PRINTED: 05/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		345478	B. WING _			C <b>05/03/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 604 LUCAS ROAD DUNN, NC 28334	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIA CIENCY)	DATE
F 000	INITIAL COMMENTS	3	F	000		
F 580 SS=D	conduct a complaint is 5/2/24. Additional info 5/3/24. Therefore, the changed to 5/3/24. (If The following intakes NC205175, NC 2159)  Past-noncompliance CFR 483.10 at tag FS "D"  CFR 483.25 at tag F "D"  One of the eleven allodeficiency. The facility 7/19/23.  Notify of Changes (In CFR(s): 483.10(g)(14)  §483.10(g)(14) Notified (i) A facility must immonsult with the resid consistent with his or representative(s) where (A) An accident involves a consistent with this or representative (s) where (b) A significant chand mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue.	were investigated: 17, NC203481, and 204884  was identified at: 580 at a scope and severity  684 at a scope and severity  egations resulted in a ty is in compliance effective  jury/Decline/Room, etc.)  (i)(i)-(iv)(15)  cation of Changes. rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to	F	580		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

05/09/2024

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.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345478	B. WING _			C 05/03/2024
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		00/00/2024
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informat	nsfer or discharge the ility as specified in ification under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2)	F 5	80		
	physician. (iii) The facility must resident and the resi when there is- (A) A change in roon as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must	lent rights under Federal or ons as specified in paragraph n. record and periodically mailing and email) and				
	that is a composite of §483.5) must disclosits physical configurationations that comprigant, and must speciform changes between the second changes are second changes.	posite distinct part. A facility istinct part (as defined in e in its admission agreement ation, including the various se the composite distinct fy the policies that apply to been its different locations				
	physician interview t physician when a res bruising in the rib are	riew, staff interview, and ne facility failed to notify the sident developed pain and ea following a fall. This was 2) of three sampled residents ruising. The findings		Past noncompliance: no plan correction required.	of	

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		345478	B. WING _			C <b>05/03</b> /	2024
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COL	 )E	03/03/	2027
				604 LUCAS ROAD			
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		DUNN, NC 28334			
(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 CC ( (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	_	(X5) COMPLETION DATE
F 580	Continued From page	e 2	F 5	580			
	11/2/23. The resider included dementia, p dorsalgia (back pain)  Resident # 2 had an Extra Strength 500 m day. This order origin  Resident # 2 also had Capsule Delayed rele	olyosteoarthritis, and order for Acetaminophen illigrams three times per					
	On 7/10/23 at 3:37 P the following informat Resident # 2 had bee and could not say ex- was assessed and fo bruises or skin tears. neurological checks was	M Nurse # 1 documented cion in a nursing entry. In found sitting on the floor actly what had occurred. She und to have no bumps, She denied pain. Her were within normal limits. Stable. The physician was ew orders.					
	cared for Resident # 7/10/23. Review of the the incident revealed noting the following in 7/10/23. She and and Resident # 2 to her coresident had no pain 1 further wrote, "A litt me know she was had breast area. I took [N it. It was red and look Nystatin powder on it	records, Nurse # 1 had 2 from 7 AM to 7 PM on e facility's investigation into a statement by Nurse # 1 nformation about the date of other nurse had assisted hair after the fall. The upon assessment. Nurse # le later [Nurse Aide # 1] let ving some pain under her urse # 2] and we looked at led yeasty. I put some . She didn't wince in pain or id 'Oh that feels better."					

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		345478	B. WING			C 05/03/2024		
	F PROVIDER OR SUPPLIER ETT WOODS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 604 LUCAS ROAD DUNN, NC 28334		13/03/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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)	N SHOULD BE	(X5) COMPLETION DATE		
F 580	1 had cared for Reson 7/10/23. Review written statement reinformation. She ha after the fall, and the a burning sensation looked and her skin raw." That was not (NA # 1) told the nu sort of powder on the have any further con NA # 1 was intervier reported the following Resident # 1 reportion Other than the burn not complain of any shift.  Nurse # 1 was intervaled and reported the following resident was not bruch assessed her on 7/10 redness that was not She had an order for (as needed) if she h	g records, Nurse Aide (NA) # ident # 2 from 7 AM to 7 PM of Nurse Aide (NA) # 1's ivealed the following d checked on Resident # 2 e resident had complained of under her left breast. She "looked like it was a little bit unusual for the resident. She rse, and the nurse put some he area. The resident did not implaints after that on her shift.  wed on 5/1/24 at 4:40 PM and ing information. She recalled ing it burned under her breast. ing under her breast, she did other pain on her 7/10/23  viewed on 5/2/24 at 1:10 PM lowing information. The uised or had pain when she 10/23. She did have some of bright red under her breast. or a powder to be used PRN had a yeast infection. She had cian on 7/10/23 when the the burning sensation under	F 5	,				
	Resident # 2 beginn AM on 7/11/23. Nur neurological checks at 8:24 PM, 7/10/23 11:26 PM, 7/11/23 a	ecords, Nurse # 3 cared for ning at 7 PM on 7/10/23 until 7 se # 3 documented were performed on 7/10/23 at 9:27 PM, and 7/10/23 at at 1:47 AM, and 7/11/23 at rological check noted the						

