DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			·	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		345349	B. WING			C 03/02/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
WOODBU	RY WELLNESS CENTER	INC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		E OC	00		
F 000	investigation survey w through 3/2/23. The f compliance with the r	equirement CFR 483.73, ness. Event ID #7T1611.	F 00	00		
	survey was conducte 3/2/23. Event ID# 7T ⁻ were investigated: N	complaint investigation d from 2/27/23 through 1611. The following intakes C00198638, NC00197254, 89182, NC00188938, and				
F 561 SS=D	10 of the 10 complai in deficiency. Self-Determination CFR(s): 483.10(f)(1)-	nt allegations did not result (3)(8)	F 56	51		3/28/23
	promote and facilitate through support of re	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					03/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345349	B. WING			C 02/2023
NAME OF PI	ROVIDER OR SUPPLIER		· T	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODBU	RY WELLNESS CENTER	INC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	N BE RIATE	(X5) COMPLETION DATE	
F 561	 §483.10(f)(3) The res with members of the of community activities by facility. §483.10(f)(8) The res participate in other activities by facility. §483.10(f)(8) The respective participate in other activity. Based on record review of shower and important to her. Record review of shower and important to her. During an interview of Resident #4 indicated scheduled shower over an activity. 	ident has a right to interact community and participate in both inside and outside the ident has a right to tivities, including social, nity activities that do not ts of other residents in the ' is not met as evidenced ew, staff and resident failed to honor a resident's ver for 1 of 32 reviewed for). itted to the facility on es that included a stroke. Data Set (MDS) dated esident #4 was cognitively dependent for bathing. behaviors of rejection of MDS indicated choosing d a bed bath was very wer logs for Saturday, sident #4 "refused a bed in 2/27/23 at 11:15 AM, I she did not receive her er the weekend. She	F 56	 F561 Self-Determination Preparation and submission of this pl correction is in response to the CMS 2567 from the 03/02/2023 survey. It not constitute an agreement or admis by Woodbury Wellness Center of the of the facts alleged or of the correctmon of the conclusions stated on the state of deficiency. The facility reserves al rights to contest the deficiencies, find conclusions and actions of the Agence This Plan of Correction (and the attact documents) also functions as the facility s credible allegation of compliance. # 1 - Address how corrective action w accomplished for those residents four have been affected by the deficient practice; For Resident # 4: " Resident was offered and provid shower on March 1, 2023, date of notification by surveyor that resident not receive preference of shower on 	Form does sion truth ess ment ings, y. shed vill be nd to	
	indicated her Saturda offered a bed bath bu	y Nurse Alde (NA) #1 t she declined stating she		2/25/23, by Director of Nursing/Desig	nee.	

Facility ID: 923206

		D HUMAN SERVICES MEDICAID SERVICES			FORM	: 04/26/2023 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPL	.ETED
		345349	B. WING		03/0	;)2/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	
WOODBUI	RY WELLNESS CENTER	INC		778 COUNTRY CLUB DRIVE IAMPSTEAD, NC 28443		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	give a shower. Reside #1 could not give her During an interview or indicated she was una Resident #4 on Satura having enough nurse switched units mid sh other staff members s showers. During an interview or Assurance (QA) Nurs nurse manager on Sa Resident #4 did not guif she was aware, she shower. The QA nurse not short staffed on S During an interview or Director of Nursing (D aware Resident #4 did the weekend. She rew other staff she was no The DON indicated if #4 would have been of shift or on Sunday. Sh adequate staff working showers.	#1 said she was not able to ent #4 was unsure why NA a shower. a shower. a 3/1/23 at 10:50 AM, NA #1 able to provide a shower for day, 2/25/23 due to not aides. NA #1 revealed she fit and did not report to the he was unable to give a 3/1/23 at 11:05, the Quality e reported she worked as turday and was not aware et her shower. She indicated would have provided the e reported the facility was aturday. a 3/2/23 at 2:10 PM, the ON) indicated she was not d not receive a shower over ealed NA #1 did not notify it able to get to the shower. she was aware, Resident offered a shower on evening the believed there was g the weekend to provide a 3/2/23 at 2:15 PM, the d NA #1 had been educated ce if she was not able to cheduled. The Administrator	F 561	 # - 2 Address how the facility will ident other residents having the potential to affected by the same deficient practice. " All inhouse residents with BIMS set 12 and above on most recent MDS interviewed by QA Nurse to ensure that preference for a shower over bath has been honored in last 30 days. Any discrepancies found on audit will be addressed thru updating resident care on bathing preferences. Audit completion 03/17/2023. # -3 Address what measures will be put into place or systemic changes made for ensure that the deficient practice will not place or systemic changes made for ensure that the deficient practice will not place or systemic changes made for ensure that the deficient practice will not place or system on 03/06/23 titled Education of Resident Showers over EB Baths. " All direct care staff educated by Director of Nursing/Designee by 03/20/2023. " Any Direct care staff not inservice by this date will be educated on next scheduled shift by Director of Nursing/Designee inservice during the orientation/onboarding process by SDC/Designee. # - 4 Indicate how the facility plans to monitor its performance to make sure for the sure for the sure formance to make sure formance	be core at plan ted ut oo ot Bed d	
		nough staff working to			that	

Facility ID: 923206

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3	C
		345349	B. WING		03/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBU	RY WELLNESS CENTE	R INC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 561	Continued From pag	je 3	F 56	51	
F 623 SS=B	CFR(s): 483.15(c)(3 §483.15(c)(3) Notice Before a facility trans resident, the facility (i) Notify the residen representative(s) of the reasons for the r	e before transfer. sfers or discharges a must- t and the resident's the transfer or discharge and nove in writing and in a er they understand. The	F 62	 Director of Nursing on 03/17// implement monitoring that shower offered on scheduled days, if desi before being offered bed bath. We Shower Schedule will be utilized fi identification of resident selection interview based on residents indic that received bed bath or refused. "Assistant Director of Nursing Managers inserviced by Director of Nursing on 03/17/23 on Weekly S Sheet Audit Tool use. "Unit Managers/Designee of F and LTC units to complete audit to weekly times 30 days, interviewing residents weekly to ensure they w offered shower prior to receiving b if preference. "Results will be reviewed and discussed in the monthly Quality Assurance Performance Improver Committee meetings. The Quality Assurance Committee will assess modify the action plan as needed ensure continued compliance. 	rs are ired, eekly or for cated and Unit of hower Rehab pol g 4-5 vere ped bath, ment / and

Event ID: 7T1611

Facility ID: 923206

If continuation sheet Page 4 of 28

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/26/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345349	B. WING		_		C 02/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER	INC		2778 COUNTRY CLUB DRI HAMPSTEAD, NC 2844			
(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 623	accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ai resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in para must include the follor (i) The reason for tran	budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(A) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; of transfer or discharge; nich the resident is	F 623				

