

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Woodhaven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff, resident and Nurse Practitioner interviews, the facility failed to provide care in a safe manner when the resident fell from the bed during incontinence care, reported knee and hip pain at a level of 9 out of 10 on a scale with 0 being no pain and 10 being the worst pain ever. The resident required evaluation at the emergency department where she was diagnosed with a non-displaced medial femoral condylar fracture (a fracture at the end of the thigh bone near the knee joint where the bones rub together causing pain and requiring strict immobilization for healing). This deficient practice affected 1 of 3 residents (Resident #1) reviewed for accidents. Findings included: A review of the manufacturer's information for the circular adjustable bed rail dated 2026 indicated that the rail was a bed mobility device that was not intended to prevent a user from inadvertently rolling out of bed. The bed rail had a solid steel locking mechanism that offered the user support during transfers. Resident #1 was admitted on [DATE] with diagnosis of stroke with left sided hemiparesis (muscle weakness or partial paralysis on one side of the body). A review of Resident #1's care plan revealed a problem dated 6/15/26 which stated that the resident used a circular bed rail to enable the resident to maintain as much independence with bed mobility as possible, with increased risk for complications including entrapment and injuries. Interventions included to ensure the resident was positioned correctly with proper body alignment while the device was in use, evaluate the use of bed rails along with risks/benefits, possible alternatives to device, need for ongoing use and reason for use, and offer appropriate level of assistance to promote safety. A care plan problem related to self-care deficit indicated that Resident # 1 required extensive assistance with bed mobility. Review of Resident # 1's quarterly minimum data set (MDS) assessment dated [DATE] indicated that the resident was cognitively intact with no behaviors and had impaired range of motion of the upper and lower extremities. Activities of daily living including transfers and bed mobility were not coded on the MDS assessment. Resident #1 weighed 206 pounds, her height was 62 inches, she did not receive an anticoagulant (blood thinner) medication, bed rails were not coded as a restraint used in bed and the resident had no falls. An interview with Nurse Aide (NA) #6 on 7/7/26 at 4:50 PM revealed that she was assigned to Resident #1 on 6/25/26 on the 3:00 PM to 11:00 PM shift. NA #6 stated that she was providing incontinence care to Resident #1 when she turned the resident on her side. NA #6 stated Resident #1 was in the center of the bed when the NA turned the resident away from her. Resident #1 was facing away from the NA. Resident #1 was holding the circular bed rail when it bent and was turned flat on it's side instead of upright against the bed. NA #6 stated that Resident #1 fell on to the floor when the bed rail bent. NA #6 stated that Resident #1 told her that the bed rail was loose prior to the incident. Review of a nursing progress note dated 6/25/26 at 5:30 PM written by Nurse #7 stated that the nurse was called to Resident # 1's room by the Nurse Aide (NA) and upon entering the room (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0909 Level of Harm - Actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on record review and staff interviews, the facility failed to ensure that a circular bed rail was maintained in safe working condition. As a result, the rail did not remain secure, and the resident fell from the bed during care sustaining a fractured femur (the long thigh bone). This deficient practice affected 1 of 1 resident (Resident #1) reviewed for bed rails. Findings included: A review of the facility's Bed and Bedrail Safety Inspection Policy dated 11/2025 indicated that maintenance personnel and clinical staff were responsible for bed safety. The policy indicated that all beds must be inspected regularly to ensure compliance with safety standards. The policy required that the maintenance director go into the resident room and inspect the bed and confirm that the installation of the rails follow the manufacturer specifications. The Maintenance Director and clinical staff were unable to provide documentation of the safety checks of the bed rails. A review of the manufacturer's information for the circular adjustable bed rail dated 2026 indicated that the rail was a bed mobility device that was not intended to prevent a user from inadvertently rolling out of bed. The bed rail had a solid steel locking mechanism that offered the user support during transfers. A facility form located on a clip board at the nurses' station on the unit that Resident #1 resided on titled Routine Maintenance Needs was reviewed. The form was a log with columns to enter the date, issue, location of the issue, the name of the reporter, maintenance reviewed date and maintenance resolution/progress. The form stated