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	09/12/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44890 Based on observations, record reviews, and resident, staff, Physician, and Vascular Clinic Nurse interviews, the facility failed to provide Thromboembolic Deterrent (TED) compression stockings and elevation of the lower extremities when up in her wheelchair which were ordered by the Vascular Nurse Practitioner (NP) on 6/5/2024 for 3 months, for a resident with bilateral lower extremity edema (swelling and puffiness of the lower legs and feet as a result of weakness or damage to veins in the legs), (Resident #27), for 1 of 2 residents reviewed for compression stockings. Findings included: Resident #27 was admitted to the facility on [DATE], with diagnoses to include rheumatoid arthritis, diabetes mellitus type 2 with diabetic neuropathy (nerve damage that causes weakness, numbness, and pain), and atrial fibrillation. A physician's progress note written by Nurse Practitioner (NP #2) dated 1/26/2024 at 12:00 P.M. read in part, History of present illness: Resident has complaints of bilateral feet turning purple/black when she was sitting in her wheelchair. She stated that the left foot was worse than the right foot. She states that when she is in bed her feet are red and hot. The note further read Resident #27's bilateral feet were beefy red with erythema (redness caused by dilated blood vessels and capillaries) and nursing staff were made aware of referring her to vascular clinic for evaluation and treatment. A physician's order written by NP #2 dated 1/26/2024 was for a referral to vascular clinic due to possible bilateral lower extremity venous insufficiency. A consultation note written by the Vascular Clinic NP on 6/5/2024 read in part that a venous/arterial ultrasound was performed on Resident #27 and revealed that she had moderate peripheral venous insufficiency in her bilateral lower extremities with the left leg being worse than the right. The Vascular Clinic NP orders were for Resident #27 to wear compression garments/stockings during waking hours, elevate legs when sitting and increase exercise as tolerated and she would reassess after 3 months of conservative management. Resident was to elevate her legs when sitting, compression stockings/garments while awake, and increase exercise, and follow-up in 3 months. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was alert and oriented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note written by NP #1 dated 8/12/2024 at 1:00 PM read in part, that Resident #27's extremities were positive for trace edema. A progress note written by NP #1 on 8/26/2024 at 1:00 PM revealed Resident #27's lower extremities had a trace of edema. A progress note written by Physician's Assistant (PA) on 9/3/2024 at 12:00 PM read in part that Resident #27 was asking questions regarding compression stocking orders that have been ordered for peripheral vascular disease (PVD). A Provider Note written by the Vascular NP at Resident #27's follow-up visit on 9/4/2024, read in part, that Resident #27 was being seen for a 3 month follow-up. Resident was supposed to wear compression garments to bilateral legs, but she was wearing only one on her right leg intermittently with minimal improvement, because there was no compression hose/garment yet for left leg. Resident #27 has significant reflux to the bilateral main superficial veins. Will consider thermal ablation [using heat to seal off varicose veins) if symptoms do not improve with conservative measures. An interview with Resident #27 was completed on 9/9/2024 at 11:30 AM. Resident #27 stated that the physician at the Vascular clinic had written orders for compression garments/stocking to be worn on her legs on 6/5/2024. She further stated that she had just received the compression stockings on 9/4/2024. Resident #27 indicated that when the compression garment had arrived there was only one in the package. Resident #27 stated that she had even called the Vascular Clinic in July 2024 and told them the facility was not applying the compression stockings or elevating her legs. Resident #27 stated she had asked the Director of Nursing (DON) on 7/26/2024 and 8/28/2024 about the compression stockings and he had reported to her that they were ordered. An interview was completed with the Long-Term Care (LTC) Support Nurse on 9/10/2024 at 1:22 PM. The LTC Support Nurse stated that the facility had ordered the compression garments/stockings in June 2024, but only one compression garment was in the package. She further stated that they had placed an order for another compression garment, and they had not received it yet. The LTC Support Nurse indicated the facility had ordered the compression stockings and they were delivered on 9/4/2024. An interview