Facility ID: 923206

If continuation sheet Page 5 of 28

ATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUI T	IPLE COI	NSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í			· · ·	MPLETED
		345349	B. WING				03/02/2023
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER	RINC			COUNTRY CLUB DRIVE PSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 5	F	523			
		e resident's appeal rights,		20			
		address (mailing and email),					
	and telephone number	er of the entity which					
		ts; and information on how					
		orm and assistance in					
	hearing request;	and submitting the appeal					
	- ·	ss (mailing and email) and					
	telephone number of	the Office of the State					
	Long-Term Care Omb						
		y residents with intellectual					
	and developmental d	isabilities or related					
		the agency responsible for					
	-	vocacy of individuals with					
	-	lities established under Part					
	· ·	tal Disabilities Assistance					
		of 2000 (Pub. L. 106-402,					
	codified at 42 U.S.C.	• /					
		ty residents with a mental sabilities, the mailing and					
		lephone number of the					
	agency responsible for	-					
	advocacy of individua	als with a mental disorder					
		Protection and Advocacy					
	for Mentally III Individ	uals Act.					
	§483.15(c)(6) Change	es to the notice.					
		ne notice changes prior to					
		or discharge, the facility					
must update the recipients of							
	as practicable once the becomes available.	he updated information					
		in advance of facility closure					
		closure, the individual who is					
		ne facility must provide					
	Writton potities - ties -	or to the impending closure					

Facility ID: 923206

If continuation sheet Page 6 of 28

STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) E	NO. 0938-039 DATE SURVEY OMPLETED
		345349	B. WING				C 03/02/2023
NAME OF PR	ROVIDER OR SUPPLIER	L		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	778 COUNTRY CLUB DRIVE		
WOODBU	RY WELLNESS CENTER	RINC		н	IAMPSTEAD, NC 28443		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 623	Continued From page	e 6	F	623			
	 Continued From page 6 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(I). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification to the resident or resident representative of the reason for discharge to the hospital for 2 of 2 sampled residents (Resident #41 and Resident #99) reviewed for hospitalization. This deficient practice had the potential to affect other residents. The findings included: 1. Resident #41 was admitted to the facility on 				F623 Notice Requirements Before Transfer/Discharge Preparation and submission of this correction is in response to the CM 2567 from the 03/02/2023 survey. not constitute an agreement or adm by Woodbury Wellness Center of th of the facts alleged or of the correct of the conclusions stated on the sta of deficiency. The facility reserves rights to contest the deficiencies, fir conclusions and actions of the Age	S Form It does hission he truth tness htement all hdings, ncy.	
		erly Minimum Data Set 022 revealed the resident's ately impaired.			This Plan of Correction (and the att documents) also functions as the facility s credible allegation of compliance.	ached	
	revealed that the resi the hospital from the	lent #41's medical records dent had been transferred to facility on 12/04/2022. She e facility on 12/12/2022.			# 1 - Address how corrective action accomplished for those residents for have been affected by the deficient practice;	ound to	
	revealed no documer the responsible party date of the transfer an the hospital.	l service progress notes ntation that the resident or was notified in writing of the nd the reason of transfer to			For Residents # 41 and Resident # "Written notification for reason f discharge on 12/04/22 was mailed resident #41 and/or resident representative of the reason for the discharge by Social Work/Designed	or to	
		7 AM, the Social Worker d. She stated that she was			03/22/202. "Written notification for reason f	or	

