	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		С
		345481	B. WING		08/25/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODLA	NDS NURSING & REHAI	BILITATION CENTER		00 PELT DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	from 08/23/18 throug Jeopardy was identifi F689 at a scope and	ation survey was conducted h 08/25/18. Immediate ed at CFR 483.25 at tag severity (J) uted Substandard Quality of			
	removed on 08/25/18 was conducted.	began on 08/17/18 and was A partial extended survey			
F 600 SS=G	Free from Abuse and CFR(s): 483.12(a)(1)		F 600		9/10/18
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	§483.12(a) The facilit	y must-			
	physical abuse, corpo involuntary seclusion This REQUIREMENT	-			
	surveillance recording	iew, observation, video g review, and resident and acility failed to prevent buse in the form of		Plan to correct specific deficiency and facts that led to the alleged deficient practice:	
	reviewed for abuse (I	g for one of three residents Resident #3). Resident #2 e his hand underneath the		Resident #3 and Resident #2 observed staff in main dining area of facility interacting and communicating between	-

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.

09/07/2018

			A (2)				<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY PLETED
			A. DOILDING				С
		345481	B. WING				
IAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
	NDS NURSING & REHAE			400	0 PELT DRIVE		
VUUDLA	NDS NUKSING & REHAL	SILITATION CENTER		FA	YETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE
F 600	Continued From page	e 1	F 60	0			
		with Resident #2 's hand	1 00		the hours of 8:30 pm and 10:26 pm on		
		near Resident #2 's groin			8/19/2018. Staff monitoring frequently		
	•	is assessed by two facility			and offering to assist resident #3 to retir	e	
1	nurses and was found			for the evening, however resident #3			
	 ,				declined assistance to bed when offered	d,	
	Findings included:				more than 1 time.		
	1a.				At approximately 10:26 pm Nursing		
	Resident #3 was adm	nitted to the facility on 2/8/18			Assistant #2 rounding to monitor resider	nt	
N N		unspecified dementia			#3 observed resident #2 with right hand		
	without behavior.				under dressing gown on top of resident		
		erly Minimum Data Set dated			#3's left thigh area.		
		resident had adequate			Resident #3 immediately assisted from	ما	
		n, usually understands, and resident was unable to			dining area, by Nursing Assistant #2 and discontinued the interaction with resider		
		e assessment. The resident			#2 upon observing resident #2 with hand		
		sistance for all activities of			located under resident #3's gown on top		
	daily living. The activ	ve diagnosis was			of her left thigh.		
	non-Alzheimer 's der	nentia.			Nursing Assistant #2 immediately report	had	
	On 8/23/18 at 1.00 pr	m Resident #3 was observed			Nursing Assistant #2 immediately report observation and concern to licensed	leu	
		nair with a private aide			nurse. Licensed nurse immediately to		
		The private aide had to			resident #3's room for assessment.		
	speak up and face the	e resident for the resident to			Nursing Assistant #2 provided resident #		
		as oriented to self with			with incontinent care, due to noted bowe		
		situation. While in Resident			movement present. Licensed nurse not	es	
		#2 attempted to enter, and ned Resident #2 to "get out			following incontinent care of bowel movement resident seemed 'tender' to		
		2 stated he wanted to talk to			labia area.		
		/or exited Resident #3 ' s			Resident #2 immediately placed under		
		ed Resident #2 away. Both eside on the same hall.			direct staff supervision with a ratio of 1:	1.	
		coldo on the barrie ridii.			100% of all other residents assessed by	/	
	The facility 's video s	surveillance (no sound) dated			licensed staff through an interview		
	8/19/18 was reviewed	d and revealed Resident #3			process with BIMs scores of >12		
	inappropriately touch	ed Resident #2 as follows:			regarding inappropriate touching by othe	ers	
	A+ 0.50 pm 1	Dogidant #2 was along in the			with no further concerns reported.		
	AL 9:56 PM I	Resident #3 was alone in the			Completed 8/24/2018.		

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				D		1	IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1 Y /	E SURVEY
			A. BUILDING	G			С
		345481	B. WING				B/25/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		0/25/2010
					00 PELT DRIVE		
WOODLA	NDS NURSING & REHAE	BILITATION CENTER			AYETTEVILLE, NC 28301		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO DATE
F 600	Continued From page	e 2	F 60	00			
	At 10:03 Re	sident #2 returned to the DR			100% of all other residents with BIMs		
		id was observed frequently			scores <12 were physically assessed	by	
	stroking his own head	· ·			licensed staff for any signs/symptoms	-	
	 At 10:08 pm 	Resident #2 placed his			abuse/neglect/mood changes/behavio	r	
	-	Resident #3 's wheel chair			changes such as changes in		
		was noted to be fidgeting			eating/sleeping patterns, with no further		
	quickly with the towel				concerns noted. Completed 8/24/2018		
		an be seen over the right			Dressdure for implementing a plan of		
		d his forearm and hand are #3 ' s dress appears to be			Procedure for implementing a plan of correction for the alleged deficient		
		in the center of her dress			practice		
		lent #3 began folding and			produce		
		el on her lap nervously			Resident #2 continued with 1:1 staffing	a	
		. Resident #2 ' s hand and			ratio, medical record reviewed by Dire		
	arm appeared to be u	Inder Resident #3 ' s dress.			of Nursing on 8/20/2018, behavior of		
		was observed to push at			inappropriate touching reported to M.E		
	Resident #2 ' s arm.				was noted by Director of nursing durin	g	
		and down in the center of			medical record review, there was a		
		and she continued to			pending urine culture/sensitivity from a	1	
	-	fold the towel on her lap and			urine collected on 8/17/2018 when		
	-	air arm until staff arrived. of Resident #2 was alone			resident complained of burning upon urination. Results of the 8/17/2018		
		buched Resident #3 in the			urinalysis obtained and resident noted		
	DR was 18 minutes.				with rather significant urinary tract		
		Nursing Assistant (NA) #2			infection, results reported to M.D. with		
	arrived to get Resider	nt #3 and quickly wheeled			orders received for antibiotic therapy		
	her out of the DR. W				which was initiated 8/20/2018. 1:1 sta	ffing	
		Resident #2 ' s scooter in			removed once antibiotic therapy initiat	ed	
		camera her dress on the			however resident remained on close		
		er upper thigh/groin and the			observation with no further behaviors		
	ieit side of the dress	was down below her knee.			noted. Resident placed back on 1:1		
	1b.				supervision on 8/24/2018 to ensure no further behaviors exhibited; resident #		
	10.				was noted to attempt to enter resident		
	Resident #2 was adm	nitted to the facility on			#3's room on 8/24/2018 to speak to he		
		cumulative diagnoses of			while a private care taker was at the		
		pathy and unspecified			bedside, the caretaker requesting resid	dent	
	dementia without beh				#2 not speak to resident #3 therefore	1:1	
					staff ratio re-initiated. Resident remain	ne	