with the Director of Nursing (DON) was conducted on 9/10/2024 at 3:36 PM. The DON stated that the facility had ordered the compression garments/stockings in July and when the package arrived it only contained one compression garment (wrap with Velcro straps that compress the legs). He further stated that he had asked Central Supply to order another one and that it had never arrived. The DON stated that Resident #27 was correct that she had asked him twice about when the compression garments would arrive once in July and again in August. He indicated that on 9/1/2024 the facility had ordered the compression stockings, and they had arrived on 9/4/2024. An interview with Resident #27 was completed on 9/11/2024 at 9:20 AM. Resident #27 stated the facility had made an appointment for her at the Vascular Clinic today at 10:30 AM for her to get fitted for compression stockings and then they would supply her with the correct compression stockings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Vascular Clinic Nurse on 9/11/2024 at 10:47 AM. The Vascular Clinic Nurse stated that the Vascular NP was on vacation. She further stated that Resident #27 did call the clinic on 7/22/2024 to express concern that the nursing staff was not applying the compression stockings or elevating her legs as ordered by the Vascular NP. The Vascular Clinic Nurse indicated that the Vascular NP was made aware of the nursing staff not applying the compression stockings. An interview was conducted with the Central Supply Supervisor on 9/11/2024 at 12:36 PM. The Central Supply Supervisor stated that she had ordered the compression garment when Resident #27 returned from the Vascular Clinic. She further stated that when the facility received the package, there was only one compression garment in the box. The Central Supply Supervisor stated that she had ordered another one on 6/21/2024 but it was still in process, and she didn't know why it was taking so long. She stated that she ordered the items she was instructed by the DON to order. She indicated she ordered the compression stockings for Resident #27 on 9/1/2024 and they received them on 9/4/2024. An observation and interview with Resident #27 sitting up in wheelchair occurred on 9/11/2024 at 2:25 PM. She was observed sitting up in wheelchair with bilateral compression stockings on and her legs were hanging dependently. Resident #27 stated that her feet were supposed to be elevated, but she didn't have anything to elevate them on. Nurse #9 was also in the room and was trying to attach the leg rests to the wheelchair. Nurse #9 stated that the leg rests did not fit Resident #27's wheelchair, and she would get someone from therapy to look at it. A progress note written by the Physical Therapist (PT) on 9/11/2024 at 2:57 PM revealed he was consulted to see Resident #27's wheelchair regarding the wrong footrests for the chair. The note further read that he had provided Resident #27 with a new wheelchair with elevating footrests on 9/11/2024. It further read that her legs were elevated to resident's tolerance and nursing staff were educated on how to elevate and lower leg rests as needed for the resident. A telephone interview was conducted with the Medical Director on 9/12/2024 at 10:02 AM. The Medical Director stated she referred Resident #27 to the Vascular Clinic because of the swelling in her legs. She further stated that if the Vascular Clinic NP had ordered compression stockings, she would expect the facility to get them in a week or so. The Medical Director stated that almost 3 months was not an acceptable amount of time to receive the compression stockings. She indicated that the compression stockings were ordered for the swelling and the purpose of the compression stockings were prevent excessive fluid buildup in the lower extremities, and to prevent complications such as weeping (fluid leaks out of the tissues onto the skin) and venous stasis ulcers. The Medical Director stated that the compression stockings for Resident #27 was a physician's order and she expected the orders to be followed. An observation and interview were completed on 9/12/2024 at 10:14 AM. Resident #27 was lying in bed without the compression stockings on her legs, her feet were noted to be red and edematous. Resident #27 stated that her feet were hurting her this morning and that she probably should be wearing her compression stockings, but she was waiting until after she received her shower to have the staff apply them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with the DON on 9/12/2024 at 10:44 AM. The DON stated the nursing staff should have followed the physician's orders and had the compression stockings in a timely manner. He further stated that he could not answer as to why it took so long for the compression stockings to be ordered and received, except there was a breakdown somewhere in the ordering process. The DON indicated that Resident #27 should have been provided with a wheelchair with footrests that could have been elevated when she was up in her chair.