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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Nurs & Alzheimer's C	1150 Pine Run Drive 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on observations, record review, staff and Wound Care Nurse Practitioner interviews the facility failed to perform daily wound care treatments on a stage IV sacral wound and a deep tissue injury to left heel (Resident #4) and a stage IV pressure wound of the right posterior medial heel (Resident #5) according to the physician's order for 2 of 3 residents reviewed for wound care. Findings included: 1a. Resident #4 was admitted to the facility on [DATE] with diagnoses to include, in part, open wound to left foot, dementia and pressure ulcer to left buttock. A physician's order written on 03/26/24 revealed clean sacrum with normal saline, apply alginate calcium with silver, cover with gauze and island border once daily and as needed. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #4 was cognitively intact. She had no behaviors or refusal of care. She had a colostomy and was always incontinent of urine. She had no impairments and used a wheelchair. She was coded has having a pressure ulcer over her bony prominence as a Stage IV and a pressure reducing mattress. Review of Resident #4's care plan revealed a plan of care updated on 04/03/24 for a pressure ulcer to sacrum, left lateral ankle and left posterior heel and at risk for development of additional pressure ulcers due to decreased ability to reposition and incontinence and refusal to allow staff to turn and reposition or get out of bed to chair. The goal was to show signs of healing and remain free from infection with interventions to include, in part, administer treatments as ordered and monitor for effectiveness, assess/record and monitor wound healing each week, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician and consult with wound physician as needed, keep pillows beneath calves to lift heels off of bed, provide incontinence care as needed and weekly full body skin assessments. Review of the staffing assignment sheets on 05/04/24, 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, 05/26/24, and 05/30/24 revealed Nurse #1 was assigned to Resident #4. Review of the Treatment Administration Record for May 2024 revealed on 05/04/24, 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, 05/26/24, and 05/30/24 the treatment for the sacral pressure ulcer was not signed with nursing initials and a check mark. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the weekly wound evaluations for the sacral wound revealed on 05/02/24 the measurement was 2. 9 X 2.1 X 1.6 centimeters with 10% necrotic (dead) area and 90% granulated (healthy) tissue with a note indicating the wound progress had improved as evidenced by decreased surface area. On 05/09/24, the measurement of the sacral wound was 2.7 X 2.7 X 0.9 centimeters with 15% slough (by product of the inflammatory phase of wound healing), and 85% granulated tissue with a note indicating improved as evidenced by decreased depth. On 05/16/24, the measurement of the sacral wound was 2.6 X 2.7 X 1.1 centimeters with 100% granulated tissue with a note indicating improved as evidenced by decreased surface area and decreased necrotic tissue. On 05/23/24, the measurement of the sacral wound was 2.4 X 2.0 X 1.2 centimeters with 100% granulated tissue with a note indicating improved as evidenced by decreased surface area. An interview was conducted with Nurse #1 on 05/30/24 at 5:00 PM and she reported that when a nurse completed a treatment she was to sign it off on the Treatment Administration Record which would indicate that the treatment was done. She reviewed the Treatment Administration Record at this time and confirmed that on 05/04/24, 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, and 05/26/24 the treatment for the sacral wound was not signed off. She stated if it was not signed off then it was not done. She stated it was very overwhelming on the unit and at times she falls behind and she did not complete the treatment on those days. On 05/31/24, a review of the Treatment Administration Record revealed the treatment for the sacral wound for Resident #4 was not signed off on 05/30/24. A follow up interview was attempted with Nurse #1 on 05/31/24 at 2:30 PM via phone regarding if the wound treatment was done on 05/30/24. Nurse #1 did not return the call. An interview was conducted with Resident #4 on 05/31/24 at 9:30 AM. Resident #4 stated that her wound dressings were not always changed everyday and the last time they were changed was on Wednesday 05/29/24. An observation of wound care to the sacral wound for Resident #4 was conducted on 05/31/24 at 2:00 PM with the facility's Wound Care Nurse Practitioner (NP) and Nurse #2. Resident #4 was repositioned on her right side and the dressing on the sacral wound was dated 05/29/24 by Nurse #4. The NP removed the dated dressing which was noted to have a moderate amount of brown drainage noted on the dressing and measured the wound. She reported the measurement was 2.0 X 2.0 X 0.6 with 50% slough and 50% granulated tissue. The NP changed the dressing according to the physician order. An interview with the Nurse Practitioner on 05/31/24 at 2:20 PM revealed she noticed that the previous dressing was dated 05/29/24. She added, the order was to change the dressing daily. She stated there was a moderate amount of drainage noted on the dressing when she removed it and now the resident was exposed to potential for infection with her wound being exposed to the secreted drainage on the old dressing. The NP stated the wound was still showing signs of improvement, but that it was important to adhere to the daily wound care order because of the resident's impaired mobility. 