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/25/20 RM APPROVE NO: 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		
		345481	B. WING				C)8/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	NDS NURSING & REHAI	BILITATION CENTER			0 PELT DRIVE YETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 3	F 60	00			
	A review of the quart	erly Minimum Data Set dated resident had adequate			under direct supervision at this time.		
	hearing, clear speech understood. The cog behaviors were exhib limited assistance wit supervision for transf was set up only. Act non-Alzheimer 's der	n, and understands and was gnition was intact, and no bited. The resident required th bathing and dressing, and fer and meals. Locomotion ive diagnosis was mentia.			100% staff education initiated 8/24/24 to include supervision of residents, emphasizing to staff to monitor for residents with behaviors that deviate the norm, such as making sexual advances towards others. This educ was initiated by the director of nursin with assistance from the regional stat	from ation	
	resident was diagnos infection from culture ordered. (no mentior	n of behavior change).			developer and the regional clinical consultant. Education included: Monitoring for residents who may turn lighting, residents sitting too closely together, inappropriate touching, and		
	the resident was place allegation of abuse. behavior (type not pr	8/20/18 late entry for 8/19/18 eed on 1:1 supervision for The resident had unusual ovided). Assessment on resident had no behaviors ntibiotics 8/20/18.			removing cognitively impaired patient from inappropriate settings immediate All education will completed on or be 9/10/2018 and will include all newly h associates during the orientation pro- prior to working independently. The Director of Nursing will ensure all	ely. fore iired	
	continued on antibiot noted. Interviews of s	8 late entry: the resident ics. No additional behaviors staff reveal no further riate behaviors no further			associates receive the education in coordination with the Unit Managers Administrator.	and	
	psychiatry evaluation	or touching. Will schedule and follow. Psychiatry ed for 8/24/2018. The staff			Monitoring Procedure The Director of Nursing and/or Unit		
		or. Plan of care updated			Managers will interview 2 non-clinica 2 clinical staff members weekly regar their level of understanding related to	ding	
	Monday night, 8/20/1 room for the duration	8/23/18 late entry: On 8, the resident stayed in his of my shift, 11:00 p.m der constant monitoring			7 types of abuse, those who are able give consent, signs/symptoms of abu and how to report.	to	
	during the shift. The Assistant posted on t	der constant monitoring re was a Certified Nursing the hall and the medication e's station. This resident did			The monitoring began on 9/4/2018. The Director of Nursing will collect ar maintain interviews in the Director of		

Facility ID: 923402

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3)	3 NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		COMPLETED
		345481	B. WING			C 08/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	00,20,2010
WOODLA	NDS NURSING & REHA	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 4	F 60	00		
	not come out of his room or interact with any residents at any time during this shift. On 8/23/18 at 3:45 pm an interview was			Nursing office and the resu interviews and observation rounding to the weekly QA	during daily	
	conducted with Residual self, situation, and tin	m an interview was lent #2 who was oriented to ne. Resident #2 was able to to provide detail of 8/19/18 in		ensure corrective action for ongoing concerns is initiate by ensuring 1:1 staffing rati residents who exhibit inapp	r trends or ed immediately io for those	
	the dining room wher Resident #2 stated th listening to music on	n Resident #3 was present. hat he was in the dining room the computer. Resident #3		behavior and the staffing le continue until interdisciplina clinicians, physician, Nursir	vel will ary team, ie. ng Assistants,	
	time he had touched was smiling). Reside	#2 stated that was the first Resident #3 (Resident #2 ent #2 commented that many acility had died or were sick		etc. provide assessment the resident appropriate to inte general resident population	ract with The	
	and not able to visit w	vith him. Resident #2 did not e facility staff said to him		monitoring will be reviewed QA committee for a minimu and will continue until no lo necessary.	im of 3 months	
	stated she was aware	lent #3 ' s private aide who e of an altercation between				
	stated that Resident a and would not conser- public place with a m private aide stated th	ident #3. The private aide #3 was a religious person nt to sexual relations in a an she does not know. The at the resident had dementia consent to sexual relations.				
	The resident was free oriented to her surrou	quently confused and not undings.				
	approximately 10:25 to retrieve Resident #	2 who stated on 8/19/18 at pm the NA entered the DR 绪 to help her get to bed. NA				
	to Residents #2 and a other, NA #2 observe and forearm under th	to the DR and walking near #3 that were next to each ed Resident #2 with his hand e dress of Resident #3 and and down near her groin.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 09/25/201 FORM APPROVE MB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONST		(X3) DATE SURVEY COMPLETED	
		345481	B. WING				C 08/25/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP CC	DDE	
WOODLA	NDS NURSING & REHA	BILITATION CENTER		400 PELT FAYETT	T DRIVE FEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	hand down to the res NA #2 noted that Reside was fidgeting with he unusual. NA #2 state the resident to her as informed her of what was also informed of second witness. NA and 2 took Resident a her. NA #2 was direc to supervise him. NA hall bathroom washin NA #2 asked Resider and he stated nothing Resident #2 for the re On 8/23/18 at 5:55 pt conducted with Nurse informed by NA #2 th moving up and under undergarment of Res that she thought Resi Resident #3 's privat stated that she and N #3 who had stool in h incontinence care Nu Resident #3 could no contact due to cognit to make decisions du On 8/24/18 at 6:30 pt conducted with the D s resident representa	aw NA #2, he moved his ident 's sock and touched it. sident #3 had brown matter ils that resembled stool. NA ent #3 looked nervous and r towel bib which was ed that she immediately took signed nurse, Nurse #2, and she observed. Nurse #1 NA #2 's observation for a #2 stated that Nurse #s 1 #3 to her room to assess eted to find Resident #2 and A #2 found Resident #2 in the og his hands of brown matter. If #2 what he was washing, g. NA #2 supervised emainder of the shift. In an interview was e #1 who stated she was at Resident #2 had his hand the dressing and inside the ident #3. NA #2 also stated ident #2 had penetrated e with his hand. Nurse #1 lurse #2 assessed that der upon touch of her labia oted. Nurse #1 stated that t give consent to sexual ive deficit and was not able e to a cognitive deficit.	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/25/2018 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345481	B. WING		_		C 25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WOODLA	NDS NURSING & REHAB	ILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 283	301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page had the opportunity to and speak to staff.	6 review the video recording	F 600				
	On 8/24/18 at 6:30 pm conducted with the D had his first psychiatry was placed on an ant of his son. Psychiatry a second counseling w Resident #3 which was first counseling on 8/2 more receptive and m comments to the DON surveyor interview, ex- inappropriately touchi #2 commented they w the family (of Residen provided of the couns she now understood a deficit cannot give sex Resident #2 that touc what he did not wrong supervised 1:1 for 24 continuously staff sup facility for his interacti During the course of to observed to have free throughout the facility communicating with F On 8/24/18 at 6:30 pm conducted with the Do she now understood a deficit cannot give sex Resident #2 that touc	DN who stated Resident #2 y evaluation yesterday and i-depressant after the death y was to follow. On 8/23/18 was done by the DON with its more successful than the 20/18. The resident was hade some of the same of the same of the transment that he made during the resident. Resident yere friends and he knew it #3). Documentation was eling. The DON stated that a resident with a cognitive cual consent and informed hing was not permitted and g. Resident #3 was hours and is currently ervised throughout the on with all residents. he survey Resident #2 was is movement in his scooter . He was not observed Resident #3. m an interview was DN. The DON stated that a resident with a cognitive kual consent and informed hing was not permitted and					
	· ·	g. Resident #3 was hours and is currently ervised throughout the					

