DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NC</u>	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		COMP	PLETED
		345349	B. WING				-
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	011	50/2021
WOODBU				2778 COUNTRY CLUB	DRIVE		
WOODBU	RY WELLNESS CENTER			HAMPSTEAD, NC 2	28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	complaint investigatio 07/26/21 through 07/3 found in compliance v	ertification survey and on was conducted on 30/21. The facility was with the requirement CFR Preparedness. Event ID					
F 000	INITIAL COMMENTS		F 0	00		FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C 07/30/2021 CODE	
	An unannounced rec investigation survey v 07/26/21 - 07/30/21, I						
	5 of the 5 complaint a substantiated.	Ilegations were not					
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)		F 70	51			8/13/21
	Drugs and biologicals	y and cautionary					
	§483.45(h) Storage o	f Drugs and Biologicals					
	Federal laws, the faci biologicals in locked of	rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.					
	locked, permanently a storage of controlled the Comprehensive D	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and					
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TI	TLE		
Electroni	cally Signed						08/12/2021

**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.

DEPARTMENT OF HEALTH / CENTERS FOR MEDICARE					F	TED: 08/30/202 ORM APPROVE NO. 0938-039	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	345349	B. WING			C 07/30/2021		
NAME OF PROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WOODBURY WELLNESS CENT	ER INC			78 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443			
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
abuse, except when package drug distri- quantity stored is m be readily detected This REQUIREMEN by: Based on observar facility failed to rem 1 of 2 medication ro Medication Room) carts (200-300 Hall The findings include Accompanied by N Long-Term Care M on 07/28/21 at 2:31 revealed a denture handwritten across denture cup were to latanoprost ophthal drop used to treat h bottles were not late expiration date of 0 the expiration date. Accompanied by N 200-300 Hall Medic 07/28/21 at 2:38 p. a ProAir HFA 90 mi medication to treat labeled for Resider of 02/2021. The ot Epi-Pen 2-Pak 0.3 epinephrine often u reactions) labeled for	and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced tions and staff interviews, the nove expired medications from coms (Long-Term Care and from 1 of 3 medication Medication Cart). ed: urse #1, an observation of the edication room was conducted I p.m. The observation cup with Resident #37's name the top of the lid. Inside the wo 2.5 milliliter bottles of lmic solution 0.005% (an eye nigh pressure in the eye). The beled and each had an 3/2021. Nurse #1 confirmed	F	761	Preparation and submission of this p of correction is in response to the CM Form 2567 from the 07/30/21 survey does not constitute an agreement or admission by Woodbury Wellness Ce of the truth of the facts alleged or of t correctness of the conclusions stated the statement of deficiency. The faci reserves all rights to contest the deficiencies, findings, conclusions an actions of the Agency. This Plan of Correction (and the attached docume also functions as the facility s credib allegation of compliance # 1 - Address how corrective action v accomplished for those residents fou have been affected by the deficient practice; • For Resident # 37 the denture co containing 2 bottles of unlabeled and expired eye drop medications were properly discarded by QA Nurse/Des on 07/28/21 • For Resident # 56 the expired in medication was properly discarded by Nurse/Designee on 07/28/21	IS It enter he don lity id ents) ents) ents) ents) ile vill be nd to up ignee haler y QA		