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	ROVIDER OR SUPPLIER WOODS NURSING ANI	O REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  604 LUCAS ROAD  DUNN, NC 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	resident had no apparature of the following information of the following i	iewed on 5/2/24 at 2:40 PM owing information. She did as of the shift which began on the resident had complained in, then she would have record. The resident etaminophen for generalized in the triangle of the saw the resident complained of the resident shall be resident to the latter of 7/11/23. NA # 2 wrote latter of 1/11/23. NA # 2 wrote latter o	F	580				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WING _			1	C <b>03/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		604 I	EET ADDRESS, CITY, STATE, ZIP CODE LUCAS ROAD IN, NC 28334	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 580	the bruising was, she back rib area. She a her breast which the issue than the bruise resident was hurting  Review of Nurse # 1 details of 7/11/23 revinformation. "On 7/1 the resident was have around 9 AM. I went resident and pressed breast. It was still repain when I pressed Powder on it. She go lunch. The CNA reposharp pain at 1 PM a supper. I went and c [she] denied pain who further wrote, "Other her breast that [NA # didn't have pain or s rolling in her wheeld!  During the interview 1:10 PM, Nurse # 1 have any excruciatin her on both 7/10/23 there was anything wrash under her breast which is the same than t	id not recall for sure where thought it had been on her so had some redness under NA thought was a different about the had told Nurse # 1 the in her ribs.  Is written statement about the realed the following 1/23 the CNA reported that ring pain under her left breast to the room to check the did the area under her left did and [Resident # 2] denied on it. I applied Nystatin at Tylenol in the AM and at orted resident was having and again sometime after checked her each time and then I pushed on it" Nurse # 1 than the yeast area under at 1] made me aware of she seem to be in pain. She was thair in the hall also."  With Nurse # 1 on 5/2/24 at reported the resident did not g pain when she checked and 7/11/23 to signal that wrong further than a yeast set. She had not observed injury and therefore had not	F	580	DEFICIENCY)		
	Resident # 2 from 7 Nurse # 4 document 7/12/23 at 1:49 PM t	records, Nurse # 4 cared for AM to 7 PM on 7/12/23. ed in a nursing entry on hat the resident complained t and was medicated with					

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		345478	B. WING _			1	03/ <b>2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 604 LUCAS ROAD DUNN, NC 28334	DDE		· · · · · · · · · · · · · · · · · · ·
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F 580	like area under the shimanipulated the resident grimace. Nurse # 2 would be asked to loo physician was next in continue to monitor the Resident # 2's Medicincluded a pain assess the times when the reactaminophen was Resident # 2's pain was AM, "6" at 12:00 PM.  Review of a written shrevealed the following Resident # 2 had when ormal pattern and diphysical therapist had an area on the resident he rib cage. She (Not look at the knot with a cyst below the skin)  Occupational therapist on 5/2/24 at 10:10 AM On 7/12/23 Resident working on reaching pain, and she (OT # 2 mass underneath the area. The resident washe did not raise the the area, but she reprourse. OT # 1 further with Resident # 2 the	the total state of the state of	F	580			

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	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 604 LUCAS ROAD DUNN, NC 28334	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	together on 5/1/24 a following information in pain when they che flank on 7/12/23. The saw. It looked like fathe physician that dathe p	e # 5 were interviewed t 4:00 PM and reported the n. Resident # 2 had not been necked the area on her left nere was no bruising they tty tissue and they did not call ny.  AM Nurse # 6 documented in Resident # 2 had no pain.  AM Nurse # 4 documented in Resident # 2 voiced no 7/10/23 fall.  PM Nurse # 4 documented in Resident # 2 was starting to bruising to her left rib area ained for an x-ray.  cility's physical therapy at 9:10 AM revealed the n. The PTA had worked with 8/23 and she had complained the PTA looked at the rib area uising. She alerted Nurse # 4.	F	580	EFICIENCY)		
	4:00 PM, Nurse # 4 the first time on 7/13 her attention. That we the physician about obtained for the first On 7/13/23 an x-ray showed "Acute appeared 5th ribs, with surthe left 6th rib." (An example of the first	with Nurse # 4 on 5/1/24 at reported she saw bruising for 1/23 when the PTA called it to 1/23 when she first talked to the bruising and orders were time to do an x-ray.  was done. The results earing fractures of the left 4th spicion of occult fracture of occult fracture is a hidden to the radiology report, the					

