| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345054 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodhaven Nurs & Alzheimer's C | 1150 Pine Run Drive<br>Lumberton, NC 28358 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173<br><br>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).<br><br>Findings included:<br><br>Resident #2 was admitted to the facility on [DATE]. 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.<br><br>The Minimum Data Set quarterly assessment dated [DATE] 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.<br><br>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.<br><br>A Physician's order written on 03/19/24 revealed an order for a referral to the Neurologist.<br><br>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.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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 [NAME] County non-emergency transport for residents who needed to be transferred with a stretcher. The Transportation Coordinator stated the neurology appointment for Resident #2 was scheduled for 10/03/23. The Transportation Coordinator stated the [NAME] 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.<br><br>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 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.<br><br>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.<br><br>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 therefore, the missed appointment for Resident #2 was not recognized. Additionally, she added [NAME] 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.<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>35173<br><br>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.<br><br>Findings included:<br><br>This tag is cross referenced to:<br><br>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).<br><br>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.<br><br>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. |