STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 04/23/24 through 04/24/24. Event ID #Q6U211. The following complaint intakes were investigated: NC00214207, NC00213579, NC00215601, NC00216048 1 of the 10 complaint allegations resulted in deficiency.	F 000		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews the facility failed to ensure a resident had transportation for a neurology appointment that was scheduled on 10/03/2023. The appointment on 10/03/23 was canceled due to the transportation provider being unavailable and was not rescheduled until 03/19/24 for 1 of 1 residents reviewed (Resident #2). Findings included: Resident #2 was admitted to the facility on 11/29/22. Diagnoses included spinal stenosis of lumbar region with neurogenic claudication (compression on spinal nerves caused by impaired blood flow), weakness of lower extremity, and leg spasms.	F 745	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F745 " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	5/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/08/2024

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F 745	Continued From page 1 The Minimum Data Set quarterly assessment dated 04/07/24 revealed Resident #2 was cognitively intact and demonstrated no behaviors. She had impairment to both sides to lower extremities and was always incontinent of bowel and bladder. She required extensive assistance with one staff physical assistance with bed mobility and all other activities of daily living; and two staff physical assistance with transfers. Review of the physician orders in the facility's current electronic medical record revealed there was no order for a follow up appointment for neurology for Resident #2. A Physician's order written on 03/19/24 revealed an order for a referral to the Neurologist. An interview with Resident #2 on 04/23/24 at 12:15 PM revealed she had been at the facility since 11/30/22 and she had an appointment with a neurosurgeon in January 2023 with a recommendation for a follow up appointment with a neurologist which was scheduled on 10/03/23 that never happened. She stated she was still waiting for this appointment. An interview was conducted with the Transportation Coordinator on 04/24/24 at 9:18 AM. The Transportation Coordinator stated she was able to transport ambulatory residents or residents who utilized a wheelchair. She stated she could not transport residents who used a stretcher and stated Resident #2 required a transporter via stretcher. She stated back in October 2023 the facility was using Robeson County non-emergency transport for residents who needed to be transferred with a stretcher. The Transportation Coordinator stated the	F 745	Resident #2 admitted to facility on 11/29/22. Resident #2 cognitively intact had an appointment on 10/03/23 for a neurology appointment. The appointment for 10/03/23 was cancelled due to transportation provider being unavailable. On 3/19/24 when the appointment miss was identified, the physician was made aware and a referral was sent to make a new appointment on 3/19/2024 and appropriate follow ups were initiated. Review of resident□s chart completed on 4/24/24 to identify any other missed appointments for identified resident. No other missed appointments were identified for this resident. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with missed appointments have the potential to be affected by the alleged deficient practice. On 5/2/24, the administrator began a review of all residents admitted prior to December 2023 to identify any missed referrals for October 2023 and November 2023. The findings included zero missed referrals as ordered. This was completed on 5/6/24. On 5/6/24 the administrator began to review scheduler calendars for October 2023 and November 2023 to identify all scheduled appointments and assess if appointment was completed or cancelled. This was completed on 5/6/24. 3 of 48	

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F 745	Continued From page 2 neurology appointment for Resident #2 was scheduled for 10/03/23. The Transportation Coordinator stated the Robeson County Non-emergency transport company did not show up that day and when she called to inquire, she was told they had no staff available to transport Resident #2 to her appointment. The Transportation Coordinator stated it was her fault the appointment was not scheduled at that time because it had fallen through the cracks and she did not follow up until the Health Information Manager (manager of medical records) told her that Resident #2 needed a neurology appointment. The Transportation Coordinator stated on 03/19/24 she was informed by the Health Information Manager that Resident #2 needed to have a follow up appointment with the neurologist rescheduled. The Transportation Coordinator stated she called the neurology office and was told since Resident #2 did not show up for the appointment in October 2023, a new referral was needed from the physician. The Transportation Coordinator stated she obtained the referral on 03/19/24 and faxed it to the neurologist's office on 03/21/24 and she was told by the neurology office staff that the provider would have to review the referral but at this time they were not booking out appointments until December 2024 or the beginning of January 2025. The Transportation Coordinator stated she was waiting for a call back from the neurology office for an appointment date and she relayed this information to the Administrator. An interview was conducted with the Health Information Manager on 04/24/24 at 2:00 PM. The Health Information Manager stated she was informed by a staff member with the Department of Social Services on 03/19/24 that Resident #2	F 745	appointments were identified to have not been rescheduled that were cancelled for any reason besides provider directive. Residents with missed appointments were reviewed by the Director of Nursing, Administrator, and Medical Director on 5/7/24 to ensure there were no identified concerns or need for clarification in orders to ensure optimal care received during that time to include not limited to: medical, pharmacological, skin/wound needs. The results included: One appointment was rescheduled on 5/7/24 with the consulting physician and appt made for 5/20/24; One appointment had been addressed via new referral sent to appropriate discipline on 3/19/24; One appointment was not rescheduled as resident has follow up appointment 5/20/24 with a provider related to medical diagnosis pertinent to missed appointment. After discussion with the medical director in regards to the 3 missed appointments, no harm or change in treatment regimen is noted. No corrective action, other than rescheduling of the missed appointment, was warranted. The Transportation Coordinator will bring any missed appointment to the attention of the Administrator and Director of Nursing on the day the appointment is missed. In addition, appointments will be discussed during the Monday □ Friday inter-disciplinary stand-up meeting including missed appointments, reason, and reschedule date to identify any residents that may have the potential to	