Facility ID: 923402

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY
			A. BUILDING	G		
		345481	B. WING			C
	ROVIDER OR SUPPLIER	545401		STREET ADDRESS, CITY, STATE, ZIP CO		8/25/2018
NAME OF F	ROVIDER OR SUFFLIER			400 PELT DRIVE	UCE	
WOODLA	NDS NURSING & REHAI	BILITATION CENTER		FAYETTEVILLE, NC 28301		
						0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE
F 600	Continued From page	e 7	F 60	00		
		tion with all residents. She				
		s resident representative was				
		propriate touching on 8/20/18				
		e opportunity to review the				
	video recording and	speak to staff.				
	On 8/24/18 at 6:45 pt	m an interview was				
	-	dministrator who stated that				
	he was aware of the					
		. The DON was handling the				
fa	facility investigation a	and staff education and the				
	24 hour and 5-day re	port to the State.				
	$O_{\rm D}$ 9/25/19 at 12:15	nm en intensious wee				
	On 8/25/18 at 12:15	3 who stated she had				
		for a year and was very				
		t #2. The inappropriate				
		behavior. NA #3 stated that				
		e dining room (DR) some of				
		She checked both residents				
		g wrong. The lights were				
	sometimes turned off					
		DR. The TV was playing at I the DR and did not think				
		with the lighting. There were				
		cy lights on in the back of the				
		its knew each other and				
	-	nes before in various places				
	-	ent #2 was known by this				
		ost a year and has not had				
	any of this type of be	havior before. The icate and set up a plan for				
	•	tched throughout the facility				
		ith all residents after the				
		nt was care planned for				
		ent #2 was monitored for his				
		action with all residents.				
	Resident #2 was curi	ently under close				
	observation.					