1b. A physician's order written for Resident #4 on 05/10/24 revealed apply skin prep to left heel and cover with bordered foam. Review of the staffing assignment sheets on 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, 05/26/24, and 05/30/24 revealed Nurse #1 was assigned to Resident #4. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record for May 2024 revealed on 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, 05/26/24, and 05/30/24 the treatment for the skin prep was not signed with nursing initials and a check mark. Review of the wound evaluations for a deep tissue injury (DTI) to back of left heel on 05/16/24 revealed the measurement was 2.3 X 1.4 centimeters with a note indicating the skin was intact with purple/maroon discoloration. On 05/23/24, the measurement for the DTI was 1.3 X 0.9 with a note indicating the skin was intact with purple/maroon discoloration. An interview was conducted with Nurse #1 on 05/30/24 at 5:00 PM and she reported that when a nurse completed a wound treatment she was to sign it off on the Treatment Administration Record which would indicate that it was done. She reviewed the Treatment Administration Record at this time and confirmed that on 05/10/24, 05/15/24, 05/18/24, 05/19/24, 05/20/24, and 05/26/24 the treatment for the deep tissue injury to left heel was not signed off. She stated if it was not signed off, then it was not done. She stated it was very overwhelming on the unit and at times she falls behind and she did not complete the treatment on those days. On 05/31/24 a review of the Treatment Administration Record revealed the treatment for the left heel for Resident #4 was not signed off on 05/30/24. A follow up phone call and text message was placed to Nurse #1 on 05/31/24 at 3:25 PM regarding if the wound treatment was done on 05/30/24. A message was left with no return call. An observation of wound care to the deep tissue injury on the left heel for Resident #4 was conducted on 05/31/24 at 2:00 PM with the facility's Wound Care Nurse Practitioner and Nurse #2. The dressing on the left heel was dated 05/29/24 and initialed by Nurse #4. The NP removed the dated dressing which was noted to have a foam dressing and a gauze covered with a dark brown substance. The NP reported the gauze had betadine on it. The deep tissue injury was measured and reported to be 1.0 X .05. The NP applied the skin prep as ordered and stated she was going to change the order and leave the area open to air instead of covering with a foam dressing. An interview with the Wound Care Nurse Practitioner on 05/31/24 at 2:20 PM revealed she noticed that the previous dressing was dated 05/29/24. She added, the order was to change the dressing daily. She stated there was betadine on the dressing and the order did not include applying betadine. The NP stated in order for the skin prep to work it has to be done daily. The point of it was to add an extra layer as protectant. A phone interview was conducted with Nurse #4 on 05/31/24 at 3:10 PM. She stated she was an acting agency wound treatment nurse. She stated on 05/29/24 she changed the dressing on Resident #4's deep tissue injury on the left heel and she thought she had followed the physician's order and it required betadine. She added, when she removed the previous dressing, it looked like it had betadine on it so she thought the wound required betadine and that was what the order said. An interview with the Director of Nursing (DON) on 05/31/24 at 5:05 PM stated he expected his nursing staff to complete the wound treatments according to the physicians' orders because if the treatments were not getting done as ordered it put the resident in a compromised state and the resident was at risk for not reaching the wound healing potential. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #5 was admitted to the facility on [DATE]. He was cognitively impaired and demonstrated no behavior to include refusal of care. He was coded as having a Stage II pressure ulcer that he was admitted with. Review of Resident #'5s care plan updated on 01/09/24 revealed resident currently had a pressure ulcer to right heel and at risk for additional pressure ulcers due to decreased ability to reposition. Interventions included, in part, to administer treatments as ordered and monitor for effectiveness. Review of the weekly wound evaluations for the Stage 4 right posterior medial heel revealed on 05/02/24 the measurement was 1.8 X 1.3 X 0.7 centimeters with 10% visible tissue and 90% granulated (healthy) tissue with a note indicating the wound progress had improved as evidenced by decreased depth, necrotic tissue, surface area and undermining. On 05/09/24, the measurement was 1.6 X 1.8 X 0.8 centimeters with 20% slough (by product of the inflammatory phase of wound healing), and 70% granulated tissue and 10% visible tissue with a note indicating not at goal. The dressing treatment plan was changed. On 05/16/24, the measurement of the right posterior medial heel wound was 1.7 X 1.7 X 0.8 centimeters with 90% granulated tissue and 10% visible tissue with a note indicating improved as evidenced by decreased necrotic tissue. On 05/23/24, the measurement of the right posterior medial heel was 1.2 X 1.4 X 0.3 centimeters with 90% granulated tissue and 10% visible tissue