Facility ID: 923206

Trig REGULATORY OR LISCIDENTIFYING INFORMATION) Trig CROSE REFERENCES TO THE APPROPRIATE DEFICIENCY) F 623 Continued From page 7 new to the facility as a social worker, and she had not notified the responsible party in writing of the date of the transfer and reason of transfer to the hospital. F 623 During an interview on 03/03/2023 at 1:00 PM with the facility Administrator, she stated the Social Worker was new and she was still learning her new role at the facility. The Administrator indicated the facility had not been providing the resident or the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to resident regresentative. 2. Resident #99 was sent to the hospital. " Audit completed by Director of Nursing on March 17, 2022 of all resident hospital transfers with admission in previous 30 days (February 15-March 17). For any items resealed on audit, Written notification or reason for the reason for the discharge by Social Work/Designee by 03/22/2023. A nursing progress note dated 2/20/23. " Social Work and Admissions staff inserviced by Director of Nursing on March 17 2023 on required written notification or responsible party the date or reason for the transfer to the hospital in writing. She indicated she was new to the facility. " Social Work and Admissions taff inserviced by Director of Nursing on March 17 2023 on requi			MEDICAID SERVICES			OMB NO. 09	
345349 C C 00000000000000000000000000000000000			· /			()	
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE WOODBURY WELLNESS CENTER INC STREET ADDRESS, CITY, STATE, ZP CODE MAMPSTEAD, NOR 28443 PROVIDERS PARK, NOR 28443 Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of the Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Content of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE Model of Participancies Provide State ADDRESS, CITY, STATE, ZP CODE						С	
WOODBURY WELLNESS CENTER INC 2778 COUNTRY CLUB BRIVE HAMPSTEAD, NC 2843 Drain PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SINULD BE (EACH CORRECTIVE ACTION SINULD BE (EACH CORRECTIVE ACTION SINULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY 0 F 623 Continued From page 7 new to the facility as a social worker, and she had not notified the resident or the responsible party in writing of the date of the transfer and reason of transfer to the hospital. F 623 During an interview on 03/03/2023 at 1:00 PM with the facility will identify Social Worker was new and she was still learning her new role at the facility. The Administrator indicated the facility bad not been providing the resident or the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written anotice of the reason for transfers. She explained going forward she would ensure a written anotice of the reason for transfer was sent to resident or resident representative. 2. Resident #99 was admitted to the facility on 201/123 with diagnoses that included octeomyelitis. His admission Minimum Data Set (MDS) indicated severe cognitive impairment. 2. Resident #99 was sent to the hospital. Review of Resident #99 was sent to the hospital. Review of Resident #99 was sent to the hospital. Review of Resident #99 was need ad 22/023 indicated Resident #99 was sent to the hospital. Review of Resident #99 was need to addit 22/023. During an interview on 32/23 at 2:0 PM, the Social Work/Designee by 03/22/2023. # -3 Address what measures will be put indicated she was new to the facility. During an interview on 32/23 at 2:20 PM, the Director of Nursing (DON) indicated she was not aware of the requirement for wit			345349	B. WING		03/02/2	023
WOODBURY WELLNESS CENTER INC HAMPSTEAD, NC 28443 Image: Construct of the construction of the constend the presentative of the construction of the cons	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
PREFIX TAG IEACH DEFICIENCY MIST BE PRECEDED BY FULL REGULTORY OR LSC IDENTFYING INFORMATION) PREFIX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCESD TO THE APPROPRIATE DEFICIENCY) CO F 623 Continued From page 7 new to the facility as a social worker, and she had not notified the resident or the responsible party in writing of the date of the transfer and reason of transfer to the hospital. F 623 discharge on 02/20/23 was mailed to resident #09 and /or resident representative of the reason for the discharge by Social Work/Designee on 03/22/2023. # - 2 Address how the facility will identify other resident for the reason for transfer was resident or the resident representative with written notifications of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to resident or resident representative. # - 2 Address how the facility will identify other resident and/or resident previous 30 days (February 15-March 17), For any items revealed on audit, Written notifications of the reason for transfer was sent to resident and/or resident representative of the reason for the discharge by Social Work/Designee by 03/22/2023. A nursing progress note dated 2/20/23 indicated Resident #99 was sent to the hospital. # -3 Address what measures will be put into a dransis on thirtien notification of a transfer to the hospital on 2/20/23. During an interview on 3/2/23 at 9:30 AM, the Social Worker revealed had not notified the resident or responsible party the date or reason for the transfer to the hospital in writing. She indicated she was new to the facility. During an interview on 3/2/23 at 9:20 AM, the Social Worker reveale	WOODBU	RY WELLNESS CENTER	LINC				
 new to the facility as a social worker, and she had not notified the resident or the responsible party in writing of the date of the transfer and reason of transfer to the hospital. During an interview on 03/03/2023 at 1:00 PM with the facility Administrator, she stated the Social Worker was new and she was still learning her new role at the facility. The Administrator indicated the facility the Administrator indicated the facility the Administrator in notifications of the reason for transfer was sent to the reason for transfer was sent to resident representative with written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to tresident representative. 2. Resident #99 was admitted to the facility on 21/1/23 with diagnoses that included osteomyellits. His admission Minimum Data Set (MDS) indicated severe cognitive impairment. A nursing progress note dated 21/20/23 indicated Resident #99's medical record did not reveal his family precived written notification of a transfer to the hospital on 21/20/23. During an interview on 3/2123 at 9:30 AM, the Social Worker revealed had not notified the reason for the facility. During an interview on 3/2123 at 9:20 PM, the Director of Nursing (DON) indicated she was not aware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF		(X5) MPLETION DATE
 new to the facility as a social worker, and she had not notified the resident or the responsible party in writing of the date of the transfer and reason of transfer to the hospital. During an interview on 03/03/2023 at 1:00 PM with the facility. Administrator, she stated the Social Worker was new and she was still learning her new role at the facility. The Administrator indicated the facility had not been providing the resident or the reasion for transfer was sent to the reason for transfer was sent to the reason for transfers. She explained going forward she would ensure a written notifications of the reason for transfers. She explained going forward she would ensure a written notification or for transfer was sent to resident #99 was admitted to the facility on 2/1/123 with diagnoses that included osteomyellits. His admission Minimum Data Set (MDS) indicated severe cognitive impairment. A nursing progress note dated 2/20/23 indicated Resident #99 was sent to the hospital. During an interview on 3/2/23 at 9:30 AM, the Social Worker revealed had not notified the reason for the transfer to the hospital in writing. She indicated she was new to the facility. During an interview on 3/2/23 at 2:20 PM, the Director of Nursing (DON) indicated she was not aware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for written notification of a ware of the requirement for wri	F 623	Continued From page	ə 7	F 62	3		
During an interview on 3/2/23 at 2:20 PM, the Director of Nursing (DON) indicated she was not aware of the requirement for written notification ofor by USPS mailing to address on file.		new to the facility as not notified the reside in writing of the date transfer to the hospital During an interview o with the facility Admir Social Worker was no her new role at the fa- indicated the facility h resident or the reside notifications of the re- explained going forwa written notice of the re- to resident or residen 2. Resident #99 was 2/1/23 with diagnoses His admission Minima indicated severe cogn A nursing progress no Resident #99 was se Review of Resident # reveal his family rece transfer to the hospital During an interview o Social Worker reveal resident or responsib for the transfer to the	a social worker, and she had ent or the responsible party of the transfer and reason of al. n 03/03/2023 at 1:00 PM histrator, she stated the ew and she was still learning cility. The Administrator had not been providing the nt representative with written ason for transfers. She ard she would ensure a eason for transfer was sent t representative. admitted to the facility on s that included osteomyelitis. Jum Data Set (MDS) hitive impairment. Det dated 2/20/23 indicated int to the hospital. 199's medical record did not ived written notification of a al on 2/20/23. n 3/2/23 at 9:30 AM, the ed had not notified the le party the date or reason hospital in writing. She		 discharge on 02/20/23 resident #99 and /or rearepresentative of the redischarge by Social Word 03/22/2023. # - 2 Address how the forther residents having affected by the same definition of the resident shaving affected by the same definition for reason for mailed to resident and/representative of the redischarge by Social Word 03/22/2023. # -3 Address what meanint place or systemic of ensure that the deficient recur; " Social Work and A inserviced by Director of March 17 2023 on requirement of the rest of th	sident eason for the ork/Designee on facility will identify the potential to be eficient practice; y Director of 2022 of all resident admission in uary 15-March 17). on audit, Written for discharge to be or resident eason for the ork/Designee by asures will be put changes made to at practice will not dmissions staff of Nursing on uired written or discharge to a to residents . Education otification can be	
a transfer to the hospital. She indicated the social worker would be completing the transfer # - 4 Indicate how the facility plans to		Director of Nursing (E aware of the requiren a transfer to the hosp	DON) indicated she was not nent for written notification of ital. She indicated the social		or by USPS mailing to	address on file.	