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SS=J CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and staff interviews, the facility failed to maintain a safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. Immediate jeopardy (JJ) began on 8/17/18 when Resident #1 exited the facility unsupervised, was missing for 40 minutes, and was found in a heavily wooled area adjacent to the facility property. The IJ was removed on 8/25/18 when	STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	<u>O. 0938-039</u> E SURVEY
345481 B. WING 00/25/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WOODLANDS NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE WOODLANDS SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE WOODLANDS SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE WOODLANDS SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY PREFIX PREFIX RUN CROVIDER OF CORRECTION COMME PREFIX PREFIX RUN CROVIDER OF CORRECTION COMME PREFIX REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX PREFIX RUN CROVID COMME F 689 Free of Accident Hazards/Supervision/Devices F 689 F 689 Prefix PS 683 STREET ADDRESS, CITY, STATE, ZIP CODE OWN S 483.25(d)(1) The readint must ensure that - State at that - State at that - State at that - State at that - S 483.25(d)(1) The resident reading review, and resident and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Plan to correct specific deficiency and facts that led to the alleged deficient practice: The resident for one of three residents reviewed for accidents. The resident was admitted to the	and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WOODLANDS NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X1)D SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D F 689 Free of Accident Hazards/Supervision/Devices SS=J CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and F 689 S483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Plan to correct specific deficiency and facts that led to the alleged deficient practice: # 1h ad an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. Plan to correct specific deficiency and facts that led to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient: splan of care. He has the diagnosis of Lewy Body Dementa. On August 17th 2018 at 12:37 pm, resident # 1 went out the back door and walked across the parking lot to the wooded area			345481	B. WING				-
WOODLANDS NURSING & REHABILITATION CENTER PAYETTEVILLE, NC 28301 (X4) D PEETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFCHEXY MUST EPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PAYETTEVILLE, NC 28301 PROVIDER'S FLAN OF CORRECTION (EACH OFFCHEXY MUST EPRECEDED BY FULL TAG PROVIDER'S FLAN OF CORRECTION (EACH OFFCHEXY MUST EPRECEDED BY FULL DEFICIENCY) OPROVIDER'S FLAN OF CORRECTION (EACH OFFCHEXY MUST EPRECEDED BY FULL DEFICIENCY) OPROVIDER'S FLAN OF CORRECTION (EACH OFFCHEXY MUST EPRECEDED BY FULL DEFICIENCY) F 689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) F 689 Present S483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. The resident was admitted to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement, therefore wanderguard bracelet was initiated and added to the patientia: plan of care. He has the diagnosis of Lewy Body Dementia. On August 15th 2018 at 12:37 pm, resident #1 1 went out the back door and walked across the parking tot to the wooded area	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2010
(Xi) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Correct SCROSS-REFERENCED TO THE APPROPRIATE Correct SCROSS-REFERENCED TO THE APPROPRIATE F 689 F ree of Accident Hazards/Supervision/Devices SS=J CFR(s): 483.25(d)(1)(1/2) F 689 F 689 9/10/18 § 483.25(d)(1) The resident environment remains as free of accidents. The facility must ensure that - § 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and safe environment for a cognitively impaired, wandering resident f0 ne of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. Plan to correct specific deficiency and facts that led to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient: s plan of care. He has the diagnosis of Lewy Body Dementia. On August 17th 2018 at 12:37 pm, resident #1 wenvily wooded area adjacent to the facility property. The IJ was					4	00 PELT DRIVE		
PREENT TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFNT TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) COMPLET TAG F 689 Free of Accident Hazards/Supervision/Devices F 689 F 689 F 689 F 689 F 689 9/10/18 SS=J CFR(s): 483.25(d)(1)(2) \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Plan to correct specific deficiency and facts that led to the alleged deficient practice: Plan to correct specific deficiency and facts that led to the facility failed to maintain a safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents. Plan to correct specific deficiency and facts that led to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet which did not trigger-lock the exit doro and the resident was able to exit the facility unsupervised. The resident #1 exited the facility unsupervised, was missing for 40 minutes, and was found in a heavily wooded area adjacent to the facility property. The IJ was removed on 8/25/18 when Plan to the avertion of wand walked across the parking lot to the wooded area	WOODLA	NDS NURSING & REHAR	BILITATION CENTER		F	AYETTEVILLE, NC 28301		
SS=J CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and staff interviews, the facility failed to maintain a safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. Immediate jeopardy (JJ) began on 8/17/18 when Resident #1 exited the facility unsupervised, was missing for 40 minutes, and was found in a heavily wooled area adjacent to the facility property. The IJ was removed on 8/25/18 when	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	ION SHOULD BE THE APPROPRIATE	
The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and staff interviews, the facility failed to maintain a safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. The resident was admitted to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient:s plan of care. He has the diagnosis of Lewy Body Dementia. On August 17th 2018 at 12:37 pm, resident # 1 went out the back door and walked across the parking lot to the wooded area			-	F	689			9/10/18
Interfacility implemented a credible allegation of 13 adjacent to the facility. He said he was removal. The facility will remain out of compliance looking for his wife. The resident was at a lower scope and severity level of D (no actual found in the woods around 1:40 pm. The harm with a potential for minimal harm that is not resident was assessed by the nurse upon Immediate Jeopardy) to ensure monitoring of entering the facility on August 17, 2018 systems are put in place and to complete event. There were minor scratches noted employee in-service. to resident b lis resident to ensure his safety. 1:1 Findings included: was maintained 24 hours a day from Resident #1 was admitted on 8/15/18 with the 8/17/18 immediately upon return to the cumulative diagnoses of dementia with Lewy facility until 8/20/18 at 11 PM.		The facility must ensu §483.25(d)(1) The re- as free of accident ha §483.25(d)(2)Each re- supervision and assis accidents. This REQUIREMENT by: Based on record rev surveillance recording staff interviews, the fa safe environment for wandering resident for reviewed for accident #1 had an expired wa did not trigger-lock th was able to exit the fa Immediate jeopardy (Resident #1 exited th missing for 40 minute heavily wooded area property. The IJ was the facility implement removal. The facility at a lower scope and harm with a potential Immediate Jeopardy) systems are put in pla employee in-service. Findings included: Resident #1 was adm	ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced iew, observation, video g review, and resident and acility failed to maintain a a cognitively impaired, or one of three residents ts (Resident #1). Resident ander guard bracelet which he exit door and the resident acility unsupervised. (J) began on 8/17/18 when he facility unsupervised, was es, and was found in a adjacent to the facility removed on 8/25/18 when ted a credible allegation of IJ will remain out of compliance severity level of D (no actual for minimal harm that is not to ensure monitoring of ace and to complete			facts that led to the alleged deficient practice: The resident was admitted to the facilit on August 15th 2018, with risk assessment completed on admission a deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient □s plan of care. He has the diagnosis of Lewy Body Dementia. On August 17th 2018 at 12:37 pm, resider 1 went out the back door and walked across the parking lot to the wooded a adjacent to the facility. He said he was looking for his wife. The resident was found in the woods around 1:40 pm. T resident was assessed by the nurse up entering the facility on August 17, 2018 and the MD and RP were notified of th event. There were minor scratches not to resident □s legs. 1:1 was initiated for this resident to ensure his safety. 1:1 was maintained 24 hours a day from 8/17/18 immediately upon return to the	and and rea The pon 3 e ted or	