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Facility ID: 923206

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDERSUPPLIER (Q1A) DENTIFICATION NUMBER: 345349       (Q2) MULTIFLE CONSTRUCTION A. BUILDING       (Q3) MULTIFLE CONSTRUCTION A. BUILDING			ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 08/30/2021 RM APPROVED O. 0938-0391
345349         07/30/2021           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           WOODBURY WELLNESS CENTER INC           WAID OPERED         SUMMARY STATEMENT OF DEFICIENCIES         STREET ADDRESS, CITY, STATE, ZIP CODE         COMPLETION           PAREIX         SUMMARY STATEMENT OF DEFICIENCIES         IPERX         PREVIDERS OF MOVIDER OR OF CORRECTION         COMPLETION           PAREIX         REGULATORY OR LSC IDENTIFYING INFORMATION)         IP         IPERX         RECOURD PROVIDER OF CORRECTIVE ACTION SHOULD BE         COMPLETION           PAREIX         REGULATORY OR LSC IDENTIFYING INFORMATION)         IP         IP         COMPLETION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		• •				COMPLETED	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, GITY, STATE, ZIP CODE       WOODBURY WELLNESS CENTER INC     2778 COUNTRY CLUB DRIVE       (X4, ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX     PROVIDERS PLAN OF CORRECTION (EACH OERROPHINGTO TO THE PROVINGES OF LAW OF CORRECTION (EACH OERROPHINGTO TO THE PROVINGES OF LAW OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX       F 761     Continued From page 2     F 761       During an interview with Nurse #1 stated all nurses are expected to check the medication rooms and medication carts every day to make sure there are no expired medications.     F 761       During an interview with the Director of Nursing (DON) on 07/28/21 at 3:39 p.m., the DON stated it was her expectation the nurses check medications for expiration dates before administering them and to remove expired medication rooms.     # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " All medication carts and medication rooms.       Wurse/Designee to ensure no other unlabeled or expired medication rooms were audited by 7/30/21 by QA Nurse/Designee to ensure no other unlabeled or expired medication roof Nursing.       # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;			345349	B. WING			_	
WOODBURY WELLNESS CENTER INC     HAMPSTEAD, NC 28443       MUID PREENS, MC 20043     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREENS, TAG     PROVIDER'S PLAN OF CORRECTIVE, ATOM SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPPLIENC (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPP	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG       (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)       COMPLETION DATE         F 761       Continued From page 2       Nurse/Designee on 07/28/21       Nurse/Designee on 07/28/21         During an interview with Nurse #1 (who also is the facility's Quality Assurance Nurse) on 07/28/21 at 3:30 p.m., Nurse #1 stated all nurses are expected to check the medication rooms and medication carts every day to make sure there are no expired medications.       F 761         During an interview with the Director of Nursing (DON) on 07/28/21 at 3:39 p.m., the DON stated it was her expectation the nurses check medications for expiration dates before administering them and to remove expired medication rooms.       # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;       " All medication carts and medication rooms were audited by 7/30/21 by QA Nurse/Designee to ensure no other unlabeled or expired medications were present. Any findings were properly discarded and reported to Director of Nursing.	WOODBU	RY WELLNESS CENTER	RINC					
<ul> <li>During an interview with Nurse #1 (who also is the facility's Quality Assurance Nurse) on 07/28/21 at 3:30 p.m., Nurse #1 stated all nurses are expected to check the medication rooms and medication carts every day to make sure there are no expired medications.</li> <li>During an interview with the Director of Nursing (DON) on 07/28/21 at 3:39 p.m., the DON stated it was her expectation the nurses check medication for expiration dates before administering them and to remove expired medication carts and medication rooms.</li> <li># - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</li> <li>" All medication carts and medication were present. Any findings were properly discarded and reported to Director of Nursing.</li> <li># -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
<ul> <li>Facility Policy Storage of Medications and Medication Checklist for Med Carts reviewed and updated if necessary by Director of Nursing on 7/30/21.</li> <li>All Licensed Nurses inserviced by August 10, 2021 by Director of Nursing/Designee on facility policy Storage of Medications and Medication Checklist for Med Carts to include proper labeling of medications and proper disposal of expired medications.</li> <li>Any newly hired Licensed Nurses will be inserviced on facility policy Storage of Medications and Medication Checklist for</li> </ul>	F 761	During an interview w the facility's Quality A 07/28/21 at 3:30 p.m. are expected to chec medication carts ever are no expired medic During an interview w (DON) on 07/28/21 at it was her expectation medications for expira administering them a medications from the	with Nurse #1 (who also is assurance Nurse) on ., Nurse #1 stated all nurses k the medication rooms and ry day to make sure there ations. with the Director of Nursing t 3:39 p.m., the DON stated in the nurses check ation dates before nd to remove expired	F	761	<ul> <li>Nurse/Designee on 07/28/21</li> <li>Education provided to Nurse # 1 Nurse #2 by Director of nursing on 7/28/21 on proper labeling and storing medications.</li> <li># - 2 Address how the facility will ider other residents having the potential to affected by the same deficient practice</li> <li>" All medication carts and medica rooms were audited by 7/30/21 by Q/ Nurse/Designee to ensure no other unlabeled or expired medications were present. Any findings were properly discarded and reported to Director of Nursing.</li> <li># -3 Address what measures will be p into place or systemic changes made ensure that the deficient practice will recur;</li> <li>" Facility Policy Storage of Medica and Medication Checklist for Med Ca reviewed and updated if necessary b Director of Nursing on 7/30/21.</li> <li>" All Licensed Nurses inserviced b August 10, 2021 by Director of Nursing/Designee on facility policy Storage of Medications and Medicatio Checklist for Med Carts to include pro- labeling of medications and proper disposal of expired medications.</li> <li>" Any newly hired Licensed Nurse be inserviced on facility policy Storage</li> </ul>	g of htify b be ce; tion A re but to not tions rts y y y pon oper s will e of	

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Event ID: 2M4411

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOF	ED: 08/30/202 <sup>°</sup> RM APPROVEE IO. 0938-039 <sup>°</sup>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	345349	B. WING	G		C 7/30/2021
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBURY WELLNESS CENTER	RINC		778 COUNTRY CLUB DRIVE		
			IAMPSTEAD, NC 28443		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761 Continued From page	e 3	F 761	Med Carts by Staff Developme Coordinator/Designee during o process. # - 4 Indicate how the facility pl monitor its performance to mak solutions are sustained; and In when corrective action will be o " Audit Tool developed by D Nursing on August 5, 2021 to audit medica and medication rooms for unlat expired medications. " Director of Nursing/Design complete audit 2 times weekly weeks and weekly ongoing to e medications are labeled and st facility policy Storage of Medic Medication Checklist for Med O Director of Nursing to review at weekly. " Results will be reviewed a discussed in the monthly Quali Assurance Performance Impro Committee meetings. The Qua Assurance Committee will asse modify the action plan as need ensure continued compliance.	rientation ans to ce sure that clude dates completed. irector of ation carts beled or nee will times 4 ensure that ored as per ations and carts. udit results nd ty vement ality ess and	

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