Facility ID: 923206

If continuation sheet Page 8 of 28

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/202 MAPPROVEI D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED
		345349	B. WING				C 1 02/2023
NAME OF PR	ROVIDER OR SUPPLIER	•	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBU	RY WELLNESS CENTER			27	778 COUNTRY CLUB DRIVE		
HOODEO				H	AMPSTEAD, NC 28443		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	e 8	F	623			
					solutions are sustained;		
	Administrator reveale aware she was support notification of a transf indicated the facility h	n 3/2/23 at 2:25 PM, the ed the Social Worker was not osed to provide written fer to the hospital. She nad put a plan in place after nsure this will be completed			 Audit tool developed by Director of Nursing on 03/17/2023. Director of Nursing/Designee to conduct audit of 100% of resident hosp discharges with admission weekly times weeks to ensure that written notification reason for discharge was provided to resident and/or representative. Results of audits will be reviewed a discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 	oital s 4 n of	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)		F	641			3/28/23
	resident's status.	of Assessments. accurately reflect the is not met as evidenced					
	Based on record rev facility failed to code	iew and staff interviews the the Minimum Data Set			F641 Accuracy of Assessments		
	(PASRR) Level II for 2	ccurately for the ning and Resident Review 2 of 2 residents (Resident 9) reviewed for PASRR.			Preparation and submission of this plar correction is in response to the CMS For 2567 from the 03/02/2023 survey. It do not constitute an agreement or admissi by Woodbury Wellness Center of the tru	orm oes ion	
	Findings included:				of the facts alleged or of the correctnes of the conclusions stated on the statem	s	
	04/09/2021 with multi	admitted to the facility on iple diagnoses that included der, and major depression.			of deficiency. The facility reserves all rights to contest the deficiencies, finding conclusions and actions of the Agency.	gs,	

Event ID: 7T1611

Facility ID: 923206

If continuation sheet Page 9 of 28

							NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	ATE SURVEY
		345349	B. WING				C)3/02/2023
NAME OF P	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBU	RY WELLNESS CENTER	RINC			78 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	e 9	F 6	41			
	(a determination letter placed appropriately) Resident #75 was plat Review of the PASRF 7/27/2021 revealed a disorder, and major d The annual Minimum 04/14/2022 had resid intact and needed ext Activities of Daily Livi not coded for PASRF An interview with the conducted on 03/02/2 stated she has worke January 2023 and the MDS. The SW also s her new position and the MDS. An interview with the and Administrator wa 1:58 PM. They stated Section "A" on the MI her. Resident #75 she screened for a PASR did not orient the SW 2. Record review ind Preadmission Screen	R level I screen dated diagnosis of anxiety, bipolar lepression. Data Set (MDS) dated ent coded as cognitively tensive assistance with most ng (ADLs). The MDS was I I for Resident #75 Social Worker (SW) was 2023 at 9:36 AM. The SW ed at the facility since e MDS nurses handle the tarted she is still training in may have missed coding Director of Nursing (DON) s conducted on 03/02/23 at t the SW was new and DS should be completed by ould have been coded as R level II and the former SW			 This Plan of Correction (and the attack documents) also functions as the facility □s credible allegation of compliance. # 1 - Address how corrective action w accomplished for those residents four have been affected by the deficient practice; For resident # 75: The annual MDS dated 04/14/202 Passar Level II coding was corrected MDS Coordinator on 03/01/2023 with Modification to the coding and was transmitted accepted on 3/7/2023. For resident # 79: The admission assessment dated: 03/29/22 (admission DATE was 03/23) Passar Level II coding was corrected MDS Coordinator on 03/01/2023 with Modification to the coding and was transmitted accepted on 3/7/2023. For resident # 79: The admission assessment dated: 03/29/22 (admission DATE was 03/23) Passar Level II coding was corrected MDS Coordinator on 03/01/2023 with Modification to the coding and was transmitted and accepted on 03/02/23 # - 2 Address how the facility will ident other residents having the potential to affected by the same deficient practica: Audit of all Admission MDS □s for 30 days (February 15-March 17) Completed by MDS Coordinator on M 17, 2023 to ensure that coding for A18 related to the Passar Level II was cod correctly. Any corrections noted on A were corrected with Modifications to th Admissions MDS and resubmitted to 	ill be id to 22 by a /22) by a tify be e; past arch 500 ed udit	
	3/23/22 with multiple	mitted to the facility on diagnoses that included lar disorder, and dementia.			State. # -3 Address what measures will be p into place or systemic changes made		

Facility ID: 923206

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391			
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		345349	B. WING			C 02/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE	- -	
				HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	question A1500 which been evaluated by a l determined to have a and/or intellectual dis An interview was con AM with the MDS Nur explained she had be with updating PASRR updated appropriately An interview was con PM with the Administr explained there had b Social Work and som entered in the system the MDS coding should	um Data Set (MDS) 23/22 was answered "No" to a asked if Resident #79 had evel II PASRR and serious mental illness ability or a related condition. ducted on 3/01/23 at 11:00 rse. The MDS Nurse en assisting Social Work and this one did not get ducted on 3/01/23 at 3:30 rator. The Administrator been changes to staff with e PASRR had not been . The Administrator stated Id have been completed for Level II and she did not	F 64	 ensure that the deficient practice will r recur; "Social Work inserviced by Director Nursing on March 17, 2023 on RAI Manual for Section A1500 MDS codir the Level II Passar. # - 4 Indicate how the facility plans to monitor its performance to make sure solutions are sustained; "Section A1500 MDS Audit Tool developed by Director of Nursing/Designee on March 17, 2023 "Social Work and MDS inserviced Director of Nursing on March 17, 2023 "Social Work and MDS inserviced Director of Nursing on March 17, 2023 use of audit log tool "Audit to be completed for next 60 days (March 17-May 17) jointly by MD Coordinator and Social Work of all admission assessments completed to verify the Level II Passar has correctly been coded. "Audit tool to be reviewed by Director of Nursing weekly. "Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 	r of ig of that by con S	
F 644 SS=D	Coordination of PASA CFR(s): 483.20(e)(1)	RR and Assessments 2)	F 64	44		3/28/23
	§483.20(e) Coordinat	ion.				

Facility ID: 923206

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	-	D HUMAN SERVICES				FORM	1 APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
		345349	B. WING				C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	02/2020
WOODBU	RY WELLNESS CENTER	INC		2	778 COUNTRY CLUB DRIVE		
				н	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 644	pre-admission screen (PASARR) program u of this part to the max avoid duplicative testi includes: §483.20(e)(1)Incorpor from the PASARR lev PASARR evaluation r assessment, care pla care. §483.20(e)(2) Referrin all residents with new serious mental disord related condition for le a significant change in This REQUIREMENT by: Based on staff intervit facility failed to obtain Screening and Reside resident with an active mental illness for 2 of PASRR (Resident #5 Findings included:	hate assessments with the ing and resident review nder Medicaid in subpart C timum extent practicable to ng and effort. Coordination rating the recommendations el II determination and the eport into a resident's nning, and transitions of ng all level II residents and ly evident or possible er, intellectual disability, or a evel II resident review upon n status assessment. is not met as evidenced iew and record review, the a Level II Preadmission ent Review (PASRR) for a e diagnosis of a serious 4 residents reviewed for and Resident #49). iginally admitted to the with diagnoses that	F	644	F644 Coordination of PASSAR and Assessments Preparation and submission of this plat correction is in response to the CMS F 2567 from the 03/02/2023 survey. It do not constitute an agreement or admiss by Woodbury Wellness Center of the tr of the facts alleged or of the correctness of the conclusions stated on the statem of deficiency. The facility reserves all rights to contest the deficiencies, findin	orm pes ion uth ss nent	
	disorder. Resident #5 medical i 11/03/2022 she had a disorder.	record revealed on new diagnosis of delusional			conclusions and actions of the Agency This Plan of Correction (and the attach documents) also functions as the facility s credible allegation of compliance.	ed	
	Resident #5's annual	Minimum Data Set (MDS)			# 1 - Address how corrective action wil	i de	