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	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS ROAD DUNN, NC 28334	1 33/33/2024
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 580	fractures were minimalignment).  Resident # # 2's phys 5/2/24 at 11:50 AM. It physician reviewed Noting Resident # 2 hmultiple times per da following the fall of 7/reported the nurses on 7/11/23 when NA 1 multiple episodes of treatment for the resistant to let them heal He (the physician) typacetaminophen in the codeine if the pain was following the identificacetaminophen was times per day on 7/13 discontinued, and shacetaminophen-code hours as needed for # 2's July 2023 Mediashe required three do dates of 7/14/23 to 7/continued to receive every day as original During an interview v 5/2/24 at 3:00 PM the facility had identified notification for Reside	sician was interviewed on During the interview, the IA # 2's written statement and complained of pain y on 7/11/23 (the day 10/23). The physician should have contacted him # 2 was reporting to Nurse # of pain. There was no dent's rib fractures other and offer pain medication. Dically liked to try to elderly but would use as severe.  Sident # 2's record revealed atton of the rib fractures her increased to 500 mg four 13/23. On 7/14/23 this was to was placed on the sident was placed on 8/24/21.  With the Administrator on the Administrator reported the sissues with physician the sident was placed a corrective and completed a corrective with completed a corrective and completed a corrective.	F 580		

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		345478	B. WING _		<del> </del>	1	03/2024
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER	,	STREET ADDRESS, 604 LUCAS ROAD DUNN, NC 2833			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	#2 was noted on the Geri-chair. The nurs was able to move all complaints of pain of has a history of fung breasts. Resident # dorsalgia (chronic bapolyosteoarthritis. Sorib fractures. She is Cymbalta daily and Sorib fractures. She is Cymbalta daily and Sorib fractures. The nurse as fungal rash under left was applied per wou protocol. Resident stand had no further comprovided incontinent for sleep with no condor burning on left breath and assessment inclures identify an assessment inclures identify and the provided incontinued under left applied per wound/sidentify approx. 12:30pm psych services who during psych assess provided scheduled	Resident Involved roximately 3:00pm Resident floor sitting in front of her e assessed resident who extremities and had no discomfort. Resident #2 all infections under her 2's diagnoses include tok pain) and he also has documented old currently on 60mg of 500mg of Extra Strength has proven to be effective.  5pm the CNA went to the teck on the resident. The urning sensation under left assessed the resident to find the breast and Nystatin powder and/skin standing order atted, "oh that feels better" tomplaints. The resident was care, dinner, and preparation applaints of pain, discomfort, the standing order atted. The nurse performed ding palpation of area and or discomfort. Redness breast and Nystatin powder kin standing order protocol. The resident was seen by noted unspecified mild pain	F	580			

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F 580	during incontinence of "sharp" rib pain. CNA nurse assessed resid denied pain. At appredinner tray arrived, a eat without complaint burning under left browning under	care, resident complained of A reported to nurse and lent's pain and resident ox. 4:30pm the resident's not resident sat up in bed to its of pain, discomfort, or east.  Toximately 12:30pm, the ited the area to left back and in assessment, the resident all nodule-like area. The inplaints of pain or discomfort odule-like area and nurse tty". The Resident continued medication with usual pain However, no pain increase orsalgia pain.  Typical therapist assisted did AM care and noted and resident complains of order for X-ray was lits revealed moderate appearing, minimally if lateral aspect of the left 4th is mild deformity of the lateral rib, which has the le healed fracture. On another the ingle in the	F	580		

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		345478	B. WING				03/2024
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		604	REET ADDRESS, CITY, STATE, ZIP CODE LUCAS ROAD NN, NC 28334	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 580	Potentially Impacted On 7/14/23, 100% at was completed by the residents with new bound of Nursing (DON) to exhibited a change in increased pain, and notified timely.  The Director of Nursiconcern identified dunotification of the phy Audit will be completed.  Measures put in Place Ensure the Deficient.  On 7/14/2023 an Ad Performance Improvattendance of the Ad Nursing, Regional Vicultical Consultant to Improvement Plan and place.  On 7/14/23, an in-see Administrative Nursir regarding Assessme Changes, and signs/nurses were educated any change in resided not limited to new bruafter a fall with docur record. In-service will	rrective Action Plan for Other Residents udit of non-alert residents e Unit Manager to identify all ruising, pain, or deformity.  gress notes for the last 14 by the Unit Manager/Director determine if a resident in condition, to include ensure the practitioner was sing will address all areas of tring the audit to include ysician for further instruction.	F	580			

