summary of findings is factually corr and in order to maintain compliance applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. Corrective Action #1 - Resident #40 taken to the 300/400 hall nurses sta NA#1 and the activities director to be assessed by the nursing staff. O2 saturation was measured at 95% on air by the Med Aide. O2 canister was changed and reset to 2 liters/nasal cannula by the Medication Aide. The resident was then taken to her room nurse # 1 where an assessment was	ed the the rect with f of was ation by e n room s n by s	
	Oxygen therapy wa be used with care. A review of the Phy September 2014 re	e (COPD) as a diagnosis. s indicated as an approach to sician orders for August 2014 - vealed the following			completed by the unit manager with assistance from the Director Nursing Services (DNS) as per facility protoc O2 Saturation; Lung assessment (crackles, wheezes, diminished lung sounds); oxygenation of nail beds; L	g col: g	
	1. Combivent inha (inhalation) four tim shortness of breath persons with COPE bronshospams (cor the bronchiole (pas through the nose an	d for respiratory treatment: alant spray one puff es a day as needed for . Combivent is used in 0 to prevent sudden nstriction) of the muscles in sageway by which air passage nd mouth to the lungs). ers per minute via nasal			of consciousness. Based on the assessment, it was determined that the residentMs O2 Saturation was 95% on room air and beds indicated adequate oxygenatio Ativan .25mg was administered by N #1 to the Resident at 10:27am as a prophylactic calming agent and in ac to the O2 was effective in relieving anxiety. Nurse #1 was immediately interview	on. Nurse ddition	

Facility ID: 923402

If continuation sheet Page 7 of 12

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SU	
	F CORRECTION	IDENTIFICATION NUMBER:		G	COMPLET	
		345481	B. WING		09/04/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODL	ANDS NURSING & RE	EHABILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETIO DATE
F 309	Continued From pa	age 7	F 309	9		
	mouth every day fo Montelukast prever wheezing and asth A review if the med (MAR) revealed Mo administered on 9/4 Nurse #1. On 9/4/14 at 10:07 Nurse #1 exited the to the medication of Resident #40 at the wheelchair as the r room. The resident breath and can not get air, there's no a tank on the back of frustrated right now resident was obser of accessory musc intercostal muscles include neck and s shortness of breath your room, I'll be th way without assess concerns and conti resident was obser from her room, whi	nt shortness of breath,		the DNS as to rationale for lack of response to residentMs needs as been instructed and trained per f policies and procedures. Due to follow facility policy and protocol, nurse was terminated on 09/04/1 DNS. Corrective Action #2 - The DNS a administrative nursing staff revie residents receiving Oxygen thera whether via concentrator or on p O2 canisters, to ascertain caniste concentrators were within norma operating ranges (9/04/14). All re reviewed were found to have pro operating canisters and concentr Corrective Action # 3 - The facilit serviced all licensed staff on 9/5/ regards to the following issues: (Treatment/Management of reside COPD/Respiratory Compromise COPD Clinical Protocol, 2) Oxyg Administration M Using Oxygen Administration Protocol, 3) Abuse Neglect M Using Abuse/Neglect I and 4) Change in residents condition/status MUsing Change Resident Condition Status Change Protocol. Portable O2 canisters have been the Medication Administration Resident	a had acility failure to the 4 by the and wed all py, ortable ers and sidents per ators. y DNS in 14 with 1) ents with M Using en (O2) e and Protocol, in ge added to	
	"Somebody please listening to me, I ar breathe and I need The resident was o	Resident #40 yelled help me, she (Nurse #1) is not n short of breath and can't someone to help me now. bserved to be frustrated and staff present at the time she		(MAR) with a new procedure, de by the DNS, of changing out port canisters if less than 500 pounds square inch (PSI) and document the ResidentMs medical record. I staff were in serviced on how to	able O2 per such in Licensed	