Facility ID: 923206

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES	0.00			RM APPROVEI 10. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345349	B. WING		0	C 3/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WOODBU			2778 COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	e inc		HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 644	Continued From page	e 12	F 64	Λ		
		/18/2022 revealed she was	1 04	accomplished for those reside	onte found to	
		e state to be a PASARR level		have been affected by the del practice;		
	During an interview o	on 03/01/2023 at 10:30 AM		For Resident #5:		
	-	W) stated she was new at		" Submission of Level II Pa	assar	
		ad not been aware of the		completed by Social Worker of	on	
	responsibility of refer	ring residents with a new		03/01/2023 with the addition of	of new	
	psychiatric diagnosis			diagnosis revealed on 11/03/2		
		e new admission. She		was halted due to Dx of Deme	entia.	
		ward she will make sure the		For Resident #49: Submission of Level II Pa		
	residents who were of psychiatric diagnoses	-		complete by Social Worker or		
	PASARR level II eval			with the addition of new diagn		
				revealed on medical record re		
	An interview was cor	ducted with the MDS nurse		10/26/21,02/10/22, 04/26/22,		
	on 03/01 /2023 at 1:4	4 PM. She stated that she		and 11/21/11. Passar was ha		
		hen a resident was newly		Dx of Dementia.		
	-	ious mental illness that was				
		sion the resident needed to		# - 2 Address how the facility	•	
		RR level II evaluation. The		other residents having the pot		
	MDS added that mov	was added, she will confirm		affected by the same deficien	t practice,	
		sident's new diagnoses was		" MDS Coordinators and D)irector of	
	referred for a PASAR	0		Nursing reviewed all MDS		
				or completed in the last 30 da		
	An interview was cor	ducted with the Director of		15-March 17) for changes in		
	,	3/02/2023 at 2:00 PM. She		medications that would indica		
		not very familiar with the		Level II PASSAR to be submit		
		PASARR level II evaluation,		was completed on 03/17/2023		
		the regulations to be		residents were identified as n	eeding Level	
		to completing a PASARR a newly identified mental		II Passar submitted.		
	illness diagnosis.	a newly lucitation mental		# -3 Address what measures	will be put	
				into place or systemic change		
	During an interview c	on 03/03/2023 at 1:00 PM,		ensure that the deficient pract		
	-	icated if a new psychiatric		recur;		
		ASARR level II evaluation,				
	then the Social Work	er will be responsible for		" Director of Nursing devel	oped Passar	

Facility ID: 923206

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO	IES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345349	B. WING				C 102/2023
NAME OF PROVIDER OR	SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	778 COUNTRY CLUB DRIVE		
	SS CENTER	(INC		н	IAMPSTEAD, NC 28443		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
PASARR also adde with SW f diagnose evaluation 2. Reside 10/26/21. Minimum indicated included, disorder. Review o 07/17/17 Review o 07/17/17 Review o Notificatio "no furthe significan status that or mental change ir Review o revealed status - 1 adjustme 02/10/22, condition and/or lau feel) - 04/ - 06/07/22 An intervi Social Wo was newl	d the MDS o confirm the swere refer n. ent #49 was Review of Data Set (M Resident #4 in part, anx f the PASRF revealed no f the PASRF on letter data r PASRR so t change oc t suggest a retardation treatment n f Resident # diagnoses t D/26/21, an: nt disorder v pseudobull causing suc ghing that of 26/22, psyce 2, and deme ew on 02/28 orker (SW), y diagnosed peeded to be	e 13 rral for an evaluation. She nurse will be following up hat the residents' new red for PASARR level II admitted to the facility on Resident #49's annual MDS) dated 08/20/22 49's current diagnoses lety disorder and psychotic R Level I application dated mental health diagnoses. R Level I Determination ed 07/17/17 revealed that creening is required unless a curs with the individual's diagnosis of mental illness or, if present, suggests a needs for those conditions." 449's medical record o include altered mental kiety disorder - 10/26/21, with depressed mood - bar affect (a medical dden uncontrollable crying does not match how you hotic disorder with delusions entia - 11/21/22. 8/23 at 2:30 PM with the she stated when a resident with a mental illness the e evaluated for a Level II ted she was not in the	F	644	Tracking Log with guidelines for completion for use by MDS and Socia Work Department "MDS Coordinators and Social Wo were inserviced by Director of Nursing March 17, 2023 on new facility Passar Tracking Log/Guidelines, with implementation. # - 4 Indicate how the facility plans to monitor its performance to make sure solutions are sustained; "MDS and Social Work to complet Passar Tracking Log for next 60 days ongoing. "Director of Nursing /Designee to 7 50% of Passar Tracking Log entries weekly times two weeks and 25 % we times 2 weeks and randomly ongoing ensure Level II Passar review was completed, if applicable, and coded correctly on MDS. "Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. ¿	that and Audit to	

Facility ID: 923206

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345349	B. WING				C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODBU	RY WELLNESS CENTER	INC			2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	been completed, and happened or why the An interview on 03/01 Admission Nurse, she admitted with her old explained there had be the information did no explained she had en update in PASRR and would be a system in information even whe position. An interview on 03/01 Minimum Data Set (M Worker would usually evaluation for a Level slipped their attention changed in personnel #49's medical record to the facility with a Le II PASARR had not be An interview on 3/01/2 Administrator stated to new application subm evaluation. She state process of completing their investigation of F The Administrator exp be reviewed and scree II PASRR assessmen Sufficient Dietary Sup	the evaluation should have she did not know what had evaluation was not done. /23 at 12:06 PM, with the e stated the resident was PASRR report. She been a turnover in staff and of get passed. She tered the data for the d moving forward there place to enter PASRR n someone leaves their /23 at 2:00 PM, the IDS) Nurse stated the Social be the one to submit an II PASARR change but this since there had been d. She confirmed Resident indicated she was admitted evel I PASARR and no Level een filed. 23 at 3:30 PM, the here should have been a hitted for a Level II PASARR ed the facility was in the g recommendations from Resident #49's PASSAR. Dained all residents would ened for any needed Level ts when changes occur. port Personnel		802			3/28/23
SS=F	CFR(s): 483.60(a)(3) §483.60(a) Staffing	-					