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F 745	Continued From page 3	F 745		

never went to her appointment that was scheduled on October 3, 2023. The Health Information Manager stated she went to the Transportation Coordinator and let her know that the appointment needed to be made.

An interview was conducted with the facility Physician on 04/24/24 via phone at 2:30 PM. The Physician reported she was not made aware of the missed appointment on 10/03/23 because she was not the physician at that time. She stated she became aware of the neurology appointment when a referral was requested on 03/19/24. The Physician stated she would have expected the Transportation Coordinator to reschedule the resident's appointment with the neurologist as soon as the other appointment was missed. The Physician stated Resident #2 has been stable since admission to the facility and has not had any change in her condition. She stated she would like to see this resident evaluated by the neurologist as recommended but felt the delay in the follow up appointment with the neurologist has not made her condition worse.

An interview was conducted with the Administrator on 04/24/24 at 2:50 PM. The Administrator stated she was aware of the estimated time of the pending appointment for Resident #2 and she was going to check surrounding neurologists to see if she could have Resident #2 evaluated sooner. The Administrator stated there was a plan of correction in place as a result of another missed appointment back in October 2023 and a new process had been implemented. The Administrator stated in their corrective action plan the facility had only gone back 30 days to review missed appointments and

be affected by a missed appointment.

" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Based on the findings of the root cause analysis, the facility has revised the transportation/appointment process. On 5/07/2024, the Administrator and/or SDC began in-servicing all QA team members, nurse leadership, facility transporter, licensed nurses to include agency licensed nurses on the Transportation/Appointment process. This training will include all current staff including agency. This training included:
- Appointment Procedure
- Transportation aide duties and responsibilities
- Nurse duties related to appointments and transportation
- Clinical Team responsibilities related to appointments and transportation
- Medical Record duties related to appointments and transportation

The Administrator and/or Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training will not be allowed to work on 5/9/24 or until the training is completed.

Should a resident miss a doctor□s appointment the Transportation Coordinator will immediately notify the Administrator and the Director of Nursing,

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F 745	Continued From page 4 therefore, the missed appointment for Resident #2 was not recognized. Additionally, she added Robeson County Transport was no longer being used by the facility due to their unreliability and the facility had signed a contract with another transport company who has been reliable and capable of transporting our residents who required a stretcher. The facility provided a corrective action plan for medically related social services with a compliance date of 01/11/24. This corrective action plan was not acceptable to the State Survey Agency for this deficiency. On 3/19/24, the Department of Social Services notified the facility Resident #2 had not attended her neurology appointment that was scheduled for 10/03/23. Prior to 03/19/24, the facility had not identified the deficient practice for Resident #2. A corrective action plan with all required components was not developed to address this deficient practice for Resident #2.	F 745	and reschedule for the next available appointment explaining the reason (i.e. follow-up, initial, post-operative, etc.) for the missed appointment to the physician office scheduler. The Unit Manager will also follow-up with the physician□s office 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 any new orders will be communicated and followed. The Unit Manager will be a resource for the Transportation Coordinator in re-scheduling appointments. Doctor□s appointments are discussed during the Monday □ Friday inter-disciplinary stand-up meeting including missed appointments, reason, and reschedule date to identify any residents that may have the potential to be affected by a missed appointment. The facility has a signed contract with BARTs Transportation and Buies Care Transport. The facility has a new signed contract with Global Transportation for wheelchair and stretcher transports. The facility no longer uses NETS (Non-Emergency Transportation System). " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 745	Continued From page 5	F 745	The Administrator and/or designee will monitor tag F745 for appointments and transportation cancellations weekly for 3 weeks and monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. " Date of Compliance The facility is compliant on May 8, 2024 The facility will continue to monitor the situation beyond this date to ensure ongoing compliance.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		5/8/24