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37673 Based on record review, pharmacist interview, and staff interviews, the facility failed to act on a pharmacy recommendation to complete an Abnormal Involuntary Movement Scale (AIMS/discus) assessment for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for psychotropic medications, Resident #57. Findings included: Resident #57 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, anxiety and major depression. Review of the physician orders on 09/10/24 for Resident #57 revealed an order for Risperdal M-Tab tablet Dispersible 0.5 MG (Milligrams) give one tablet by mouth at bedtime related to recurrent major depressive disorder and moderate schizophrenia unspecified. Place on tongue and let dissolve (Order start date 09/25/23). A quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 was reviewed. Resident #57 had intact cognition. He had no moods or behaviors. He had no hallucinations or delusions. He had no extremity mobility impairments. He had received the following medications during the look back period: Antipsychotic, antidepressant, diuretic and opioid. Antipsychotic medication was received on a routine basis only. The care plan completed on 09/09/24 for Resident #57 included the following focus area: Receives antipsychotic medication with a risk for adverse side effects and diagnoses of major depressive disorder and schizophrenia. The goal was for Resident 57's risk for adverse reactions related to the used of antipsychotic medication to be minimized through current interventions for 90 days. Interventions included, in part, to administer medication as ordered by the physician; report any of the following to the nurse immediately if noted: involuntary movements, nausea/vomiting, palpitations, chest pain, change in balance and coordination, muscle rigidity, or restlessness; and report sedation or change in mental functioning if noted. Review of the medical record on 09/10/24 for Resident #57 revealed an AIMS/discus assessment was last completed ten months prior on 11/01/23. The result of the assessment revealed he was at a low risk for a movement disorder and to continue to monitor according to the policy. Review of a Consultant Pharmacist's Medication Regimen Review dated 07/15/24 documented Resident #57 was due for an AIMS/discus assessment related to the use of the antipsychotic medication Risperdal. The recommendation was signed as acted upon by Unit Manager #1 but not dated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Interim Director of Nursing on 09/10/24 at 2:15 PM he explained when a pharmacy report was received from the pharmacist, he gave the recommendations to Unit Manager #1 to review and take the appropriate actions. He stated he failed to review the resident's record after the report was returned to him from Unit Manager #1 to ensure any needed recommended actions had been taken. He stated it was ultimately his responsibility to ensure the pharmacy recommendations were addressed. In an interview with Unit Manager #1 on 09/10/24 at 2:37 PM she confirmed that she had signed off on the pharmacy report that the AIMS/discus assessment for Resident #57 had been completed as recommended by the pharmacist. She stated she had delegated the task to another nurse but had failed to double check and make sure the task had been completed. She stated it was her full responsibility to make sure the assessment had been completed and that she should have completed the assessment herself but had not. In an interview with the Administrator on 09/10/24 at 2:05 PM she stated she expected all residents receiving psychotropic medications to have an AIMS assessment completed every six months. She noted Resident #57 had an AIM/discus assessment done last in November of 2023 and an assessment had not been completed within the last six months as expected. In an interview with the Consulting Pharmacist on 09/11/24 at 3:15 PM she stated she had notified the facility in July that an AIMS/discus assessment for Resident #57 was due for Risperdal use, an antipsychotic. She explained that a resident on an antipsychotic medication should have an assessment completed every six months to determine if there were any side effects from the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44890 Based on observations, record reviews, and staff interviews, the facility failed to discard expired opened multidose medications, date an opened multidose medication and dispose of loose unidentifiable pills in the drawer of the medication cart (1100 Long