	-	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345054	B. WING		C 04/24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/24/2024
10 4112 01 11				1150 PINE RUN DRIVE	
WOODHA	VEN NURS & ALZHEIME	R'S C		LUMBERTON, NC 28358	
(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 APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 00	0	
	A complaint investiga from 04/23/24 throug #Q6U211.	tion survey was conducted n 04/24/24. Event ID			
	The following compla investigated: NC002 NC00215601, NC002	14207, NC00213579,			
	1 of the 10 complaint deficiency.	allegations resulted in			
F 745 SS=E	Provision of Medically	Related Social Service	F 74	5	5/8/24
	maintain the highest p and psychosocial well This REQUIREMENT by: Based on observatio physician interviews to resident had transport appointment that was The appointment on the transportation p	ial services to attain or bracticable physical, mental I-being of each resident. is not met as evidenced ins, record review, staff and he facility failed to ensure a tation for a neurology scheduled on 10/03/2023. 10/03/23 was canceled due provider being unavailable uled until 03/19/24 for 1 of 1		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or wi take the actions set forth in this plan of correction. The plan of correction constitutes the facility □s allegation of	d do ill of
	Findings included: Resident #2 was adm	hitted to the facility on		compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
	11/29/22. Diagnoses	included spinal stenosis of urogenic claudication		F745	
	(compression on spin impaired blood flow),	al nerves caused by weakness of lower		 Address how corrective action wi accomplished for those residents four 	
	extremity, and leg spa	351115.		have been affected by the deficient practice;	
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				05/08/2024

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.

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
						С
		345054	B. WING		04	1/24/2024
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODHA	VEN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE		
nooblia				LUMBERTON, NC 28358		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 745	Continued From page	a 1	F 74	5		
1 / 10		et quarterly assessment	F 74	3		
	dated 04/07/24 revea			Resident #2 admitted to facility o	n -	
		demonstrated no behaviors.		11/29/22. Resident #2 cognitive		
		to both sides to lower		had an appointment on 10/03/23		
		always incontinent of bowel		neurology appointment. The app		
		quired extensive assistance		for 10/03/23 was cancelled due t		
	with one staff physica			transportation provider being una	available.	
	mobility and all other	activities of daily living; and		On 3/19/24 when the appointme	nt miss	
	two staff physical ass	sistance with transfers.		was identified, the physician was	s made	
				aware and a referral was sent to		
		ian orders in the facility's		new appointment on 3/19/2024 a		
		dical record revealed there		appropriate follow ups were initia		
		llow up appointment for		Review of resident s chart com		
	neurology for Resider	nt #2.		4/24/24 to identify any other miss appointments for identified reside		
	A Physician's order w	ritten on 03/19/24 revealed		other missed appointments were		
	an order for a referral			for this resident.	lacitilica	
	An interview with Res	sident #2 on 04/23/24 at				
	12:15 PM revealed sl	he had been at the facility		" Address how the facility will	identify	
	since 11/30/22 and sl	he had an appointment with		other residents having the poten	tial to be	
	a neurosurgeon in Ja	-		affected by the same deficient pr	actice;	
		a follow up appointment with				
		vas scheduled on 10/03/23		All residents with missed appoint		
		. She stated she was still		have the potential to be affected	-	
	waiting for this appoir	ntment.		alleged deficient practice. On 5/2		
	An interview was con	ducted with the		administrator began a review of a residents admitted prior to Decer		
		linator on 04/24/24 at 9:18		2023 to identify any missed refer		
		tion Coordinator stated she		October 2023 and November 20		
		ambulatory residents or		findings included zero missed re		
	-	a wheelchair. She stated		ordered. This was completed on		
		ort residents who used a				
	-	Resident #2 required a		On 5/6/24 the administrator bega	an to	
		her. She stated back in		review scheduler calendars for C		
		ility was using Robeson		2023 and November 2023 to ide	-	
		cy transport for residents		scheduled appointments and ass		
		insferred with a stretcher.		appointment was completed or c		
	The Transportation C	oordinator stated the		This was completed on 5/6/24.	3 of 48	