Event ID: FDDE11

Facility ID: 923402

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	S FOR MEDICARE &					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345481	B. WING		0	8/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
WOODLA	NDS NURSING & REHA	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(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 / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	e 9	F 68	39		
		h other diseases, behavioral		Investigation completed	and found that	
		y and visual hallucinations,		the wanderguard placed		
	diabetes, and depres			was expired therefore in		
				team members conclude		
		ss Minimum Data Set (MDS)		placement of an active r	-	
		sident #1 was reviewed and		wanderguard, all other v		
		nent of adequate hearing,		management systems w	-	
	•	iderstood and sometimes ion was severely impaired.		therefore wander managed would keep resident suf		
		iterest in doing things and		monitored. Upon return		
t	there were no behavi			8/17/18, resident⊡s war	-	
		U		immediately replaced by		
	assessments were not completed. The resident participated in the assessment.		Nursing with a current wo			
		plan was updated on				
	8/17/18 to reflect war	ndering behaviors.		An REQ (Review to Ens		
				initiated on 08.17.18. TI	0	
		nt report dated 8/17/18 was		was found to be not be	u	
		ement was within the first 72 nd the resident ' s wander		because it was expired, was noted to be 3/2018.	-	
		nitter bracelet that locks or		was noted to be 3/2016.		
		when approached] was		Expired wanderguard br	acelet was found	
	expired.			to be the root cause for		
				practice. The wandergu		
	Resident #1 ' s 8/17/	18 elopement was observed		this particular wandering		
		ility 's surveillance video		management system ha	ve an expiration	
		19, 25, 26, 27, and 31 which		date or □life□ of approx		
		alls and exit doors. The		unfortunately the wande	0	
	video recording had	no sound.		placed on this patient ex licensed nurse who app		
	On 8/17/18 at 12:26	pm the resident was		watchmate bracelet was		
	-	ed in sneakers, wearing a		expiration date when sh		
		around on the sloped hall		wanderguard bracelet to	-	
		the two gated courtyards		licensed nurse had not r		
		at enters at the end of hall		that the wanderguards h		
	-	t door (door has a wander		dates. The wanderguar		
	guard alarm).			from a locked cart locate station of the 300/400 ha	-	
			1	station of the 300/400 h	an area, iocaleu	1

Facility ID: 923402

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							0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDII	NG_			С
		345481	B. WING _				0 25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2010
				4	00 PELT DRIVE		
WOODLA	NDS NURSING & REHA	BILITATION CENTER		E	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 689	Continued From page	o 10		~~~			
1 003	1.5		F	689		o.r.	
		rt yard from the long-sloped 500 with a facility exit door.			The cart was audited to ensure no oth expired wanderguard bracelets, as wa		
		coo with a facility call door.			other storage carts located within the		
	At 12:37 pm the resid	dent re-entered the building			facility, nursing stations, desk, offices,		
		other door in the court yard			central supply units, and maintenance		
	that is near the facilit	y exit door.			shop. All audits of these areas were		
					complete by close of business on Frida	ay,	
		dent walked through hall 500			August 17, 2018. Director of nursing		
	resident was observe	The door did not lock. The			ensured all audits were sufficiently completed.		
	pavement into the ne						
					Procedure for implementing a plan of		
	At 1:06 pm 4-5 staff r	members were observed to			correction for the alleged deficient		
	be looking in all room	ns from cameras 25, 29, 31.			practice		
	At 1:09 pm a staff me	ember was observed to exit			On 08.17.18, the Unit Manager and th	е	
		around the facility grounds.			scheduler, checked 100% of all the oth		
					residents with wander guards in use		
		d camera recordings to view			residing within the facility which include		
		ty (per Maintenance Manager			total skilled residents, there were no o		
	who is responsible).				wander guards found expired and all v		
	At 1:30 pm the Direct	tor of Nursing (DON) was			functioning properly. The wander gua bracelets were checked by utilizing the		
		ig to enter the woods across			manufacturer (wanderguard checker		
		all 500 ' s facility exit door.			when placed directly beside the	<i>]</i> ,	
					wanderguard the transmitter will beep		
		members were observed on			repetitively and a light turns green loca		
		e woods behind the DON			on the \Box checker \Box .		
	with 2 more staff imm	nediately behind them.					
	At 1.10 pm the	ant was recorded wall in a			On 08.17.18, the Director of Nursing		
	At 1:40 pm the reside	ent was recorded walking			began in-servicing all nurses on the following:		
		mar stan.			" Elopement Prevention and		
	Timeframe 12:37 pm	leaves building and 1:40 pm			Maintenance with Wanderguard alarm		
		to the building with staff.			systems.		
					o All resident will be assessed on		
		m an observation was done			admission and quarterly for elopement	t	
		room. The resident was			risk.		
	sitting on his bed and	d was observed to ambulate			o Residents found at risk shall be		

Facility ID: 923402

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						<u>NO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · ·	TE SURVEY
			A. BUILDING	G		С
		345481	B. WING)8/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		0,20,2010
				400 PELT DRIVE		
WOODLA	NDS NURSING & REHA	BILITATION CENTER		FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	EAPPROPRIATE	COMPLETIC DATE
F 689	Continued From page	e 11	F 68	39		
	independently and st	eadily. There was a sitter in		identified by staff in the care	plan and care	
		pervision. The resident had		guides.		
		s arms and legs that were		o Transmitter bracelets (w		
		t walked to the front door		will be attached to wrist or ar		
		nder guard triggered the		being checked for expiration		
		or would not open until the eet away from the door.		tested to make sure they we	refunctioning	
		d by an oncoming visitor who		properly. Return demonstration of	bow to find	
		im wearing a wander guard		expiration date to ensure that		
	and the alarm sound			expired on the wander guard		
				how to check to ensure it is v		
	On 8/23/18 at 10:15 a	am an interview was		" All nursing staff (RN, LP	N, Nurse	
	conducted with the M	laintenance Manager (MM)		Aide) to be trained prior to be	eing allowed	
		was an elopement on		to work, this includes full time	e, part time	
		ould not find Resident #1 in		and PRN employees.		
	-	M provided the facility		" This will also be added t new hire orientation.	o the facility	
		d the resident was observed n rehabilitation exit door on		new nice orientation.		
		er guard did not alarm. On		Education began on 8/17/18	and 100% of	
		was seen exiting to the gated		employees will be re-educate		
		main hall that leads to hall		before 9/10/2018 to include r		
	500 and re-entered o	nto hall 500 nearest to the		which will be educated during	g the	
		nich bypasses the nursing		orientation process. Employe		
		e building. While in the		permitted to work until they h	ave received	
		was video recorded looking		this education.		
		e he eloped. The resident running into the woods.		The Maintenance Director ac	Ided alarming	
		boked for the resident who		boxes 8/25/2018 before 12:0	-	
		ids next to the facility. The		exit doors which lead to the p		
		cratches from the brush.		any other exit area with the p		
	The resident had to b	e coaxed and led by his		have on/off switches for exte		
		facility. MM checked the		with keypads and/or the door		
		was not working, it had		to be otherwise not monitore		
		s checked with a working		alarming boxes will alert the		
		ocked. The exit doors that		the doors exiting to the patio	or gated	
	have alarms and war			areas are opened.	akad dailu bu	
		cked weekly and found to be		All doors and alarms are che maintenance director or man		
	working.			duty. However, on 8/23/18 tl		