Hall) and failed to discard an opened multidose medication per manufacturer's instructions stored for use in the medication cart (Memory Care Unit) for 2 of 6 medication carts reviewed. And the facility failed to remove expired medications available for use in the automated medications dispensing machine in 1 of 4 medication rooms (the Rehab Unit) reviewed for medication storage. Findings included: 1) Observation of the 1100 Long Hall medication cart was conducted on 9/9/2024 at 10:47 AM in the presence of Nurse #9 revealed the following medications were stored on the medication cart: 1a. According to the product manufacturer's instructions, in-use Humalog prefilled insulin KwikPen should be stored at room temperature of less than 86 degrees Fahrenheit (F) and used within 28 days. Resident #25's Humalog prefilled insulin KwikPen was labeled with the opened date of 8/7/2024 and should have been disposed of on 9/4/2024. According to the product manufacturer's instructions, in-use Incruse Ellipta inhaler should be disposed of 6 weeks after opening. Resident #74's Incruse Ellipta inhaler was labeled with the opened date of 7/1/2024 and should have been disposed of on 8/12/2024. According to the product manufacturer's instructions, in-use Timolol Maleate Opthalmic 0.5% Solution should be discarded 28 days after opening. Resident #68's Timolol Maleate Ophthalmic 0.5% Solution was labeled with the opened date of 8/5/2024 and should have been discarded on 9/2/2024. 1.b Resident #1's opened in-use albuterol sulfate 90 microgram (mcg) inhaler was not labeled with an opened date. 1.c Seven unidentifiable pills of different colors and shapes were observed in the bottom of the drawer of the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with Nurse #9 on 9/9/2024 at 11:00 AM. Nurse #9 stated that there should not have been any pills loose in the drawers of the medication cart. She further stated there should not have been any expired medications on the cart. Nurse #9 indicated that all opened multi-dose medications should have a date opened label on them. She stated it was the nurse's responsibility to check for expired medications and loose pills on the medication cart. She further stated that she had not had a chance to check her medication cart that morning. An interview was conducted with the Director of Nursing (DON) on 9/12/2024 at 10:45 AM. The DON stated it was the facilities responsibility to ensure that medications were stored according to manufacturer's instructions and to discard expired medications. He further stated there were not supposed to be any loose pills in the medication cart drawers. 2) An observation was conducted on 9/10/2024 at 12:43 PM of the Memory Care unit medication cart in the presence of Nurse #8. The observation revealed an open box of Ipratropium Bromide 0.02% nebulizer solution vials in foil packages. According to the manufacturer's instructions the individual vials are to be disposed of 7 days after opening. The date on the opened foil package was 9/1/2024 and it should have been disposed of 9/8/2024. An interview with Nurse #8 was completed on 9/10/2024 at 12:55 PM. Nurse #8 stated that there should not be any expired medications on the medication cart. She further stated that she had checked the medication cart for expired medications that morning, but she must have just missed the opened package of Ipratropium Bromide vials. An interview with the DON was completed on 9/12/2024 at 10:45 AM. The DON stated that it was the nurse's responsibility to check the medication cart for expired medications and to remove them from the cart. 3) An observation of the Rehab Unit Medication Storage room was completed on 9/10/2024 at 1:50 PM in the presence of the Rehab Nurse Manager. An observation of the automated medication dispensing machine refrigerator revealed a Novolin 70/30 insulin FlexPen with the expiration date of 8/31/2024, and an Aspart insulin FlexPen with an expiration date of 5/31/2024 were available for use. An interview with the Rehab Nurse Manager occurred on 9/10/2024 at 1:50 PM. The Rehab Nurse Manager stated that she was not sure who was responsible for removing expired medications from the automated medication dispensing machine. She further stated that a pharmacy consultant came to the facility every month and checked the medication carts and medication storage rooms. An interview with the DON was completed on 9/10/2024 at 2:07 PM. The DON stated it was his responsibility to check the automated medication dispensing machine refrigerator for expired medications. He further stated there should not have been expired insulin in the machine available for use. The DON indicated that the staff needed to be more aware of expiration dates and follow the manufacturer's instructions for storage of medication.