with a note indicating improved as evidenced by decreased depth and surface area. Review of a physician order written on 05/09/24 revealed an order for the right posterior medial heel to clean with normal saline, pat dry, apply anasept moist gauze with hydrogel with silver once daily and cover with gauze island border dressing. Review of the staffing assignment sheets on 05/18/24, 05/19/24, 05/26/24, and 05/30/24 revealed Nurse #1 was assigned to Resident #5. An observation of the Treatment Administrator Record for May 2024 revealed on 05/18, 05/19, and 05/26 the treatment for the right posterior medial heel for Resident #5 was not signed with nursing initials and a check mark. An interview was conducted with Nurse #1 on 05/30/24 at 5:00 PM and she reported that when a nurse completed a wound treatment she was to sign off on the Treatment Administration Record which would indicate that it was done with her initials and a check mark. She reviewed the Treatment Administration Record at this time and confirmed that on 05/18, 05/19, and 05/26 the treatment for the right posterior medial heel for Resident #5 was not signed off. She stated if it was not signed off then it was not done. She stated it was very overwhelming on the unit and at times she falls behind and she did not complete the treatment on those days. Nurse #1 stated she did not inform the Unit Manager or the Director of Nursing that she was falling behind. On 05/31/24, a review of the Treatment Administration Record revealed the treatment for the right posterior medial heel for Resident #5 was not signed off on 05/30/24. An observation of Resident #5's right heel on 05/31/24 at 2:25 PM revealed the wound dressing was dated 05/29/24 by Nurse #4. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up phone call and text message was placed to Nurse #1 on 05/31/24 at 3:25 PM. A message was left with no return call. An interview with the Wound Care Nurse Practitioner on 05/31/24 at 2:25 PM revealed that the order was to change the dressing daily on Resident #5's right posterior medial heel and it should be getting done daily as ordered to promote wound healing. An interview with the Director of Nursing (DON) on 05/31/24 at 5:05 PM stated he expected his nursing staff to complete the wound treatments according to the physicians' orders because if the treatments were not getting done it put the resident in a compromised state and the resident was at risk for not reaching the wound healing potential. The DON reported there was staff available to assist if a nurse needed additional assistance, but he was not informed that Nurse #1 needed any help.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35173 Based on observations, record review, and staff interviews the facility failed to implement the Enhanced Barrier Precautions (EBP) policy regarding applying Personal Protective Equipment (PPE) to include applying gloves and gown during high contact resident care activities. Two nursing staff were observed providing care to a resident with a stage IV pressure ulcer who was receiving wound care to the sacrum and were not wearing a gown during care. This occurred for 1 of 2 residents (Resident #1) observed for Infection Control. Review of the facility's policy for Enhanced Barrier Precautions (undated) revealed It is the policy of this facility to use enhanced barrier precautions (EBP) based on guidance from the Center for Disease Control (CDC). EBP expands use of personal protective equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated. It refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi drug resistant organisms to staff hands and clothing. The policy applied to all residents with wounds (any skin opening requiring a dressing) to include, but not limited to, pressure ulcers, diabetic foot ulcers, and unhealed surgical wounds. An observation of wound care was conducted on Resident #1 on 05/29/24 at 2:30 PM with Nurse #4 and Nurse Aide (NA) #1. During the wound care observation, NA #1 and Nurse #4 were noted to not have on a protective gown and only had gloves on. There was noted to be a hanging storage unit for personal protective equipment on the bathroom door which was empty. An interview with Nurse Aide #1 on 05/29/24 at 2:52 PM revealed she was shown the Enhanced Barrier Precautions sign on the entrance door to Resident #1's room which read in part, Enhanced Barrier Precautions: Providers and staff must wear gloves and gown for the following high contact resident care activities, dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes and wound care. NA #1 stated she had been trained regarding Enhanced Barrier Precautions and that the facility had just started with doing this, but there was no PPE on the door like their usually was so she did not think to put on a gown. An interview was conducted with Nurse #4 on 05/29/24 at 2:55 PM. She stated she had been trained on Enhanced Barrier Precautions, but she forgot to apply a gown. An interview with the Director of Nursing on 05/31/24 at 5:00 PM reported Resident #1 was on Enhanced Barrier Precautions due to his pressure ulcer and having a dialysis access device and staff should be applying PPE to include gown and gloves whenever providing direct patient care on Resident #1. An interview was conducted with the Administrator on 05/31/24 at 5:15 PM. The Administrator stated she implemented an in service in April 2024 when the Enhanced Barrier Precautions was first initiated, but that more education needed to be provided regarding enhanced barrier precautions.