Facility ID: 923402

If continuation sheet Page 8 of 12

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED	
		345481	B. WING			09/0)4/2014	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
NOODL	ANDS NURSING & RE	HABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 309	Continued From pa	ge 8	F 3	09				
	help her. The oxyge of the resident's wh "empty" of oxygen. the 500 unit where help the resident, th physically in sight. A Assistant) #1 was of resident oxygen cyl complained to Nurse breath/difficult brea medical attention. N asked Resident #1 explained to her sh was coming from h had told Nurse #1 w to her room. NA #1 oxygen gauge, rem entirety from the ho wheelchair, then ac director, the residen wheelchair to the 30 get another oxygen resident's oxygen s medication aide at resident continued breathing and anxie 10:14 am, oxygen p liters per minutes w and Nurse #1 arrive cannula for proper #40 "Are you okay? to her. At 10:15 am much better now ar no labored (difficult	en cylinder gauge on the back eelchair was observed Upon looking for someone on the resident was located, to here was no staff member At 10:08 am NA (Nursing observed and notified the inder was empty and she is #1 of shortness of thing and needed immediate NA (Nursing Assistant) #1 was she okay and the resident e could not breathe, no air er oxygen tank and that she who instructed her to go back immediately looked at the oved the oxygen cylinder in its older on the back of the scompanied by the activities it was escorted in her 00/400 hall nurses station to cylinder. At 10:13 am, the aturation was assessed by the 95% on room air; however the with shortness of breath, deep ety and flushed in color. At ber a new oxygen cylinder at 2 vas applied by nasal cannula ed and adjusted the nasal fit and then asked Resident " The resident stated "I feel nd I'm not as frustrated" with ly) breathing observed. R revealed Nurse #1 on 9/4/14	ΓJ		the airway, breathing and circulation assessment and its priority to other general nursing duties. Staff reeduc to insure that residents in respirator distress are thoroughly and comple assessed. This includes that the or O2 is on and functioning; O2 satural levels have been checked; vitals sig taken; lungs have been auscultated wheezing, crackling or any abnorma- breaths sounds. Staff are to assess irregular labored breathing, nail been monitored for cyanosis. Any license nurse not attending the in-service w be placed on the schedule until the or appropriate designee, has review in-service material with said nurse. Any resident on portable O2 caniste have the use of portable O2 caniste have the use of portable O2 caniste added to the applicable residents W ensure residentsM canisters have to physically checked every shift by lic personnel while the resident is up a using the O2 portable canister. If the resident is in bed or in room and the portable canister is not needed, it w turned off and the resident placed of provided O2 concentrator set at the ordered settings and delivered as ordered. O2 saturation levels will be every shift for residents with orders continuous O2 and documented on Upon examination of the canister b licensed personnel, or appropriate designee, any canister found to be than 500PSI will be exchanged for a	cated y tely dered ation gns for al for al for ds to be ed vill not DNS, ved all ers will ers MAR to been censed ind he e taken for MAR. y less		

Facility ID: 923402

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		AND HUMAN SERVICES				FORM	10/06/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED	
		345481	B. WING	·		09/	04/2014	
	PROVIDER OR SUPPLIER	HABILITATION CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PELT DRIVE AYETTEVILLE, NC 28301	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	of the director of nu Resident #1's prima aware the resident of continuous oxygen. the resident to go to in the middle of her resident stopped he Nurse #1 stated the concern she was at informed her she w not breathe. She fu #40's concerns sho the time the resider of breath and could the resident was ca room independently placing herself on the she had an opportur resident was alert at task independently. response was inappr requested help from her med pass. She to ensure the oxyge of the resident's wh since taking over ca at 7:00 am. On 9/4/14 at 10:35 (DON) stated "Ever resident is having tr should immediately further stated she e immediately stoppe	am, Nurse #1 in the presence rising, acknowledged she was ary nurse. She stated she was was ordered to have She indicated she instructed o her room because she was medication pass when the er in route from the med room. Fe was no other emergency thending to when Resident #40 as short of breath and could rther acknowledged Resident ould have been her priority at not breathe; however she felt upable of going back to her y, as she instructed her and he oxygen concentrator; until unity to get to her because the and capable of doing such a Nurse #1 acknowledged her oropriate when the resident in her and she continued with concluded she did not check en cylinder located on the back eelchair had sufficient oxygen, are of the resident on her shift	F	309	guidelines, the licensed staff will of to document every shift on the MA resident receiving Oxygen Therap saturation levels will also continue checked, each shift, on all resider receiving Oxygen Therapy, wheth concentrator or portable O2 canis All licensed nursing will be re-in so by the DNS, or appropriate design on/before 9/29/14 on facility policy regarding the definition of abuse, misappropriation of resident prope facility expectations regarding kee residents safe from abuse, negled misappropriation of resident prope licensed nurse will be allowed to v re-in serviced on care of a resider oxygen. All newly hired nurses will be in-se during orientation by the DNS, or appropriate designee of the facility regarding abuse, neglect, misappropriation of resident funds facility expectations for following f policy and protocol regarding kee residentMs safe from abuse, neglect misappropriation of resident funds facility expectations for following f policy and protocol regarding kee residentMs safe from abuse, neglect misappropriation of resident prope care of resident on oxygen, and evaluation of portable O2 canister Corrective Action #4 - Mobile reside dependent on portable O2 canister Oxygen Monitoring Tool by the DN appropriate designee 5 X week for followed by weekly X 4 weeks, foll monthly X 1 months; followed by	AR any y. O2 to be the er by ters. erviced hee reping all erty, and erviced y policy s, the acility bing all erty. No vork until to n erviced y policy s, the acility bing all ect, erty and s. dents ers will s using IS, or r 2 weeks;		