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		15/03/2024
HARNETT	WOODS NURSING AND	REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	e 12	F 5	580		
		Notification of Changes. No 7/17/23 without receiving the				
	Sustained: IDT Team will review and pain assessment monthly x1 month to notified of changes in related to new bruisir Unit Managers will ac identified during the a the Notification Audit	Falls, Change of condition, as 5x/week x4 weeks then ensure the physician was a condition and changes ag, pain, and deformity. The address all areas of concern audit. The DON will review Tool weekly x4 weeks then ensure all areas of concern				
	Tools to the Executive Performance Improvementally for 2 months Committee will review Change of Condition trends and/or issues interventions put into need for further frequenced for further following actions:  Beginning on 5/1/24 of facility was made. Mulinterviewed and report for facility was made. Mulinterviewed and report for facility was made. Not a problem with the statement for facility for facility was made.	d Change of Condition Audit e Quality Assurance ement (QAPI) committee . The Executive QAPI v the Notification, Pain, and Audit Tools to determine that may need further place and to determine the ency of monitoring.  7/23 ve action was validated by at 9:05 AM a tour of the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE S COMPL	
		345478	B. WING _			05/0	; )3/2024
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP OF 604 LUCAS ROAD DUNN, NC 28334	CODE	0070	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	I .	(X5) COMPLETION DATE
F 580	review. These addition were notifying the physicondition arose with a The facility presented their inservice educate corrective action plant.	placed on a sample for nal reviews revealed staff ysician when a change in sampled residents.  I documented evidence of ion and audits per their	F 5	580			
F 684 SS=D	7/17/23 was validated Quality of Care CFR(s): 483.25  § 483.25 Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident residents received accordance with profession practice, the comprehencare plan, and the rest This REQUIREMENT by:  Based on record reviphysician interview the complete assessment 2 started complaining signs of bruising follow (Resident # 2) out of who sustained bruising findings included:	are Indamental principle that Int and care provided to Interest and care provided to Interest and care in Interest	F 6	Past noncompliance: no correction required.	plan of		
	Resident # 2 resided 11/2/23. The resider	at the facility from 6/1/21 to nt's diagnoses in part					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345478	B. WING			C NE/03/3034
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 604 LUCAS ROAD DUNN, NC 28334		05/03/2024
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Extra Strength 500 m day. This order origin Resident # 2 also ha Capsule Delayed relewhich originated on 8 antidepressant used  Resident # 2's quarte assessment, dated 7 as moderately cognit assessed to need exhygiene needs and to Resident # 2's care p was at risk for falls. The resident's care plant and remained as an as of 7/10/23.  On 7/10/23 at 3:37 Pethe following informate Resident # 2 had been and could not say exwas assessed and for bruises or skin tears neurological checks ther vital signs were sometified without any resident # 2 had been and could not say exwas assessed and for bruises or skin tears neurological checks the vital signs were sometified without any resident # 2 had been and could not say exwas assessed and for bruises or skin tears.	order for Acetaminophen nilligrams three times per nated on 1/13/23.  d an order for Cymbalta ease 60 milligrams daily 3/24/21. (Cymbalta is an at times to manage pain.)  erly Minimum Data Set //10/23, coded the resident ively impaired. She was also tensive assistance with her ransferring.  elan revealed the resident This had been added to the at her original admission date active part of her care plan  M Nurse # 1 documented tion in a nursing entry. en found sitting on the floor actly what had occurred. She and to have no bumps, She denied pain. Her were within normal limits. In the physician was new orders.	F 6	84		
	the incident revealed	ne facility's investigation into a statement by Nurse # 1 information about the date of				