for all emergent needs to call maintenance. The form indicated an entry reported by Nurse Aide (NA) # 8 dated 6/22/26 which indicated Resident #1's bed rail was broken. An interview was conducted via phone with Nurse #9 on 7/9/26 at 12:42 PM. Nurse #9 indicated that she was assigned to Resident #1 on 6/22/26 from 7:00 PM to 7:00 AM. Nurse #9 stated that NA #8 told her that the bed rail was loose. Nurse #9 stated that she instructed NA #8 to put an entry on the maintenance log at the nurse's station. Nurse #9 indicated that she looked at the bed rail and noted that it was loose. Nurse #9 indicated that normally the Maintenance Director checked the log at the nurse's station so she assumed that Resident #1's bed rail would be repaired. Attempts were made to interview NA#8 with voice mail messages and text messages on 7/9/26 at 9:00 AM and 7/10/26 at 9:00 AM. No return call was received. NA #8 was no longer employed at the facility. An interview with Resident #1 conducted on 7/7/26 at 11:30 AM. During the interview Resident #1 was observed with a splint on her leg from the upper thigh to the ankle. Resident #1 stated that she fell out of bed recently and broke her leg and it was very painful. Resident #1 stated that when she fell, the railing collapsed and it was very traumatic. Resident #1 stated that the railing was loose prior to the incident. Resident #1 stated that she had reported to NA #8 and Nurse #9 that the railing was loose prior to the incident. Resident #1 stated that no one came to fix the rail after she reported it. Resident #1 indicated that the Maintenance Director was not checking the bed rails daily nor had he completed a thorough monthly inspection of the rails. An interview was conducted with NA #7 on 7/7/26 at 4:30 PM. NA #7 reported that she had been assigned to Resident #1 during the week prior to the fall. She stated that Resident #1 informed her that the bed rail was loose, and she assumed the issue had already been reported. NA #7 confirmed that she did not personally report the loose rail, did not check or test the rail herself, and did not submit a work order for repair. NA #7 indicated that she was familiar with the maintenance work order system but did not review the Routine Maintenance Log located on the clipboard at the nurses' station to verify whether the loose rail had already been documented. She also did not enter a work order into the computer. NA #7 explained that she typically worked in another area of the facility and was new to this assignment. She stated that she had been (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, and the Consultant Pharmacist, the facility failed to maintain a system of records of receipt and disposition of a controlled medication (Alprazolam - an antianxiety medication) sufficient to enable accurate reconciliation. The Director of Nursing (DON) rewrote a controlled medication count sheet for a residents Alprazolam after administration times had been altered by nursing staff, replacing the original sheet instead of retaining it. The DON also signed the rewritten sheet as a witness to a controlled dose being wasted, although staff confirmed no waste ever occurred. The facility was unable to produce the original controlled medication count sheet for review. This occurred for 1 of 2 residents reviewed for medication administration (Resident #2). Findings included: Resident #2 was admitted on [DATE] with diagnoses including anxiety. A physician's order dated 2/3/26 for Resident #2 revealed Alprazolam 0.25 milligram (mg) to be administered orally every 8 hours as needed for anxiety. Review of a copy of the controlled medication count sheet for Resident #2's Alprazolam 0.25 mg revealed that on 2/12/26 at 12:55 AM, Nurse #1 documented administering one dose of Alprazolam. This entry had been crossed out and replaced with a notation indicating that Nurse #1 and the Director of Nursing (DON) signed as witnesses to one dose being wasted at the same time. Further review of the controlled count sheet revealed that on 2/12/26 at 4:55 AM, Nurse #1 documented administering another tablet of Alprazolam to Resident #2, which did not meet the ordered 8-hour interval between doses. During an interview on 7/8/26 at 4:30 PM with the Director of Nursing (DON) and Corporate Nurse Consultant, the DON stated that on 2/12/26, Nurse #2 reported to Unit Manager #1 that Resident #2's Alprazolam had been administered too early by the night shift nurse (Nurse #1). The DON stated she was new in her position and sought guidance from the previous DON (Unit Manager #2) on how to correct the medication error. The DON stated that in order to fix the medication error Unit Manager #2 accessed Resident #2's electronic medical record, crossed out the original administration times, and rewrote them to match the ordered 8-hour interval. The DON stated that when she returned to work two days later (2/16/26), Nurse #2 reported more concerns with Resident #2's Alprazolam stating that her (Nurse #2's) medication administration times had changed. The DON saw that the administration times on the controlled medication count sheet had