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	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		0.4505.4	D WING		С
		345054	B. WING		04/24/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODHA	VEN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE COMPLÉTI	
F 745	Continued From page	2	F 74	5	
F 745	neurology appointme scheduled for 10/03/2 Coordinator stated th Non-emergency trans up that day and wher was told they had no Resident #2 to her ap Transportation Coord the appointment was because it had fallen did not follow up until Manager (manager o that Resident #2 need appointment. The Tra- stated on 03/19/24 sh Health Information M needed to have a foll neurologist reschedu Coordinator stated sh and was told since Re for the appointment in referral was needed for Transportation Coord the referral on 03/19/20 neurologist's office or by the neurology office would have to review they were not booking December 2024 or th 2025. The Transport was waiting for a call	nt for Resident #2 was 23. The Transportation e Robeson County sport company did not show in she called to inquire, she staff available to transport opointment. The inator stated it was her fault not scheduled at that time through the cracks and she the Health Information f medical records) told her ded a neurology ansportation Coordinator ne was informed by the anager that Resident #2 ow up appointment with the led. The Transportation ne called the neurology office esident #2 did not show up n October 2023, a new from the physician. The inator stated she obtained 24 and faxed it to the n 03/21/24 and she was told are staff that the provider the referral but at this time g out appointments until e beginning of January ation Coordinator stated she back from the neurology nent date and she relayed	F 74	 appointments were identified to habeen rescheduled that were cancernany reason besides provider direct Residents with missed appointmereviewed by the Director of Nursin Administrator, and Medical Director 5/7/24 to ensure there were no ide concerns or need for clarification is to ensure optimal care received d that time to include not limited to: pharmacological, skin/wound nee The results included: One appoint was rescheduled on 5/7/24 with th consulting physician and appt mat 5/20/24; One appointment had be addressed via new referral sent to appropriate discipline on 3/19/24; appointment was not rescheduled resident has follow up appointmer 5/20/24 with a provider related to diagnosis pertinent to missed appointments, no harm or in treatment regimen is noted. N corrective action, other than resch of the missed appointment, was warranted. The Transportation Coordinator w any missed appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director of the appointment to the att of the Administrator and Director o	elled for tive. nts were ng, or on entified in orders uring medical, ds. ment he de for een o One as nt medical h the 3 change o neduling ill bring tention of
	Information Manager The Health Information	ducted with the Health on 04/24/24 at 2:00 PM. on Manager stated she was ember with the Department		missed. In addition, appointments discussed during the Monday □ F inter-disciplinary stand-up meeting including missed appointments, re and reschedule date to identify ar	riday J eason,