Facility ID: 923402

		MEDICAID SERVICES			OMB NO. 0938- (X3) DATE SURVEY	
			· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
			A. BUILDING	с		
			B. WING		08/25/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF			
				400 PELT DRIVE		
WOODLA	NDS NURSING & REHAE	BILITATION CENTER		FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE DATE	
F 689	Continued From page	e 12	F 68	9		
	On 8/23/18 at 10:30 a	am an observation was done		maintenance director had	d been	
		ion of all facility exit doors.		interrupted during his mo	-	
	Hall 100 's emergend			devices, he would have o		
		en opened was shut off and		audit prior to end of day,		
		IM used a key to turn the		the surveyor accompanie Maintenance Director arr	-	
	alarm on and it tested	ј окау.		to the 100 hall exit it was		
	On 8/24/18 at 9:40 ar	n an interview was		turned to the off position		
		e #1 who was assigned to		alarming box was immed		
		18 day shift. Nurse #1 had		the on postion by the ma		
	worked at the facility	for approximately 20 years		director and found to be	functioning once	
	-	with the facility policy.		engaged to the on position		
		noticed Resident #1 was		DON/SDC initiated re-ed		
	-	t approximately 12:45 pm.		8/23/2018 of all staff rega	-	
		ently been to therapy and at the nurses ' station.		alarming boxes to ensure turned off following door		
		all 400 to find the resident		The licensed nursing stat		
		so the DON was notified,		each exit door with alarm		
		s called. Code PINK is		installed every shift durin	5	
	where all the rooms in	n the facility are checked		walking rounds to validat		
		cameras are observed to		are turned to the on posi		
		ctivity. Nurse #1 stated she		functioning. All education		
		he time the resident was		completed by licensed pe		
		recording when he left the 500 exit door. Nurse #1		be completed prior to em their next scheduled shift		
		nt was found in the woods		complete and will be add		
		/. When the resident was		orientation hires to be co		
		ed to run. The resident was		working independently.		
		proximately 20 - 30 minutes.		regarding the alarming b		
		essed, and no injury was		completed on or before 9	0/10/2018.	
		s wander guard was not		The feelling and the local second		
	operating.			The facility updated all pl 8/24/2018 for resident	-	
	Nurse #1 also stated	that Resident #2 was		wanderguard placement		
		bre he eloped and had a		expiration date within the		
	-	. Nurse #1 stated she had		order. The physician ord	-	
		sident was a wanderer. The		check for placement, fun		
		checked every night shift		expiration date each shift		
	with a testing device	and there was a listing of all		expiration date listed with	hin the body of	