Facility ID: 923206

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345349	B. WING				C 02/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
WOODBU	RY WELLNESS CENTER	INC			778 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 802	appropriate competer out the functions of the taking into considerat individual plans of car and diagnoses of the in accordance with the required at §483.70(ef §483.60(a)(3) Suppor The facility must prov personnel to safely ar functions of the food a §483.60(b) A member Services staff must pa interdisciplinary team (2)(ii). This REQUIREMENT by: Based on observation interviews, the facility to ensure timely meal affect residents receive Findings included: This tag is cross-refer observations, record to and staff interviews, t timely meals for 3 of t had the potential to at food from the kitchen. During observations in 10:15 AM and 3/1/23 Manager was observed	loy sufficient staff with the noises and skills sets to carry e food and nutrition service, ion resident assessments, re and the number, acuity facility's resident population e facility assessment)). t staff. ide sufficient support nd effectively carry out the and nutrition service. r of the Food and Nutrition articipate on the as required in § 483.21(b) ' is not met as evidenced ns, record review, and staff failed to have sufficient staff s. This had the potential to <i>v</i> ing food from the kitchen. reenced to F809. Based on review, and resident, family, he facility failed to provide he 3 meals observed. This ffect all residents receiving n the kitchen on 2/27/23 at at 12:00 PM, the Dietary ed in the cooking area. He s out and he was working	F	802	Tag F802 Sufficient Dietary Support Personnel Preparation and submission of this pla correction is in response to the CMS F 2567 from the 03/02/2023 survey. It du not constitute an agreement or admiss by Woodbury Wellness Center of the tr of the facts alleged or of the correctness of the conclusions stated on the statem of deficiency. The facility reserves all rights to contest the deficiencies, findir conclusions and actions of the Agency This Plan of Correction (and the attach documents) also functions as the facility s credible allegation of compliance # 1 - Address how corrective action wil	orm oes ion ruth ss nent ngs, ied	

Facility ID: 923206

If continuation sheet Page 16 of 28

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/26/2023 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345349	B. WING				02/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER	INC			778 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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)		(X5) COMPLETION DATE
F 802	Dietary Manager reve due to being short sta revealed the afternoo were out the week of manager revealed co chef to assist with sho there around 1 month During an interview of Administrator reveale requested assistance short staffed. Corpora	n 3/2/23 at 11:15 AM, the ealed trays were served late iffed in the kitchen. He n cook and two dietary aides survey. The dietary rporate had sent a regional ort staffing and he had been box n 3/2/23 at 2:00 PM, the d that the facility had from corporate due to being ate sent a regional dietary dicated several new people	F	802	accomplished for those residents four have been affected by the deficient practice; As this had the potential to affect all inhouse residents: "Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacan until permanent hires for positions cou be obtained to ensure facility has sufficient staff to ensure timely meals. Hiring process of Facility- Dietary Services Vendor enhanced, for examp with temporary additional signing bout structure), more frequent updated ads Indeed, etc, in ongoing attempts to attr additional staff for Dietary Services Department. # - 2 Address how the facility will ident other residents having the potential to affected by the same deficient practice As this had the potential to affect all ot residents: "Facility- Dietary Services Vendor supplied additional Corporate Support Personnel to Facility to fill shift vacand until permanent hires for positions cou be obtained to ensure facility has sufficient staff to ensure timely meals. "Hiring process of Facility Food and Nutrition Vendor enhanced, for examp with temporary additional signing bout structure, more frequent ads updates of Indeed, etc in ongoing attempts to attr additional staff for Dietary Services Department.	cies ld le ls on ract ify be s; her cies ld le ls on	

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						O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
						С
		345349	B. WING			3/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WOODBU	RY WELLNESS CENT	ER INC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 802	Continued From pa	age 17	F 80	2		
				 # -3 Address what measures into place or systemic change ensure that the deficient pract recur; " Daily Labor Budget Guid by Facility Dietary Services Vendor/Administrator on 03/2 provide guidance on general of staffing patterns daily to allow staff to ensure timely meals. " Food Service Director ins Facility Dietary Services Vend Director/Administrator on 03/2 Daily Labor Budget Guide witt implementation. " Daily Deployment Schedd developed by Facility Dietary Vendor/Administrator on 03/2 provide daily staffing sheets for Services Department. " Food Service Director ins Daily Deployment Schedule b Vendor Regional Director/Adr 03/20/2023 with implementati 03/20/2023. " Daily Deployment Schedule b Vendor Regional Director/Adr 03/20/2023. " Daily Deployment Schedule b Vendor Regional Director/Adr 	s made to ice will not e developed D/2023 to expected for sufficient erviced by lor Regional 20/2023 on n ule Service D/2023 to or Dietary erviced on y Facility ninistrator on on on ule to be ice	
				 # - 4 Indicate how the facility monitor its performance to ma solutions are sustained; " Audit Tool was develope Administrator on 03/20/2023 f 	ike sure that ed by	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIDI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					С	
		345349	B. WING		03/02/2023	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTE	RINC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETIC	
F 802 F 809 SS=F	facility must provide regular times compa- the community or in needs, preferences, §483.60(f)(2)There in hours between a sub breakfast the followin nourishing snack is	/Snacks at Bedtime)-(3) cy of Meals resident must receive and the at least three meals daily, at arable to normal mealtimes in accordance with resident requests, and plan of care. must be no more than 14 bstantial evening meal and ng day, except when a served at bedtime, up to 16 etween a substantial evening	F 802	 Registered Dietitian inservice Audit Tool by Administrator on 03 Effective week of 03/20/2023 Dietitian/Designee will audit Daily Deployment Schedule 5 times weet times 2 (two) weeks, then 3 times times 2 (two) weeks, then at least times 4(four) weeks to ensure suffing provided to ensure timely Results of Registered Dietitian/Designee audits to be ree by Administrator weekly times 4 (weeks then every 2 (two) weeks to 4(four). Results will be reviewed and discussed in the monthly Quality Assurance Performance improve Committee meetings. The Qualit Assurance Committee will assess modify the action plan as needed ensure continued compliance. 	/20/2023. eekly s weekly t weekly fficient meals. eviewed four) times ment y s and	