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	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 604 LUCAS ROAD DUNN, NC 28334	DDE	03/03/2024	
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Resident # 2 to her classident had no pain 1 further wrote, "A little me know she was had breast area. I took [N it. It was red and look Nystatin powder on it anything. She just said According to staffing 1 had cared for Reside on 7/10/23. Review of written statement reveniformation. She had after the fall, and the aburning sensation used looked and her skin "I raw." That was not ure (NA # 1) told the nurse sort of powder on the have any further common NA # 1 was interviewed reported the following Resident # 1 reporting Other than the burning not complain of any of shift.  Nurse # 1 was interviewed and reported the following Resident was not bruis looked at her on 7/10 redness that was not	ther nurse had assisted hair after the fall. The upon assessment. Nurse # e later [Nurse Aide # 1] let ving some pain under her urse # 2] and we looked at ed yeasty. I put some . She didn't wince in pain or d 'Oh that feels better."  Tecords, Nurse Aide (NA) # lent # 2 from 7 AM to 7 PM f Nurse Aide (NA) # 1's ealed the following checked on Resident # 2 resident had complained of inder her left breast. She looked like it was a little bit insual for the resident. She e, and the nurse put some area. The resident did not plaints after that on her shift.  Ted on 5/1/24 at 4:40 PM and information. She recalled g it burned under her breast. It is gunder her breast, she did ther pain on her 7/10/23  Tewed on 5/2/24 at 1:10 PM wing information. The sed or have pain when she looked in powder to be	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345478	B. WING _			C <b>05/03/2024</b>	
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Resident # 2 beginni AM on 7/11/23. Nurs neurological checks at 8:24 PM, 7/10/23 11:26 PM, 7/11/23 at 5:32 AM. Each neuroresident had no apparatus # 3 was intervand reported the follonot recall the specific 7/10/23 at 7 PM. If the specifically of rib paid documented it in the routinely received ac pain.  On 7/11/23 the psychological point in the resident # 2, and the "mild pain."  Review of staffing recared for Resident # 7/11/23. Review of a revealed a written stoccurrences on the other following informatical point in the resident # 2 complained of p NA # 2 bathed and done Resident # 2 complained while being turned in 3 PM NA # 2 answer and the resident com At 6 PM Resident # 3 rolling over to her left.	cords, Nurse # 3 cared for ng at 7 PM on 7/10/23 until 7 e # 3 documented were performed on 7/10/23 at 9:27 PM, and 7/10/23 at 1:47 AM, and 7/11/23 at clogical check noted the arent distress.  iewed on 5/2/24 at 2:40 PM owing information. She did cs of the shift which began on the resident had complained in, then she would have record. The resident setaminophen for generalized the initiatric nurse practitioner inedical record she saw the resident complained of cords revealed NA # 2 had 2 from 7 AM to 7 PM on facility's investigative report attement by NA # 2 about the date of 7/11/23. NA # 2 wrote tion. At 9 AM Resident # 2 ain beneath her breast while	F	584			

AND DI AN OF CORRECTION INDENTIFICATION NUMBER		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345478	B. WING _			C 5/03/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 604 LUCAS ROAD DUNN, NC 28334	•	3/03/2024
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From p	page 17	F 6	584		
	and reported the for Resident # 2 complained of pair report where the parent where the parent where the bruising on her back rib ar under her breast different issue that Nurse # 1 the resident was laround 9 AM. I was resident and president and pain at 1 Pl supper. I went ar [she] denied pain further wrote in he yeast area under me aware of she in pain. She was hall also."  During the intervict 1:10 PM, Nurse # have any excrucia her on both 7/10/3 there was anything	iewed on 5/3/24 at 12:15 PM following. Every time she cared on 7/11/23 the resident in. She was alert enough to pain was and she would say, bad." She had some bruising the (NA#2) did not recall for sure grows, she thought it had been the as she also had some redness which the NA thought was a sin the bruise. She had told ident was hurting in her ribs.  # 1's written statement about the revealed the following for 11/23 the CNA reported that the having pain under her left breast the ent to the room to check the sed the area under her left red and [Resident # 2] denied the don it. I applied Nystatin the gets Tylenol in the AM and at the eported resident was having M and again sometime after and checked her each time and when I pushed on it." Nurse # 1 the statement, "Other than the her breast that [NA # 1] made didn't have pain or seem to be rolling in her wheelchair in the sew with Nurse # 1 on 5/2/24 at 1 reported the resident did not alting pain when she checked 23 and 7/11/23 to signal that any wrong further than a yeast the east. She had not identified the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345478	B. WING _			C 05/03/2024
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 604 LUCAS ROAD DUNN, NC 28334	DE	00/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	when she assessed  According to staffing Resident # 2 from 7 Nurse # 4 documen 7/12/23 at 1:49 PM of left side discomfo Tylenol. On 7/12/23 documented the reslike area under the smanipulated the resor grimace. Nurse # would be asked to lophysician was next continue to monitor  Resident # 2's Medi included a pain asset the times when the Acetaminophen was Resident # 2's pain 8 AM, "6" at 12:00 F  Review of a written revealed the following Resident # 2 had whormal pattern and physical therapist had an area on the resident erib cage. She (Nook at the knot with a cyst below the skillocupational therapon 5/2/24 at 10:10 Amonths.	Resident # 2.  grecords, Nurse # 4 cared for AM to 7 PM on 7/12/23. ted in a nursing entry on that the resident complained rt and was medicated with at 5:51 PM, Nurse # 4 ident had a very small knot skin below the rib cage. When ident did not complain of pain 4 further noted the physician pok at the area when the in the facility, and they would the resident.  Cation Administration Record resident's routine administered. On 7/12/23 was documented to be "0" at PM and "0" at 8 PM.  Statement by Nurse # 4 reginformation. On 7/12/23 reeled around as per her did not complain of pain. A read asked Nurse # 4 to look at tent's left lower back below lurse # 4) asked Nurse # 5 to her, and the area looked like in.	F6	84		
	or grimace. Nurse # would be asked to ke physician was next continue to monitor  Resident # 2's Medi included a pain asset the times when the Acetaminophen was Resident # 2's pain 8 AM, "6" at 12:00 F  Review of a written revealed the followin Resident # 2 had whormal pattern and physical therapist had an area on the resident # cyst below the skillocupational therapon 5/2/24 at 10:10 A On 7/12/23 Resident working on reaching	4 further noted the physician ook at the area when the in the facility, and they would the resident.  cation Administration Record essment was completed at resident's routine administered. On 7/12/23 was documented to be "0" at PM and "0" at 8 PM.  statement by Nurse # 4 and information. On 7/12/23 meeled around as per her did not complain of pain. A and asked Nurse # 4 to look at lent's left lower back below lurse # 4) asked Nurse # 5 to her, and the area looked like in.				