Facility ID: 923402

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		MEDICAID SERVICES				<u>NO. 0938-03</u> TE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
						С	
345481		B. WING			8/25/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE			
NOODLA	NDS NURSING & REHAE	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301			
				•		0(5)	
(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	CTION SHOULD BE	(X5) COMPLETIC DATE	
F 689	Continued From page	e 13	F 68	39			
		r guards at each nurses '		the order for additional c	ommunication		
		ted she did not know if the		and awareness. The lice			
		uard was tested the night of		be responsible to ensure			
	8/16/17.			transmitter is checked fo			
				placement, and expiratio			
	On 8/24/18 at 10:18 a	am an interview was		after verifying, the licens			
	conducted with the or	ccupational therapist (OT) #1		initial as validation the p			
		8 she worked with Resident		completed in the electron			
	#2 in the therapy roor	n. The resident was		administration record.			
		ot state he did not want to					
		leave. The resident was		Monitoring Procedure			
	intermittently confuse	d and was able to		_			
	communicate. Hallud	cinations were noted and		The Director of Nursing a	and/or Nurse		
		sation. When the physical		Manager will monitor res			
		completed the resident was		wander guard bracelets	to ensure their		
		rses 'station at 12:20 pm.		daily bracelet check has	-		
	-	report. OT #1 stated she		by the licensed nurses to			
		he resident was wearing		placement, function, and	•		
	shoes at the time.			The licensed nurse will u			
				wanderguard checking d			
	On 8/24/18 at 10:35 a			for each wanderguard to			
		ng Assistant (NA) #1 who		device is in place, function			
	-	ident #1 on 8/17/18 on day		expired. This will be acco			
		as newly admitted and was		reviewing the MAR/TAR			
		tential for wandering. On		documentation by the lic			
	8/17/18 the resident r	am. The resident was		the daily clinical meeting with wanderguard orders			
		not verbalize that he wanted		and/or nurse manager w			
		he facility. NA #1 stated the		orders and documentation			
		sident #1 he was sitting at		2 residents per day in the			
		NA #1 stated that she		for those residents that h	•		
		was missing around 12:20 to		guard bracelet. This will			
		ays were brought to the hall.		daily for 2 weeks and the			
	The resident can wall			months or until resolved	-		
		oms were immediately		Assurance Committee.			
		PINK was called because		are identified, the staff m			
		found. The family was		reeducated on checking			
		the resident left with the		bracelet per the MD orde	-		
	family and he had no	ot. The grounds outside the		monitoring was initiated			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/2 FORM APPI OMB NO. 093	ROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345481	B. WING _		C 08/25/20	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		-
WOODLA	NDS NURSING & REHAI	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMP	(X5) PLETIC DATE
F 689	building were also ch room check. NA #1 s into the search, the v observed which revea the building into the v in the woods was sta found. The resident of approximately 20 min assessed by the nurs injury. The resident of he was sweating. Th every 10-minute wato shift. The resident of working and was repl wander guard. On 8/23/18 at 5:00 pt conducted with the D was placed on 10-min The DON stated that guard check was cha document its present The root cause analy non-working wander On 8/23/18 at 5:15 pt conducted with the C who stated and provi guard which was dato The Administrator, Ca and Director of Nursii Immediate Jeopardy The facility provided a allegation for immedi	ecked concurrently with tated that about 10 minutes ideo recordings were aled the resident had exited woods and an outside search rted. The resident was was missing for nutes. The resident was se and was found to have no was provided water because he resident was placed on an ch for the day and evening s wander guard was not laced with a tested/working man interview was ON who stated Resident #1 nute checks for 24 hours. the process for wander unged on 8/17/18 to be and the expiration date. rsis for the elopement was a guard. m an interview was corporate Nursing Consultant ded the non-working wander ed 3/17 and expired. orporate Nurse Consultant ng were notified of the on 8/24/18 at 2:54 pm. an acceptable credible ate jeopardy removal on	F	 The Director of Nursing monthly report from the record of all residents w wanderguard monitorin with a bracelet found to date within the following a new wanderguard ap updated expiration date updated to coincide with wanderguard placemer All newly admitted resid assessed to require a w management transmitter reviewed during the dai reviews by the Director Unit Manager to ensure the expiration dates of effective 8/24/2018. All expired wander mar transmitters will be disc personnel when remove Reports will be present QA committee by the D to ensure corrective act ongoing concerns is ini appropriate. The week attended by the DON, MDS Coordinator, Unit Nurse, Therapy, HIM, D and the Administrator. The Director of Nursing Administrator will be reating and monitinterventions and monitinterventing and monitinterventions and monitinterventions and mon	e electronic health with orders for g, any resident have an expiration g 60 days will have plied with an e. Order will be h new ht. dents who are vander er, will have orders ily clinical quality of Nursing and/or e the orders include the transmitters hagement harded by licensed ed from use. ed to the weekly irector of Nursing tion for trends or tiated as ly QA Meeting is Nound Nurse, Manager, Support Dietary Manager and the licensed sponsible for itoring of all	
	On 8/23/18 at 5:15 pm an interview was conducted with the Corporate Nursing Consultant who stated and provided the non-working wander guard which was dated 3/17 and expired. The Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the Immediate Jeopardy on 8/24/18 at 2:54 pm. The facility provided an acceptable credible allegation for immediate jeopardy removal on 8/25/18 which included the following: Plan to correct specific deficiency and facts that			QA committee by the D to ensure corrective act ongoing concerns is ini appropriate. The week attended by the DON, M MDS Coordinator, Unit Nurse, Therapy, HIM, D and the Administrator. The Director of Nursing Administrator will be re- implementing and mon	irector of Nursing tion for trends or tiated as ly QA Meeting is Wound Nurse, Manager, Support Dietary Manager and the licensed sponsible for toring of all	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	OMB NC	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· ,		1 Y /	LETED
			С			
		345481	B. WING			25/2018
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WOODLANDS NURSING & REHABILITATION CENTER			40			
WOODLANDS NORSING & REHADILITATION CENTER			FA	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 15	F 689			
	led to the alleged def	icient practice				
		nitted to the facility on				
	August 15th 2018, with risk assessment completed on admission and deemed to be a					
	moderate risk for elop	pement; therefore				
	-	t was initiated and added to				
		care. He has the diagnosis itia. On August 17th 2018 at				
		1 went out the back door				
		e parking lot to the wooded				
	-	acility. He said he was				
	woods around 1:40 p	he resident was found in the				
		e upon entering the facility				
	-	and the MD and RP were				
		There were minor scratches				
		egs. 1:1 was initiated for e his safety. 1:1 was				
	maintained 24 hours					
		urn to the facility until				
	8/20/18 at 11 PM. In	vestigation completed and				
	tound that the wande					
		rguard placed on the				
	resident was expired	rguard placed on the therefore interdisciplinary				
	resident was expired team members concl	rguard placed on the				
	resident was expired team members concl an active non-expired wander management	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning,				
	resident was expired team members concl an active non-expired wander management therefore wander ma	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would				
	resident was expired team members concl an active non-expired wander management therefore wander man keep resident sufficie	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would ntly monitored. Upon return				
	resident was expired team members concl an active non-expired wander management therefore wander man keep resident sufficient to the facility on 8/17/	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would				
	resident was expired team members concl an active non-expired wander management therefore wander ma keep resident sufficie to the facility on 8/17/ was immediately repl	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would ntly monitored. Upon return (18, resident 's wanderguard				
	resident was expired team members concl an active non-expired wander management therefore wander man keep resident sufficient to the facility on 8/17/ was immediately repl Nursing with a current expired).	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would ntly monitored. Upon return (18, resident ' s wanderguard aced by the Director of t wanderguard (i.e. one not Ensure Quality) was initiated				
	resident was expired team members concl an active non-expired wander management therefore wander man keep resident sufficient to the facility on 8/17/ was immediately repl Nursing with a current expired). An REQ (Review to 1 on 08.17.18. The was	rguard placed on the therefore interdisciplinary uded with the placement of d wanderguard, all other systems were functioning, nagement system would ntly monitored. Upon return (18, resident ' s wanderguard aced by the Director of t wanderguard (i.e. one not				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/25/2013 FORM APPROVEI OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345481		B. WING		C 08/25/2018		
	ROVIDER OR SUPPLIER	BILITATION CENTER	4	TREET ADDRESS, CITY, STATE, ZIP COE 00 PELT DRIVE AYETTEVILLE, NC 28301	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 689	Expired wanderguard the root cause for the wanderguard bracele wandering monitoring an expiration date or years, unfortunately t placed on this patient licensed nurse who a bracelet was not awa when she applied the the patient. The licer education that the wa dates. The wandergu locked cart located at 300/400 hall area, loc facility. The cart was audited wanderguard bracele carts located within th desk, offices, central maintenance shop. <i>A</i> were complete by clo August 17, 2018. Dir audits were sufficient Procedure for implem for the alleged deficient On 08.17.18, the Unir scheduler, checked 1 residents with wande within the facility whic residents, there were found expired and all The wander guard br utilizing the manufact); when placed direct	I bracelet was found to be deficient practice. The ts for this particular management system have ' life ' of approximately 3 he wanderguard bracelet expired 3/2017; the pplied the watchmate re of the expiration date wanderguard bracelet to used nurse had not received inderguards had expiration uard was retrieved from a the nursing station of the cated central within the to ensure no other expired ts, as was all other storage he facility, nursing stations, supply units, and All audits of these areas se of business on Friday, ector of nursing ensured all ly completed. thenting a plan of correction ent practice t Manager and the	F 689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345481	B. WING				C 25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WOODLA	NDS NURSING & REHAE	BILITATION 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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE
F 689	 in-servicing all nurses Elopement F with Wanderguard ala o All resident will b and quarterly for elop o Residents found staff in the care plan a o Transmitter brace attached to wrist or an expiration date and te were functioning prop Return demo expiration date to ensist the wander guard devensure it is working. All nursing s be trained prior to bei includes full time, part This will also hire orientation. Education began on 8 on 8/22/18 except for work on the weekend employees will not be have received this ed Nursing will ensure th prior to the employee The Maintenance Dire boxes on 8/25/2018 b 	n the ' checker'. ector of Nursing began s on the following: Prevention and Maintenance arm systems. e assessed on admission ement risk. at risk shall be identified by and care guides. elets (wanderguard) will be nkle after being checked for ested to make sure they berly. onstration of how to find sure that it is not expired on vice and how to check to taff (RN, LPN, Nurse Aide) to ng allowed to work, this t time and PRN employees. be added to the facility new B/17/18 and was completed four employees that only or on vacation. These e allowed to work until they ucation. The Director of nat this education occurs	F 6		Y)		
	exit area with the pote	ential that have on/off gates with keypads and/or					