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		MEDICAID SERVICES				<u>OMB NO</u> T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G			C
		345054	B. WING				_ 24/2024
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 04/	24/2024
					50 PINE RUN DRIVE		
WOODHA	VEN NURS & ALZHEIME	ER'S C			IMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 745	Continued From page	e 3	F 74	45			
	never went to her ap				be affected by a missed appointment.		
		er 3, 2023. The Health			" Address what measures will be pu	.+	
		stated she went to the linator and let her know that			" Address what measures will be pu into place or systemic changes made to		
	the appointment need				ensure that the deficient practice will no		
					recur;		
	An interview was cor	nducted with the facility			,		
	Physician on 04/24/2	4 via phone at 2:30 PM. The			Based on the findings of the root cause	e	
	Physician reported sl	he was not made aware of			analysis, the facility has revised the		
		ent on 10/03/23 because			transportation/appointment process. C		
		sician at that time. She			5/07/2024, the Administrator and/or SE		
	stated she became a			began in-servicing all QA team membe	ers,		
	appointment when a			nurse leadership, facility transporter,			
	03/19/24. The Physic			licensed nurses to include agency			
		ortation Coordinator to ent's appointment with the			licensed nurses on the Transportation/Appointment process.		
		as the other appointment was			This training will include all current staf	f	
	-	an stated Resident #2 has			including agency. This training include		
		mission to the facility and			- Appointment Procedure	a.	
		nge in her condition. She			- Transportation aide duties and		
	stated she would like				responsibilities		
	evaluated by the neu	rologist as recommended			- Nurse duties related to appointme	nts	
	but felt the delay in th	ne follow up appointment with			and transportation		
	the neurologist has n	ot made her condition			- Clinical Team responsibilities relate	ed	
	worse.				to appointments and transportation - Medical Record duties related to		
	An interview was cor	ducted with the			appointments and transportation		
		24/24 at 2:50 PM. The					
		she was aware of the			The Administrator and/or Director of		
		e pending appointment for			Nursing will ensure that any of the abo	ve	
	Resident #2 and she				identified staff who does not complete		
	surrounding neurolog	gists to see if she could have			in-service training will not be allowed to	b	
		ed sooner. The Administrator			work on 5/9/24 or until the training is		
		an of correction in place as a			completed.		
		sed appointment back in					
		new process had been			Should a resident miss a doctor⊡s		
		dministrator stated in their			appointment the Transportation		
		n the facility had only gone			Coordinator will immediately notify the	na	
	DACK 30 DAYS TO FEVIE	ew missed appointments and			Administrator and the Director of Nursi	ng, I	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		345054			04/24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 PINE RUN DRIVE	
WOODHA	VEN NURS & ALZHEIME	R'S C		LUMBERTON, NC 28358	
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
F 745	Continued From page	e /	F 74		
F 740	therefore, the missed #2 was not recognize Robeson County Tra- used by the facility du the facility had signed transport company w capable of transportin required a stretcher. The facility provided medically related soc compliance date of 0 action plan was not a Survey Agency for th the Department of Soc facility Resident #2 h neurology appointme 10/03/23. Prior to 03/ identified the deficient corrective action plan	a appointment for Resident ad. Additionally, she added insport was no longer being ue to their unreliability and d a contract with another ho has been reliable and ng our residents who a corrective action plan for tial services with a 1/11/24. This corrective acceptable to the State is deficiency. On 3/19/24, tocial Services notified the ad not attended her and not attended her and that was scheduled for (19/24, the facility had not at practice for Resident #2. A m with all required developed to address this		 and reschedule for the next available appointment explaining the reason (i follow-up, initial, post-operative, etc.) the missed appointment to the physic office scheduler. The Unit Manager also follow-up with the physician is of for any further orders until the rescheduled appointment date; and communicate the rescheduled appointment to the facility medical director and resident/family. This follow-up will be documented and arr orders will be communicated and followed. The Unit Manager will be a resource for the Transportation Coordinator in re-scheduling appointments. Doctor is appointments are discussed during the Monday inter-disciplinary stand-up meeting including missed appointments, reas and reschedule date to identify any residents that may have the potentia be affected by a missed appointment The facility has a signed contract with BARTs Transportation and Buies Ca Transport. The facility has a new sig contract with Global Transportation f wheelchair and stretcher transports. facility no longer uses NETS (Non-Emergency Transportation System) Indicate how the facility plans to monitor its performance to make sur solutions are sustained; 	i.e.) for cian rwill office ny new a ed son, ll to t. h re gned or The stem).

Facility ID: 923461

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/10/20 FORM APPROV OMB NO. 0938-03	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345054	B. WING		C 04/24/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODHA	/EN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC	
F 745 F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(c)(d)(ent Activities	F 74	 The Administrator and/or design monitor tag F745 for appointment transportation cancellations were weeks and monthly for 3 monther resolved. Reports will be preserved. Reports will be preserved weekly Quality Assurance coment the Administrator to ensure control action initiated as appropriate. Compliance will be monitored at ongoing auditing program revieweekly Quality Assurance Meetweekly QA Meeting is attended. Administrator, Director of Nurst Coordinator, Therapy, Health I Manager, and the Dietary Dire " Date of Compliance The facility is compliant on Mathematication beyond this date to entrol on the source. 	ents and eekly for 3 hs or until ented to the mittee by rrective and ewed at the eting. The d by the ing, MDS nformation ctor.	
	§483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monito	eedback, data systems and sh and implement written				
	systems to obtain and	maintenance of effective d use of feedback and input other staff, residents, and				

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NC	0: 05/10/2024 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			SURVEY LETED
		345054	B. WING		_		24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WOODHA	VEN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE	8		
(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 867	information will be use are high risk, high vol opportunities for impre- §483.75(c)(2) Facility systems to identify, cc information from all de not limited to the facili §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methode development, monitor §483.75(c)(4) Facility including the methode systematically identify analyze and use data adverse events in the facility will use the data prevent adverse events §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad	res, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will <i>x</i> , report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained.	F 867				