Facility ID: 923206

If continuation sheet Page 19 of 28

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345349	B. WING			C 02/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				2778 COUNTRY CLUB DRIVE		
WOODBU	RY WELLNESS CENTER	INC		HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 809	Continued From page	9 19	F 8	09		
	§483.60(f)(3) Suitable meals and snacks mu who want to eat at no of scheduled meal set the resident plan of ca This REQUIREMENT by: Based on observation resident, family, and s failed to provide timely observed. This had the residents receiving for Findings included: Resident #91 was add 10/27/22 with diagnoss Parkinson's. His quart (MDS) dated 2/2/23 in cognitive impairment. During an interview of Resident #91 indicate frequently late and alw times. During an interview of family member indicat at lunch time to assist were often late. Record review of the f indicated that the 400 breakfast at 9:15 AM	e, nourishing alternative ist be provided to residents in-traditional times or outside rvice times, consistent with are. Is not met as evidenced ins, record review, and staff interviews, the facility y meals for 3 of the 3 meals is potential to affect all od from the kitchen. In 2/27/23 at 11:00 AM, d that meals were ways served at different in 2/27/23 at 11:10 PM, a ted she goes to the facility ther mother. Lunch trays facility's meal times hall was to receive and lunch at 1:30 PM.		 Tag F809 Frequency of Meals Preparation and submission of this pl correction is in response to the CMS 2567 from the 03/02/2023 survey. It not constitute an agreement or admiss by Woodbury Wellness Center of the of the facts alleged or of the corrective of the conclusions stated on the state of deficiency. The facility reserves al rights to contest the deficiencies, find conclusions and actions of the Agence This Plan of Correction (and the attact documents) also functions as the facility s credible allegation of compliance # 1 - Address how corrective action waccomplished for those residents four have been affected by the deficient practice; As this had the potential to affect all inhouse residents, including resident "Facility- Dietary Services Vendor supplied additional Corporate Suppor Personnel to Facility to fill shift vacan until permanent hires for positions co be obtained to ensure facility has sufficient staff to ensure timely meals 	Form does sion truth ess ment ngs, y. hed ill be nd to #91: t cies uld	
	or preaklast trays dell	VELEU IO 400 NAII.		# - 2 Address how the facility will ider	tify	

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	-	D HUMAN SERVICES				FORM	1 APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE		(X3) DATE	. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· , ,			· /	LETED
							C
		345349	B. WING			03/	02/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER	INC			778 COUNTRY CLUB DRIVE		
				п			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
			-		DEFICIENCE)		
F 900		00					
F 809	Continued From page		- F 8	809			
		nade on 3/1/23 at 1:50 PM			other residents having the potential to l		
	of lunch trays delivere	a to 400 hall.			affected by the same deficient practice As this had the potential to affect all oth		
	During an interview o	n 3/2/23 at 11:10 AM, the			residents:		
		cated the trays were late			" Facility- Dietary Services Vendor		
		nort staffed in the kitchen.			supplied additional Corporate Support		
		illing in for the cook the day			Personnel to Facility to fill shift vacanci		
		e trays arriving that late was			until permanent hires for positions coul	d	
	unacceptable.				be obtained to ensure facility has sufficient staff to ensure timely meals.		
	During an interview o	n 3/2/23 2:05 PM. the					
	-	d she was aware of an issue			# -3 Address what measures will be pu	t	
		. She revealed the kitchen			into place or systemic changes made to		
	usually notifies the flo	or if trays were late.			ensure that the deficient practice will no	ot	
					recur;		
					" Dietary Services Vendor Management, Facility Nursing		
					Management and Administrator met an	d	
					reviewed Meal Times Policy on 3/16/23		
					with revisions made, if applicable		
					" Food Service Director Inserviced of	on	
					Meal Times Policy by Facility Dietary		
					Services Vendor Regional Director/Administrator on 03/20/2023		
					" All Facility Dietary Service Vendor		
					staff assigned to this location will be		
					inserviced on Meal Times Policy by Fo		
					Service Director/Designee by 03/22/20		
					Any staff not inserviced by this date wil inserviced by the start of their next	i be	
					scheduled shift.		
					" All newly hired staff of Facility Diet	ary	
					Service Vendor assigned to this locatio	-	
					after 03/22/2023 will be inserviced on		
					Meal Times Policy during onboarding		
					orientation process by Food Service		
					Director/Designee Dietary Services Management,		
					Nursing Management and Administrate	or	

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STATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	COMPLETED
		345349	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/02/2023
				2778 COUNTRY CLUB DRIVE	
WOODBU	RY WELLNESS CENTER	RINC		HAMPSTEAD, NC 28443	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP! DEFICIENCY)	OULD BE COMPLET
F 809	Continued From page		F 80	DEFICIENCY)	elivery ons made ivery ely meal viced on y Facility al 2023. (endor I be ry 3. Any vill be ext ty Dietary location ed on uring by o be re by ed by 103/20/23 endor staff nserviced Food /22/2023. ate will be ext
				after 03/22/2023 will be inservice Food Cart Delivery Sheet during	

Event ID: 7T1611

Facility ID: 923206

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3	C
		345349	B. WING		03/02/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODBU	RY WELLNESS CENTE	RINC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 809	Continued From pag	je 22	F 80	9 onboarding orientation process Service Director/Designee	by Food
				# - 4 Indicate how the facility pla monitor its performance to make solutions are sustained;	
				 Audit Tool Developed by Administrator on 03/20/2023 for of Meal Delivery Times by Dieta Services Staff. Registered Dietitian inservi newly developed Audit Tool by F Dietary Services Vendor Region Director/Administrator on 02/20 	ary iced on Facility nal
				Director/Administrator on 03/20, with implementation. "Effective week of 03/20/202 Registered Dietitian/Designee v random audit of Meal Delivery T 50% of meal delivery times wee 2 (two) weeks, then 25% of Mea Times weekly times 2 (two) wee 10% of Meal Delivery Times we	23 vill conduct Fimes for ekly times al Delivery eks, then
				 2 (two) weeks, and at least week thereafter to ensure timely mea "Results of Registered Dietitian/Designee audits to be by Administrator weekly times 4 weeks then every 2 (two) weeks 4(four). "Results will be reviewed and the second seco	I delivery. reviewed I (four) s times
				discussed in the monthly Qualit Assurance Performance Improv Committee meetings. The Qua Assurance Committee will asse modify the action plan as neede ensure continued compliance.	y /ement lity ss and

Event ID: 7T1611

Facility ID: 923206

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345349	B. WING				C 102/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	0
WOODBU	RY WELLNESS CENTER	INC		2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 812 SS=F		ore/Prepare/Serve-Sanitary 2)	F	812			3/28/23
	§483.60(i) Food safet The facility must -	y requirements.					
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	ed satisfactory by federal, es. bod items obtained directly subject to applicable State alations. s not prohibit or prevent roduce grown in facility ompliance with applicable					
	serve food in accorda standards for food se This REQUIREMENT by:				Tag F812 Food Procurement,		
	record review, the fac remove leftover food a kitchen walk-in refrige leftover food in 2 of 3 nourishment room ref Findings included: 1. A tour was conduct with the Dietary Mana refrigerator. Observat opened bag of sliced	ility failed to date and stored for use in one of one erator and failed to discard (100 hall and 200 hall)			Store/Prepare/Serve Preparation and submission of this plat correction is in response to the CMS F 2567 from the 03/02/2023 survey. It do not constitute an agreement or admiss by Woodbury Wellness Center of the tr of the facts alleged or of the correctness of the conclusions stated on the statem of deficiency. The facility reserves all rights to contest the deficiencies, findin conclusions, and actions of the Agency This Plan of Correction (and the attach	orm bes ion uth ss nent gs, 4.	
	date.				documents) also functions as the facility s credible allegation of		