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	TE SURVEY
					С	
	345481		B. WING			8/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WOODLA	NDS NURSING & REHAE	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	a 18	F 68	20		
1 000		ning boxes will alert the staff	FUC	59		
		iting to the patio or gated				
	areas are opened.					
	All doors and alarms	are checked dailv by				
	maintenance director or managers on duty.					
		the maintenance director				
		during his monitoring of the ve completed the audit prior				
		er, when the surveyor				
	-	Maintenance Director arrived				
) hall exit it was found to be				
		tion . The 100 hall alarming turned to the on postion by				
	the maintenance dire					
		aged to the on position. The				
		ucation 8/23/2018 of all staff				
		ng boxes to ensure boxes owing door opening/closing.				
	The facility will monitor					
	alarming boxes instal					
	licensed nurse walkin					
	, united and the second s	urned to the "on" position education is being completed				
		and will be completed prior				
		g their next scheduled shifts				
	-	and will be added to the new				
	independently.	e completed prior to working				
	The facility updated a					
		it ' s with wanderguard the expiration date within				
		. The physician orders				
		acement, function, and				
	expiration date each					
		within the body of the order nication and awareness.				
	i or additional commu	nication and awareness.	1	1		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 09/25/201 DRM APPROVE NO. 0938-039
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345481	B. WING				C 08/25/2018
NAME OF P	ROVIDER OR SUPPLIER	I		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	NDS NURSING & REHAE	BILITATION CENTER			PELT DRIVE ETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 689	the wander transmitter function, placement, a shift; after verifying, tt initial as validation that the electronic medical Monitoring Procedure The Director of Nursin will monitor residents bracelets to ensure th been completed by th placement, function, a licensed nurse will us device each shift for a the device is in place expired. This will be a the MAR/TAR to valid the licensed nurse in all residents with war and/or nurse manage documentation comp day in the clinical me have a wander guard completed daily for 2 3 months or until residentified, the staff me checking the wander order in PCC. This m 8.23.18. The Director of Nursin from the electronic he with orders for wander expiration date within have a new wandergu	er is checked for proper and expiration date each he licensed nurse will then e process was completed in tion administration record. If and/or Nurse Manager with wander guard heir daily bracelet check has he licensed nurses to ensure and expiration date. The e the wanderguard checking each wanderguard to ensure , functioning, and not accomplished by reviewing late the documentation by the daily clinical meeting for iderguard orders. The DON or will review the orders and liance for 2 residents per eting for those residents that bracelet. This will be weeks and then weekly for olved by the Quality e. If inconsistencies are ember will be reeducated on guard bracelet per the MD onitoring was initiated on	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
345481			B. WING				25/2018
NAME OF PROVIDER OR SUPPLIER			1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
WOODLANDS NURSING & REHABILITATION CENTER					400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG				ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	require a wander mar have orders reviewed quality reviews by the Unit Manager to ensu- expiration dates of the 8/24/2018. All expired wander m- be discarded by licen removed from use. Reports will be prese committee by the Direc corrective action for the is initiated as appropri- Meeting is attended by MDS Coordinator, Un- Therapy, HIM, Dietary Administrator. The Director of Nursin Administrator will be a the credible allegation Immediate Jeopardy at 2:45 pm when valid credible allegation for interviews of two licer assistants, one house Maintenance Manage completion and a revi	d placement. sidents who are assessed to hagement transmitter, will d uring the daily clinical e Director of Nursing and/or the orders include the e transmitters effective anagement transmitters will sed personnel when inted to the weekly QA ector of Nursing to ensure rends or ongoing concerns riate. The weekly QA by the DON, Wound Nurse, it Manager, Support Nurse, y Manager and the hg and the licensed responsible for implementing h. removal date: 8/25/18 (IJ) was removed on 8/25/18 dation was completed of the i J removal as evidenced by heed nurses, two nursing ekeeper, and the er for evidence of in-service iew of the new elopement	F	68			
		valuation and new ement of the wander guard spiration date, and working					

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		ID HUMAN SERVICES			FOR	M APPROVED	
		MEDICAID SERVICES				O. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI COM	E SURVEY PLETED	
			A. BUILDII	\G	С		
345481			B. WING		08/25/2018		
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	NDS NURSING & REHAE	BILITATION CENTER		400 PELT DRIVE			
				FAYETTEVILLE, NC 28301			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)			
F 689	Continued From page	o 21	F	89			
	condition.						

Event ID: FDDE11

Facility ID: 923402

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