If continuation sheet Page 7 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/10/2024 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345054	B. WING		_		C 24/2024
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WOODHA	VEN NURS & ALZHEIME	R'S C		150 PINE RUN DRIVE .UMBERTON, NC 28358	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	will be designed to eff level to prevent qualit safety problems; and (iii) How the facility will of its performance im- ensure that improvem §483.75(e) Program a §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track n resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha	causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or all monitor the effectiveness provement activities to hents are sustained. activities. clility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. hance improvement hedical errors and adverse /ze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility	F 867				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/10/2024 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345054	B. WING				C / 24/2024
NAME OF PR	ROVIDER OR SUPPLIER		-	S	IREET ADDRESS, CITY, STATE, ZIP CODE		
				11	50 PINE RUN DRIVE		
WOODHA	VEN NURS & ALZHEIME	RSC		L	UMBERTON, NC 28358		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 867	Continued From page collection and analysi (c) and (d) of this sect §483.75(g) Quality as §483.75(g)(2) The qua assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to mak This REQUIREMENT by: Based on observation and physician intervie Assurance and Perfor Program (QAPI) failed procedures and moniti committee put into pla investigation on 12/15	e 8 s described in paragraphs tion. sessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its uplementation of the QAPI er paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including he QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced hs, record review and staff twy, the facility ' s Quality mance Improvement d to maintain implemented tor interventions that the ace following a complaint 5/23. This was for 1 iginally cited in the area of		867	DEFICIENCY) The statements made on this plan of correction are not an admittance to a do not constitute an agreement with alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or y take the actions set forth in this plan correction. The plan of correction	f and the vill of	
		on the current complaint //24. The continued failure			constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will l		
	during 2 surveys of re	cord shows a pattern of the ustain an effective Quality			corrected by the dates indicated.		
	Findings included: This tag is cross refer	enced to:			 Address how corrective action v accomplished for those residents for have been affected by the deficient practice; 		
	This lay is closs relef						

Facility ID: 923461

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING	3	C
		345054	B. WING		04/24/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODHA	VEN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE LUMBERTON, NC 28358	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	Continued From page	9 9	F 86	57	
	staff and physician internet of the state of	nt that was scheduled on bintment on 10/03/23 was ransportation provider being not rescheduled until sidents reviewed (Resident vestigation on 12/15/23, the e a resident had ements for initial htment with the Orthopedic 3, resulting in the resident e Orthopedic Surgeon until /17/23 orthopedic surgeon identified with a wound on peared necrotic (dead , and the skin around it a bruise. ducted with the 24/24 at 2:45 PM. The when the facility did their tag F745 from 12/15/23, as far as 30 days to review missed appointments. She he back further, they would esident #2 missed her		 Facility failed to ensure a resident had transportation for a neurology appointment on 10/03/23. The appointment was rescheduled on 3/19 when facility became aware of the mise appointment. No plan of correction wimplemented when the missed appointment was identified. Review or resident's chart completed on 4/24/24 identify any other missed appointments were identified. The face immediately reviewed the complaint investigation from 12/15/23 and the subsequent recitation on 4/24/24. The specific deficiency in the area of mediarelated social services was identified analyzed. Address how the facility will ident other residents having the potential to affected by the same deficient practice. The facility conducted a detailed root cause analysis to understand why the implemented procedures were not maintained and why the monitoring of interventions was not effectively done. The team did not audit a full month of October 2023 and November 2023. team did not complete a new plan of correction when the October 2023 mis appointment was identified in March 2 	9/24 ssed as f to ts ed ility e cally and ify be e; e; f ring For The ssed