Event ID: 7T1611

Facility ID: 923206

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345349					E CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING			C 03/02/2023			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			00.02.2020	
		_		27	78 COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	RINC		HA	AMPSTEAD, NC 28443			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 812	Continued From pag	o 24		312				
1 012								
		on 2/27/23 at 10:05 AM, the cated he was told he did not			compliance.			
	have to label cheese				# 1 - Address how corrective action	will be		
					accomplished for those residents for			
	During an interview o	on 3/1/23 at 11:40 AM, the			have been affected by the deficient			
		ager revealed opened			practice;			
		ted and thrown away by the			" On 2/27/23 observed items sto	red		
	discard date.				without a date in kitchen walk-in			
	During an interview o	on 3/1/23 at 3:40 PM, the			refrigerator were discarded by Dieta Manager	ary		
	-	ed the Dietary Manager was			" On 2/27/23, observed opened	items		
		toring the kitchen walk-in			and containers of food in Long Tern			
	cooler.				(100 Hall) nourishment room refrig			
					and Rehab (200 Hall) nourishment	room		
		the nourishment room			refrigerator that were not properly			
		instruction for all items			labeled, dated or were expired to in			
		ator to be labeled with the om number, and will be			any labeled items beyond 72 hours days) were discarded by Dietary Ma			
	discarded in 72 hours				days) were discarded by Dietary in	anager.		
	A tour was conducted	d on 2/27/23 at 4:20 PM with			# - 2 Address how the facility will id	entify		
		of the facility 's nourishment			other residents having the potential	to be		
		refrigerator revealed an			affected by the same deficient prac			
		with no date. The 200-hall			" On 2/27/23 audit completed, a	-		
		a plastic container of			other items stored without a date in			
	•	2/21/23, an opened container ited 2/23/23, and a plastic			kitchen walk-in refrigerator were discarded by Dietary Manager			
	container of cheesec	-			" On 2/27/23, audit completed of	of all		
					nourishment room refrigerators and			
	During an interview o	on 2/27/23 at 4:25 PM, the			opened items and containers of foo	•		
		ealed his staff monitored the			were not properly labeled, dated or			
		carded expired foods. He			expired to include any labeled items			
	in the refrigerator.	e foods could have been left			beyond 72 hours (3 days) were disc by Dietary Manager.	carded		
	-	on 3/1/23 at 3:40 PM, the			# -3 Address what measures will be	•		
		ed that the unit managers			into place or systemic changes mad			
		ment room refrigerators daily ager monitors weekly. She			ensure that the deficient practice w recur;			

Facility ID: 923206

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2023 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345349		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED	
		B. WING		C 03/02/2023				
NAME OF PROVIDER OR SUPPLIER WOODBURY WELLNESS CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE			03/02/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	AMPSTEAD, NC 28443 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 812	was unsure how the	e 25 foods could have been left in n refrigerators past 3 days.	F	812	 Food Service Director verbally Inserviced on proper food storage/labe by Facility Dietary Services Vendor Regional Director/Administrator on 02/27/2023 . Food Service Director Inserviced Labeling and Prescribed Snack and Nourishment Policies, to include Label Dating, Storage, Discarding of food its in Kitchen and Nourishment Room refrigerators, by Facility Dietary Service Vendor Regional Director/Administrato 03/20/2023 All facility Dietary Service Vendor assigned to this location will be inservi on Labeling and Prescribed Snack and Nourishment Policies, to include Label Dating, Storage, Discarding of food its in Kitchen and Nourishment Room refrigerators, by Food Service Director/Designee by 03/22/2023. Any staff not inserviced by this date will be inserviced by the start of their next schedule shift. All newly hired staff of Facility Die Service Vendor assigned to this location after 03/22/2023 will be inserviced on Labeling and Prescribed Snack and Nourishment Policies, to include Label Dating, Storage, Discarding of food its in Kitchen and Nourishment Room refrigerators, during onboarding orientation process by Food Service Director/Designee. All nursing staff will be inserviced Labeling, Dating, Storage, Discarding food items in Nourishment Room refrigerators by SDC/Designee by 03/22/2023. Any staff not inserviced by 	on ling, ems ces or on staff ced d ling, ems / tary on ling, ems		

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Facility ID: 923206

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/202 MAPPROVEI D. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING				C /02/2023
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBURY WELLNESS CENTER INC				2778 COUNTRY CLUB DRIVE			
WOODBO	RI WELLNESS CENTER			H	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From page	225 2	F	812	this date will be inserviced by the star their next schedule shift. " All newly hired staff after 03/22/2 will be inserviced on Labeling, Dating. Storage, Discarding of food items in Nourishment Room refrigerators durir onboarding orientation process by Fo Service Director/Designee. # - 4 Indicate how the facility plans to monitor its performance to make sure solutions are sustained; and include of when corrective action will be comple " Audit Tool Developed by Administrator on 03/22/2023 for auditi of proper food storage in kitchen and nourishment room refrigerators. " Registered Dietitian inserviced on newly developed Audit Tool by Facility Dietary Services Vendor Regional Director/Administrator on 03/22/2023 with implementation. " Effective week of 03/22/2023 Registered Dietitian/Designee will cor audit of all Kitchen and Nourishment Room refrigerators 4 times weekly tim (two) weeks, then 3 times weekly tim (two) weeks and weekly thereafter. " Results of Registered Dietitian/Designee audits to be review by Administrator weekly times 4 (four) weeks then every 2 (two) weeks times 4(four). " Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvemen Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to	023 ng od that dates ted. ing m / , nduct nes 2 nes 2 ved) s	

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If continuation sheet Page 27 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 345349 B. WING 03/02/2023	EDICARE & MEDICAID SERVICE	FORM APPROVED OMB NO. 0938-0391					
345349 B. WING 03/02/2023	CIES (X1) PROVIDER/SUPPLIE	NCIES (X1) PROVID	/SUPPLIER/CLIA (X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345349		345349 B. WING				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	SUPPLIER	R SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBURY WELLNESS CENTER INC 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	ESS CENTER INC	NESS CENTER INC					
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION 	ACH DEFICIENCY MUST BE PRECEDED BY	EACH DEFICIENCY MUST BE PR	EDED BY FULL PREF	X (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	SHOULD BE COMPLETION		
F 812 Continued From page 27 F 812 ensure continued compliance.	d From page 27	led From page 27	F	812			

Event ID: 7T1611

Facility ID: 923206

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