Facility ID: 923402

		AND HUMAN SERVICES				PRINTED: 10/06/201 FORM APPROVEI OMB NO. 0938-039		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		345481	B. WING			09/	04/2014	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP COL			
WOODL	ANDS NURSING & RE	HABILITATION CENTER			100 PELT DRIVE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 10	F	309				
1					quarterly X 3 quarters; and as	needed.		
	oxygen cylinders ar unit) medication rod oxygen. On 9/4/14 at 11:05 Resident #40, the E observed by the res resident in her room Upon their exit and stated "I am okay n trouble for anyone H elaborate further co complaint to Nurse she experienced. On 9/4/14 at 11:20 with Resident #40 r seen the resident a she believed the res could not breathe p her. NA #1 added th capable of making I On 9/4/14 at 11:26	am, Nurse #2 stated supply re kept on the 300/400 (one om only for backup cylinder am, in an attempt to interview DON and Nurse #2 were sident's bedside talking to the n, while she rested in the bed. entering the room the resident ow, I don't want to cause any here." Resident #40 would not oncerning her previous #1 or the respiratory episode am, NA #1 stated she worked egularly and she had never ct the way she did. She added sident was short of breath and roperly when she informed he resident was alert and was her needs known to the staff. am, the Activity Director stated esident #40 state she needed g difficulties breathing, she			10% of residents will be rando selected by the facility admini- interviewed by the Social Serv or appropriate designee, with resident rights as it pertains to be free of abuse, neglect, and misappropriation of property a facilityMs expectations of prov- appropriate assessment and The random 10% of residents interviewed weekly times 8 we followed by monthly X 4 mont by quarterly X 2 quarters, and Results of the monitoring for of with portable O2 canisters an- random audit of residents will to the morning administrations the DNS, Social Service Direct appropriate designee weekly The results will be reviewed a discussed and appropriate fol action implemented as needed this 8 week period, the DNS, Service Director, or appropriate	strator to be vice Director, regards to o the right to and the viding treatment. s will be eeks, hs; followed I as needed. compliance d the 10% be brought s meeting by ctor, or X 8 weeks. and low up ed. Following Social		
	oxygen cylinder to t because she wante received oxygen. On 9/4/14 at 12:30 a copy of the MAR. combivent inhalant shortness of breath	nt behind NA #1 who had the the next nurses station ad to ensure the resident pm, the administrator provided The MAR did not reflect one puff as needed for was administered on 9/4/14 he respiratory event or ng.			 will bring compliance with mothe facility monthly Quality Assand Assurance Committee Mamonthly X 4 months, then the meeting quarterly X 2 quarters discussion by the QAA team. Any non-compliance will be return the team with regards to the renon-compliance and the QAA revise the plan as needed to a solution. 	sessment eeting facility QAA s for eviewed by oot cause of team will		

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		AND HUMAN SERVICES				FORM	10/06/2014 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345481	B. WING			09/	04/2014
	Provider or supplier ANDS NURSING & RE	EHABILITATION CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PELT DRIVE AYETTEVILLE, NC 28301		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 11	F3	809	compliance. All discussions by the QAA team we documented in the QAA meeting in Any revisions to the plan will be documented in the QAA meeting in and appropriate staff will be in serve the DNS, Social Service Director, or appropriate designee as applicable regards to changes in the plan. Any change in the plan for monitor portable O2 canisters or for intervi- random 10% of residents will requi- monitoring outlined above to begin	ninutes. ninutes viced by or e with ing ewing ire the	

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If continuation sheet Page 12 of 12