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		345478	B. WING _			C <b>05/03/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00:00:202:
				604 LUCAS ROAD		
HARNEII	WOODS NURSING AND	REHABILITATION CENTER		DUNN, NC 28334		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	area. The resident washe did not raise the inthe area, but she repondence. OT # 1 further with Resident # 2 the the resident had compound the reside	resident's clothing in the rib as in the gym and therefore resident's clothing to look at orted it to the resident's reported she had worked previous day (7/11/23) and plained of left sided pain.	F 6	84		
	regarding whether the resident's front side of and replied they had in bed at the time they were also interviewed been aware that NA # Nurse #1 on 7/11/23 in her ribs when they assessment of the kn was aware Resident as she had not been aware complaints of rib pain. The pain issue had not report to her.  On 7/13/23 at 12:47 #4 a nursing entry that R complaints from her 7 On 7/13/23 at 1:47 Pf.	ey had looked at the  f her ribs under her breast not done so. She had been y assessed her. The nurses I regarding whether they had £ 2 had been reporting to that the resident was hurting were doing their ot. Nurse # 4 reported she £ 2 had a fall on 7/10/23 but are of the resident's the previous day (7/11/23). ot been passed along in  AM Nurse # 6 documented in tesident # 2 had no pain.  AM Nurse # 4 documented in tesident # 2 voiced no 7/10/23 fall.				
		M Nurse # 4 documented in lesident # 2 was starting to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		INSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WING _				03/2024
	ROVIDER OR SUPPLIER WOODS NURSING ANI	D REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		1 00.	<u>vv. 202 .                               </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	and orders were obtained assistant on 5/2/24 at following information Resident # 2 on 7/13 of pain in her ribs. Thand saw she had bruing the interview 4:00 PM, Nurse # 4 to 100 PM, Nurse # 1's and 100 PM, Nurse # 1's physician reviewed Nurse # 1's action of 100 PM, Nurse PM	bruising to her left rib area ained for an x-ray.  cility's physical therapy at 9:10 AM revealed the . The PTA had worked with 1/23 and she had complained the PTA looked at the rib area alising. She alerted Nurse # 4.  with Nurse # 4 on 5/1/24 at reported she saw bruising for 1/23 during her assessment it to her attention.  was done per physician owed "Acute appearing th and 5th ribs, with acture of the left 6th rib." (An dden fractures) According to the fractures were minimally	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WING _			1	C <b>03/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		1 00/	00/2024
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 21	F	684			
	the resident's rib frac heal and offer pain m typically liked to try a but would use codein	tures other than to let them edication. He (the physician) cetaminophen in the elderly e if the pain was severe.					
	following the identification acetaminophen was it times per day on 7/13 discontinued, and sho	ation of the rib fractures her ncreased to 500 mg four 3/23. On 7/14/23 this was					
	hours as needed for p # 2's July 2023 Media she required three do dates of 7/14/23 to 7/	pain. According to Resident cation Administration Record, uses of this between the 31/23. The resident also Duloxetine delayed release					
		y prescribed on 8/24/21.					
	5/2/24 at 3:00 PM the facility had identified Resident # 2 through	with the Administrator on a Administrator reported the dissues with assessment for their quality assurance ared a corrective action plan.					
	#2 was noted on the Geri-chair. The nurse was able to move all complaints of pain or has a history of funga breasts. Resident #2	ction plan. Resident Involved roximately 3:00pm Resident floor sitting in front of her e assessed resident who extremities and had no discomfort. Resident #2 al infections under her 2's diagnoses include					
	rib fractures. She is	ne also has documented old					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345478	B. WING_			C
NAME OF PI	ROVIDER OR SUPPLIER	040470		STREET ADDRESS, CITY, STATE, ZIP	CODE	05/03/2024
		REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	At approximately. 3:1 resident's room to che Resident reported "but breast. The nurse as fungal rash under left was applied per wour protocol. Resident stand had no further coprovided incontinent for sleep with no comor burning on left breathenight with uninters. On 7/11/2023 during CNA pain under left than assessment including resident denied pain continued under left that applied per wound/sk At approx. 12:30pm to psych services who reduring psych assessing provided scheduled Eand noted to be effect during incontinence of "sharp" rib pain. CNA	sport to be effective.  5pm the CNA went to the eck on the resident.  Jurning sensation" under left issessed the resident to find breast and Nystatin powder and/skin standing order ated, "oh that feels better" implaints. The resident was care, dinner, and preparation inplaints of pain, discomfort, ast. Resident slept through rupted sleep.  AM care resident reported to breast. The nurse performed ding palpation of area and for discomfort. Redness breast and Nystatin powder and in standing order protocol. The resident was seen by sected unspecified mild pain ment. Resident was extra Strength Tylenol 500mg tive. At approx. 1:00pm area, resident complained of A reported to nurse and	Fé	584	ICY)	
	denied pain. At approdinner tray arrived, at eat without complaint burning under left bree.  On 7/12/2023 at approtection to a produce to nurse. On assessing with a small nodule-limited in the control of the control	lent's pain and resident ox. 4:30pm the resident's and resident sat up in bed to so of pain, discomfort, or east.  Fox. 12:30pm, the physical rea to left back and reported ment, the resident was noted ke area. The Resident had nor discomfort on palpation				