been crossed out and replaced with different administration times. The DON stated that because the count sheet had been altered, she created a new controlled medication count sheet for Resident #2's Alprazolam and required all nurses who administered the medication since 2/3/26 to sign the new sheet. She stated Nurse #1 had administered the Alprazolam too early, which was the medication error they were attempting to correct. The DON also acknowledged she signed as a witness to a dose being wasted, though she did not witness any waste, stating this was poor judgment. She confirmed the original controlled medication count sheet could not be located. The DON stated she could not attest to whether the remaining quantity of Alprazolam 0.25 mg for Resident #2 was accurate after signing as a witness to a waste she did not observe. During a phone interview on 7/9/26 at 11:AM Nurse #2 stated on the morning of 2/12/26 during her shift count of controlled medications she noticed that Nurse #1 had administered Resident #2's Alprazolam too soon so she reported this to her Unit Manager (#1) who reported to the DON. Nurse #2 stated the previous DON (Unit Manager #2) came in the facility a few nights later and struck out the Alprazolam administration times in Resident #2's electronic medical record. Nurse #2 stated then a new count sheet was started but due to the altered controlled count (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Woodhaven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Pine Run Drive Lumberton, NC 28358	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet she could not confirm that the administration times or the actual count of Alprazolam were accurate on the count sheet or in the electronic medical record during that time. During a phone interview on 7/9/26 at 11:45 AM, Unit Manager #2 (previous DON) stated she was no longer employed at the facility. She reported that on or about 2/14/26, the current DON called her after her shift and asked her to return to the facility to fix a medication error. She stated she was not given a clear explanation of the error but believed she was instructed to enter an Alprazolam dose administered by Nurse #1 two nights prior. Unit Manager #2 stated she accessed Resident #2's electronic medical record, went into the administration history, struck out all Alprazolam administrations documented over the previous two days, then entered an as-needed Alprazolam dose administered by Nurse #1, and then re-entered all the administration times she had removed. She acknowledged this was poor judgment and stated she should not have altered medication administration times. She also reported she did not verify the controlled medication count afterward and could not attest to whether the Alprazolam count for Resident #2 was accurate during that time. During a phone interview on 7/9/26 at 3:00 PM Nurse #1 stated she did not realize that she gave an extra dose of Alprazolam to Resident #2 on 2/12/26 until she returned to work the following day. Nurse #1 called the previous DON (Unit Manager #2) and told her about the medication error. She stated Unit Manager #2 came in to the facility to fix the medication error in Resident #2's electronic medical record. Nurse #1 stated she was instructed to cross out the medication administration times on Resident #2's count sheet and sign that one dose of Alprazolam was wasted. Nurse #1 stated one dose of Alprazolam was not wasted. Nurse #1 stated her end of shift count on the morning of 2/12/26 was accurate but she could not attest to the medication count after that time. During a phone interview on 7/9/26 at 3:45 PM the Consultant Pharmacist stated monthly medication regimen reviews were conducted, and a second Consultant Pharmacist audits medication carts. She stated the 2/18/26 audit notes showed issues only with expired medications and reminders not to sign narcotics out early. She indicated controlled medication count sheets should not be altered in order to ensure the accuracy, integrity, and proper reconciliation of controlled medications. During an interview on 7/9/26 at 4:00 PM, the Administrator stated medication counts must remain accurate and unaltered and indicated routine audits would be implemented to ensure this.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, and Nurse Practitioner interviews, the facility failed to administer an as needed antianxiety medication (Alprazolam) according to the physician's order. This occurred for 1 of 2 residents reviewed for administration of controlled medications (Resident #2). Findings included: Resident #2 was admitted on [DATE] with diagnoses including anxiety. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #2 had moderately impaired cognition. Resident #2 did not receive antianxiety medications during the assessment period. A physician's order dated 2/3/26 for Resident #2 revealed Alprazolam 0.25 milligram (mg) to be administered orally every 8 hours as needed (PRN) for anxiety. Review of a copy of the controlled medication count sheet for Resident #2's Alprazolam 0.25 mg revealed the following entries:- 2/12/26 at 12:55 AM - Nurse #1 documented administration, the entry was later crossed out and countersigned by the Director of Nursing (DON) to indicate one dose was wasted.