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F 867	Continued From page 6	F 867		

resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to

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F 867	Continued From page 7	F 867		

determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data

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F 867	Continued From page 8 collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility ' s Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a complaint investigation on 12/15/23. This was for 1 deficiency that was originally cited in the area of medically related social services and was subsequently recited on the current complaint investigation on 04/24/24. The continued failure during 2 surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to:	F 867	The statements made on this plan of correction are not an admittance to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 867	Continued From page 9 F745: Based on observations, record review, staff and physician interviews, the facility failed to ensure a resident had transportation for a neurology appointment that was scheduled on 10/03/2023. The appointment on 10/03/23 was canceled due to the transportation provider being unavailable and was not rescheduled until 03/19/24 for 1 of 1 residents reviewed (Resident #2). During a complaint investigation on 12/15/23, the facility failed to ensure a resident had transportation arrangements for initial post-operative appointment with the Orthopedic Surgeon on 10/4/2023, resulting in the resident not being seen by the Orthopedic Surgeon until 11/17/2023. At the 11/17/23 orthopedic surgeon visit Resident #1 was identified with a wound on her right knee that appeared necrotic (dead tissue), black in color, and the skin around it appeared darker like a bruise. An interview was conducted with the Administrator on 04/24/24 at 2:45 PM. The Administrator stated when the facility did their plan of correction for tag F745 from 12/15/23, they only went back as far as 30 days to review for any residents with missed appointments. She stated if they had gone back further, they would have identified that Resident #2 missed her appointment in October 2023.	F 867	Facility failed to ensure a resident had transportation for a neurology appointment on 10/03/23. The appointment was rescheduled on 3/19/24 when facility became aware of the missed appointment. No plan of correction was implemented when the missed appointment was identified. Review of resident's chart completed on 4/24/24 to identify any other missed appointments for identified resident. No other missed appointments were identified. The facility immediately reviewed the complaint investigation from 12/15/23 and the subsequent recitation on 4/24/24. The specific deficiency in the area of medically related social services was identified and analyzed. • Address how the facility will identify other residents having the potential to be 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 during previous POC as it was a 30 review. For this review the administrator reviewed October 2023 and November 2023. The team did not complete a new plan of correction when the October 2023 missed appointment was identified in March 2024.	

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F 867	Continued From page 10	F 867	The facility reviewed all resident records to identify if any other residents were potentially affected by the same issue. On 5/2/24, the administrator began a review of all residents admitted prior to December 2023 to identify any missed referrals during October 2023-November 2023. This was completed on 5/6/24. Zero missed referrals were noted. On 5/6/24 the administrator began to review the scheduler calendars for October 2023 and November 2023 to identify all scheduled appointments and assess if appointment was completed or cancelled. This was completed on 5/6/24. Residents with missed appointments were reviewed by the Director of Nursing, Administrator, and Medical Director on 5/7/24 to ensure there were no identified concerns or need for clarification in orders to ensure optimal care received during that time to include not limited to: medical, pharmacological, skin/wound needs. The Transportation Coordinator will bring any missed appointment to the attention of the Administrator and Director of Nursing on the day the appointment is missed. In addition, appointments will be discussed during the Monday – Friday inter-disciplinary stand-up meeting including missed appointments, reason, and reschedule date to identify any residents that may have the potential to be affected by a missed appointment. • Address what measures will be put	

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F 867	Continued From page 11	F 867	into place or systemic changes made to ensure that the deficient practice will not recur; Based on the findings of the root cause analysis, the facility will revise its procedures to ensure that they are effectively implemented and monitored. This may include additional training for staff, improved documentation, and more frequent monitoring. Audit tools have been revised to ensure compliance of F745. On 5/07/2024, the Administrator and/or SDC began in-servicing all QA team members, nurse leadership, facility transporter, licensed nurses to include agency licensed nurses on the revised Transportation/Appointment process. The Administrator and/or Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training will not be allowed to work on 5/9/24 or until the training is completed. On 5/07/2024, the Administrator and/or SDC began in-servicing Administration and Quality Assurance team on adverse events, how to respond to adverse events, reporting adverse events, corrective action of adverse events, and minimizing risk. This was completed on 5/8/2024. • Indicate how the facility plans to monitor its performance to make sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 04/24/2024

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F 867	Continued From page 12	F 867		

solutions are sustained;

The facility will strengthen its Quality Assurance and Performance Improvement (QAPI) program. The QAPI committee will regularly review the effectiveness of the revised policies and procedures and make necessary adjustments. The facility will put in place a monitoring system through audits to ensure ongoing compliance. This will include regular audits, feedback from residents and staff, and review of data and trends.

The Administrator and/or designee will monitor appointments and transportation cancellations weekly for 3 weeks and monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. To remain in compliance for F867, QAPI team will monitor audits, discuss findings, and implement new plan of correction if process has failed.

- Date of Compliance

The facility is compliant on May 8, 2024
The facility will continue to monitor the situation beyond this date to ensure ongoing compliance.

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