NAME OF PROVIDER OR SUPPLIER  HARNETT WOODS NURSING AND REHABILITATION CENTER    CAUTION   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HARNETT WOODS NURSING AND REHABILITATION CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 23 of the nodule-like area and nurse noted nodule was "fatty". The Resident continued with scheduled pain medication with usual pain noted intermittently. However, no pain increase noted from chronic dorsalgia pain.  On 7/13/2024 the physical therapist assisted resident with back and resident complains of pain on transfer. An order for X-ray was obtained. X-ray results revealed moderate osteoporosis, acute appearing, minimally displaced fractures of lateral aspect of the lateral portion of the left 6th rib, which has the			345478	B. WING _			_
F 684  Continued From page 23 of the nodule-like area and nurse noted nodule was "fatty". The Resident continued with scheduled pain medication with usual pain noted intermittently. However, no pain increase noted from chronic dorsalgia pain.  On 7/13/2024 the physical therapist assisted resident with bath and AM care and noted bruising on left back and resident complains of pain on transfer. An order for X-ray was obtained. X-ray results revealed moderate osteoporosis, acute appearing, minimally displaced fractures of lateral aspect of the left 4th and 5th ribs. There is mild deformity of the lateral portion of the left 6th rib, which has the			ID REHABILITATION CENTER		604 LUCAS ROAD		00/03/2024
of the nodule-like area and nurse noted nodule was "fatty". The Resident continued with scheduled pain medication with usual pain noted intermittently. However, no pain increase noted from chronic dorsalgia pain.  On 7/13/2024 the physical therapist assisted resident with bath and AM care and noted bruising on left back and resident complains of pain on transfer. An order for X-ray was obtained. X-ray results revealed moderate osteoporosis, acute appearing, minimally displaced fractures of lateral aspect of the left 4th and 5th ribs. There is mild deformity of the lateral portion of the left 6th rib, which has the	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD BE O TO THE APPROPRIATE	COMPLETION
7/13/2023 Extra Strength Tylenol straight order was increased to 4x/day. The resident received 3 doses; however, the resident had no complaints of pain. Therefore, on 7/14/2023 Extra Strength Tylenol straight order was discontinued, and order received for Acetaminophen-Codeine 300-30mg every 6 hours as needed for pain. Resident requested only 3 doses from 7/14/2023 to 7/31/2023.  Identification and Corrective Action Plan for Other Potentially Impacted Residents On 7/14/2023 an Ad Hoc Quality Assurance Performance Improvement meeting was held with attendance of the Administrator, Director of Nursing, Regional Vice President, and Regional Clinical Consultant to review Performance Improvement Plan and put corrective action in place.  On 7/14/23, 100% audit of non-alert residents was completed by the Unit Manager to identify all residents with new bruising, pain, or deformity	F 684	of the nodule-like ar was "fatty". The Re scheduled pain med intermittently. Howe from chronic dorsalg.  On 7/13/2024 the pl resident with bath al bruising on left back pain on transfer. Ar obtained. X-ray res osteoporosis, acute displaced fractures and 5th ribs. There portion of the left 6th appearance of remo 7/13/2023 Extra Str was increased to 4x doses; however, the of pain. Therefore, Tylenol straight ordereceived for Acetam every 6 hours as ne requested only 3 do 7/31/2023.  Identification and Co Potentially Impacted On 7/14/2023 an Ac Performance Improvattendance of the Ac Nursing, Regional Volinical Consultant to Improvement Plan applace.  On 7/14/23, 100% a was completed by the schedule of the Action of the Acti	ea and nurse noted nodule sident continued with lication with usual pain noted ever, no pain increase noted gia pain.  Inysical therapist assisted and AM care and noted and resident complains of a order for X-ray was ults revealed moderate appearing, minimally of lateral aspect of the left 4th is mild deformity of the lateral a rib, which has the ote healed fracture. On ength Tylenol straight order day. The resident received 3 resident had no complaints on 7/14/2023 Extra Strength er was discontinued, and order inophen-Codeine 300-30mg eded for pain. Resident ses from 7/14/2023 to  Directive Action Plan for Other day. The Residents are Quality Assurance of the Coulity Assurance of the Co	F	384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345478	B. WING _				C <b>03/2024</b>