- 2/12/26 at 4:55 AM - Nurse #1 documented administering another dose, just 4 hours after the prior dose, outside the 8-hour order interval. Review of Resident #2's nursing progress notes from 2/12/26 between 12:00 AM and 7:00 AM contained no documentation of increased anxiety or behaviors that would justify the additional PRN dose. Review of Resident #2's Medication Administration Record (MAR) dated February 2026 revealed no behavior monitoring entries indicating increased anxiety during that period. During a phone interview on 7/9/26 at 3:00 PM Nurse #1 stated she did not realize that she gave an extra dose of Alprazolam to Resident #2 on 2/12/26 until she returned to work the following day. Nurse #1 called the previous DON (Unit Manager #2) and told her about the medication error. Nurse #1 stated she was instructed to cross out the medication administration times on Resident #2's count sheet and sign that one dose of Alprazolam was wasted. She stated one dose of Alprazolam was not wasted and she administered Alprazolam to Resident #2 twice during her shift at 12:55 AM and again at 4:55 AM because Resident #2 had increased anxiety and requested Alprazolam. Nurse #1 stated she should have contacted the physician to get a one time order for an additional dose of Alprazolam, but she did not do that. During a phone interview on 7/9/26 at 4:00 PM, the Nurse Practitioner stated that Resident #2 was admitted for short-term rehabilitation and discharged home on 2/21/26. She reported that her involvement was limited to the discharge assessment and that she was not aware of any concerns related to uncontrolled anxiety. She noted that Alprazolam 0.25 mg was a low dose but may still cause side effects such as increased sedation or drowsiness but there was no change in Resident #2's condition reported to her during that time. During an interview on 7/9/26 at 1:30 PM the Director of Nursing confirmed the extra dose of Alprazolam administered to Resident #2 on 2/12/26 at 4:55 AM was not in accordance with the order. She stated the entry indicating a dose was wasted on the count sheet was poor judgment. She stated that although Resident #2 experienced episodes of increased anxiety, Nurse #1 failed to obtain a one-time order from the physician before administering an extra dose. The DON stated the physician was notified on 2/16/26 regarding the extra dose administered, but no additional orders were received.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records for 1 of 2 residents reviewed for administration of controlled medications (Resident #2). Findings included: Resident #2 was admitted on [DATE] with diagnoses including anxiety. A physician's order dated 2/3/26 for Resident #2 revealed Alprazolam 0.25 milligrams (mgs) to be administered orally every 8 hours as needed for anxiety. Review of Resident #2's controlled medication count sheet (an inventory log used to record a running total for each controlled medication) revealed Alprazolam 0.25 mgs was removed from the locked storage on the following dates and times: 2/10/26 at 10:02 PM signed by Nurse #3 2/12/26 at 12:55 AM signed by Nurse #1 2/12/26 at 5:36 PM signed by Nurse #2 2/12/26 at 11:00 PM signed by Nurse #1 2/13/26 at 7:00 AM signed by Nurse #1 2/14/26 at 9:30 PM signed by Nurse #3 2/16/26 at 9:56 AM signed by Nurse #4 Review of Resident #2's Medication Administration Record (MAR) dated February 2026 revealed no documentation of Alprazolam administration for any of the above dates and times. The MAR contained no initials, times, or notations indicating administration, refusal, delay, or omission. During a phone interview on 7/9/26 at 1:15 PM, Nurse #3 stated she recalled administering Alprazolam to Resident #2 but had been instructed to re-sign the controlled count sheet during that time and must have forgotten to document the medication on the MAR. During a phone interview on 7/9/26 at 3:00 PM, Nurse #1 reported she had administered an extra dose of Alprazolam to Resident #2 on 2/12/26, resulting in a medication error. She stated she was instructed to re-sign the controlled count sheet and the missing MAR documentation may have been related to trying to correct the error or just forgetting to sign the MAR. During a phone interview on 7/9/26 at 11:00 AM, Nurse #2 stated a new controlled count sheet had been started for Resident #2, but she could not confirm specific administration times. She believed she had signed the MAR when administering the medication. During an interview on 7/9/26 at 1:00 PM, Nurse #4 stated she recalled administering Alprazolam to Resident #2 for increased anxiety but, as a new staff member at the time, forgot to document the administration on the MAR. During an interview on 7/9/26 at 1:30 PM, the Director of Nursing stated that although a medication error occurred regarding Resident #2's Alprazolam and a new controlled count sheet was initiated, nurses were required to document every administered medication on the MAR.		