Facility ID: 923461

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/10/202 DRM APPROVE NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED	
		345054	B. WING				C 04/24/2024	
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODHA	VEN NURS & ALZHEIME	R'S C		1150 PINE RUN DRIVE LUMBERTON, NC 28358				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 10	F	867	The facility reviewed all resider to identify if any other residents potentially affected by the same 5/2/24, the administrator begar of all residents admitted prior to December 2023 to identify any referrals during October 2023-1 2023. This was completed on Zero missed referrals were not On 5/6/24 the administrator begar October 2023 and November 22 identify all scheduled appointm assess if appointment was com cancelled. This was completed Residents with missed appoint reviewed by the Director of Nur Administrator, and Medical Dire 5/7/24 to ensure there were no concerns or need for clarification to ensure optimal care received that time to include not limited pharmacological, skin/wound m The Transportation Coordinato any missed appointment to the of the Administrator and Director Nursing on the day the appoint missed. In addition, appointment discussed during the Monday - inter-disciplinary stand-up meet including missed appointments and reschedule date to identify residents that may have the po be affected by a missed appoint	s were e issue. On n a review o missed November 5/6/24. ed. gan to s for 2023 to nents and npleted or l on 5/6/24. ments were rsing, ector on o identified on in orders d during to: medical, needs. r will bring e attention or of tment is ents will be - Friday tting s, reason, r any otential to		
					Address what measures w	/ill be put		
RM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: Q6	11211	Fac	cility ID: 923461	If continuation a	heet Page 11 o	

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/10/202 RM APPROVEI NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345054	B. WIN	G		o	4/24/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN NURS & ALZHEIME			11	150 PINE RUN DRIVE		
WOODHA	VEN NORS & ALZHEIME			L	UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 867	Continued From page	e 11		= 867	into place or systemic changes i ensure that the deficient practice recur; Based on the findings of the roo analysis, the facility will revise its procedures to ensure that they a effectively implemented and mo This may include additional train staff, improved documentation, a frequent monitoring. Audit tools been revised to ensure complian F745. On 5/07/2024, the Administrator SDC began in-servicing all QA to members, nurse leadership, faci transporter, licensed nurses to in agency licensed nurses on the r Transportation/Appointment pro Administrator and/or Director of will ensure that any of the above staff who does not complete the training will not be allowed to wo 5/9/24 or until the training is com On 5/07/2024, the Administrato SDC began in-servicing Adminis and Quality Assurance team on events, how to respond to adver reporting adverse events, correct action of adverse events, and m risk. This was completed on 5/8	e will not t cause s are nitored. ning for and more have nce of and/or eam ility nclude revised cess. The Nursing e identified in-service ork on npleted. r and/or stration adverse rse events, ctive inimizing	
					 Indicate how the facility plan monitor its performance to make 		
RM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: Q6L	1211	Fac	cility ID: 923461	If continuation sh	aat Paga 12 o

Facility ID: 923461

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING		COMPLETED	
		345054	B. WING		C 04/24/2024	
NAME OF PROVIDER OR SUPPLIER			I			
				1150 PINE RUN DRIVE		
WOODHA	VEN NURS & ALZHEIME	R'S C		LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLETION ICED TO THE APPROPRIATE DATE	
F 867	Continued From page 12		F 867			
				solutions are sustained;		
				The facility will strengthen its Qua Assurance and Performance Improvement (QAPI) program. The committee will regularly review the effectiveness of the revised polici procedures and make necessary adjustments. The facility will put in monitoring system through audits ensure ongoing compliance. This include regular audits, feedback f residents and staff, and review of and trends. The Administrator and/or designe	e QAPI e es and n place a to will rom data	
				monitor appointments and transpic cancellations weekly for 3 weeks monthly for 3 months or until reso Reports will be presented to the v Quality Assurance committee by t Administrator to ensure corrective initiated as appropriate. Complian be monitored and ongoing auditin program reviewed at the weekly of Assurance Meeting. To remain in compliance for F867, QAPI team monitor audits, discuss findings, a implement new plan of correction process has failed.	ortation and lived. veekly the action ace will g Quality will and	
				Date of Compliance		
				The facility is compliant on May 8 The facility will continue to monito situation beyond this date to ensu ongoing compliance.	or the	

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DEPART CENTER	FOR	D: 05/10/2024 M APPROVED O. 0938-0391					
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345054	B. WING		C 04/24/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			-	
WOODHA	VEN NURS & ALZHEIME	R'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358				
PREFIX (EACH DEFICIENCY MU		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	IOULD BE COMPLETION		

Event ID: Q6U211

Facility ID: 923461

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