	ROVIDER OR SUPPLIER WOODS NURSING AN	D REHABILITATION CENTER		604 LU	TADDRESS, CITY, STATE, ZIP CODE  CAS ROAD , NC 28334	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 684	days were reviewed of Nursing (DON) to exhibited a change i increased pain, and completed if indicate concerns identified. 7/17/23.  On 7/14/23 Interview manager and social regarding any pain regarding any pain reproper pain manage treatment or diagnos completed by 7/17/2 concerns.  On 7/14/23, the unit and Administrator in the past 30 days to assessed and the precommendations. Transparent of the past 30 days to assessed and the precommendations. Transparent in the past 30 days to assessed and the precommendations. Transparent in the past 30 days to assessed and the precommendations. Transparent in the past 30 days to assessed and the precommendations. Transparent in the past 30 days to assessed and the precommendations assessed and the precommendation of 7/14/23, the unit educated the alert are regarding reporting rehanges in condition resident is assess and further recommendations. The past of the past of the precision of 7/14/23, an in-sea Administrative Nursi Data Set Nurse, Unit past of the pas	gress notes for the last 14 by the Unit Manager/Director determine if a resident in condition, to include ensure an assessment was ed. There were no additional Audit was completed by  It worker with alert residents not addressed to ensure ment and/or any additional stics needed. Interviews were 3 with no additional manager, Director of Nursing stiated an audit of all falls for ensure residents were hysician notified for further the audit was completed by tional concerns.  manager and social worker and oriented residents new or worsening pain and/or to include falls to ensure the and the physician is notified for	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  HARNETT WOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 604 LUCAS ROAD DUNN, NC 28334	•	03/03/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	full assessment (2) physician/NP and resigns/symptoms of findings of the asses physician/NP/reside any new orders in the Changes in condition to falls with injury, no complaints of pain, a change.  All newly hired nursionientation regarding of physician and reschange of condition 7/17/23 without received monitoring Plan to Marse, DON, Admin will review incident in changes in condition x/week x 4 weeks the ensure a full assess provider and RR not in the clinical record the IDT audit tools, address all areas of audit. The DON will x4 weeks then monitareas of concern are QAPI Committee in QAPI Committee will assess in QAPI Committee will assess in QAPI Committee will assess with the committee in QAPI Committee will assess with the committee in QAPI Committee will assess with the committee will assess with the committee will assess and the committee will assess with the committee will assess with the committee will assess and the committee will assess with the committee will assess	n including (1) completing a Notification of Changes to the esident representative (3) fracture (4) document the essment, notification of the nt representative and entering he resident's clinical record. In include, but are not limited ew onset or increased and/or an obvious physical es will be in-service during grassessment and notification ident representative upon. No nurse will work after eiving the in-service.  Make Sure that Solutions are elude Minimum Data Set istrator and Unit Managers reports, progress notes for an and pain assessments 5 ten monthly x 1 month to ment was completed with diffication and documentation. This will be documented on The Unit Managers will concern identified during the review the audit tools weekly thly x1 month to ensure all	F6	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345478	B. WING			C	
NAME OF PROVIDER OR SUPPLIER  HARNETT WOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 604 LUCAS ROAD DUNN, NC 28334		05/03/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		(X5) COMPLETION DATE	
F 684	Continued From page 26 further interventions put into place and to		F 6	684			
		or further frequency of					
	Resolution Date: 7/17/23						
	the following actions: Beginning on 5/1/24 a facility was made. Mu interviewed and report care and services. Not a problem with a lack assessment of their in member of a cognitive also interviewed and and services.  Other residents were review. These addition	rted they were pleased with one of the residents reported					
		documented evidence of ion and audits per their					
	On 5/3/24 the facility's 7/17/23 was validated	s plan of correction date of d.					