STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Nursing & Rehabilitation Center	400 Pelt Drive Fayetteville, NC 28301

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21483 Based on record review and staff interviews, the facility failed to provide a CMS-10123 (Centers for Medicare and Medicaid Services) Notice of Medicare Non-Coverage (NOMNC) at least two days prior to discharge from Medicare part A services for 1 of 3 sampled residents (Resident #127). The findings included: Resident #127 was admitted to the facility under skilled Medicare Part A services to receive physical, occupational and speech therapy on 11/02/2023. Review of the Admission Minimum Data Set (MDS) dated [DATE] indicated the resident's cognition was intact. She was dependent on staff for eating, toileting and personal hygiene. Review of the Physical Therapy discharge summary note indicated the date of services started on 11/03/2023 until 11/22/2023. Review of the Occupational Therapy discharge summary note indicated the date of services started on 11/03/2023 until 11/23/2023. A review of the medical record revealed a CMS-10123 NOMNC letter was issued, and the Responsible Party (RP) was notified on 11/28/2023 by the Business Office Manager that skilled services would be ending on 11/30/2023. An interview was conducted with the Social Worker (SW) on 05/02/2024 at 2:30PM SW indicated she did not have a reason for why the NOMNC was not sent out as soon as the resident was discharged from Rehab services. She added that the Business Office Manager was responsible for issuing the NOMNC letter. An interview with the Rehabilitation Director on 05/02/2023 at 11:42 AM revealed that the rehabilitation services for Resident #127 ended on 11/23/2023 and the resident did not have any other skilled services remaining. He indicated that the Business Office Manager should have provided the and NOMNC letter to the Responsible Party (RP) when the rehab services ended on 11/23/2023. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Business Office Manager on 05/02/2024 at 2:19 PM and she revealed that Resident #127's Medicare A coverage was to end on 11/23/2023 and this should have been discussed with the RP before 11/23/2023. She said that it was her responsibility to check with the family if they had filed for NOMNC appeal. The Business Office Manager added she did not know the reason the NOMNC was not sent out to RP before 11/23/2023. She indicated that she was aware that the NOMNC was to be issued 2 days prior to the end of services. The Business Office Manager indicated she notified the resident and the RP on 11/28/2023 about the NOMNC letter for Resident#127 skilled services. She indicated that The NOMNC letter was missed and was sent later which was on 11/28/2023. An interview was conducted on 05/03/2024 at 3:01 PM with the interim Administrator and she revealed it was her expectation that the residents at the facility or RP should be provided appropriate notices prior to being discharged from Medicare.

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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** 48007 Based on record review, staff, pharmacist, and Nurse Practitioner (NP) interviews the facility failed to respond to the consultant pharmacist's recommendations for 1 out of 5 residents reviewed for unnecessary medications (Resident #42). Findings include: Resident #42 was admitted into the facility on [DATE] with multiple diagnoses including atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), gastroesophageal reflux disease, and arthritis. A review of Resident #42's admission Physician orders for March 2024 included the following: Cardizem Controlled Delivery 120 milligrams (mg) daily, enteric coated aspirin 81 mg daily, Protonix delayed release 40 mg tablet daily, Tylenol 8 hour extended release one tablet every 8 hours as needed for pain, and pentoxifylline extended release 400 mg tablet twice daily. A review of Resident #42's Pharmacy Consultant review dated 3/21/24 included the following: the electronic medical record indicates medications are crushed. Please consider the following alternatives: 1) Change Cardizem CD 120 milligram (mg) capsule daily to diltiazem 30 mg (work with cardiology for change). 2) Change aspirin enteric coated 81 mg daily to aspirin chewable 81 mg daily. 3) Change Protonix 40 mg delayed release to Protonix 40 mg granule packet daily. 4) Change Tylenol 8 hour extended release 650 mg give one tablet every 8 hours as needed for pain to Tylenol 325 mg give 2 tablets as needed for pain. 5) Evaluate pentoxifylline extended release 40 mg tab twice a day for alternative as this extended release should not be crushed. On the Pharmacy Note to the Attending Physician/Prescriber dated 3/21/24 there was a note dated 3/15/24 stating Cardizem changed to twice a day did not want to make any changes per the Nurse Practitioner. There was no other documentation in Resident #42's medical record regarding the Pharmacy Consultant review dated 3/21/24. An interview with the Director of Nursing on 5/2/24 at 10:00 AM stated that when she gets the Pharmacy Consultant Recommendations that she forwards them to the physician. She further stated that she does not always get them back. She further stated that she did not know who put the note on the Pharmacy Consultant review dated 3/21/24. An interview with the Nurse Practitioner on 5/2/24 at 1:55 PM revealed that she changed the Cardizem in March 2024 due to Resident #42 having increased episodes of atrial fibrillation and had an appointment with cardiology scheduled who manages Resident #42. She stated that the nursing staff usually speaks to her regarding any pharmacy recommendations and did not know why she did not address the other medications at that time. An interview with the Regional Director of Operations on 5/2/24 at 2:15 PM indicated that the physicians should be responding to the pharmacist regarding their medication regime reviews. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Pharmacy Consultant on 5/3/24 at 3:00 PM indicated that she expected the physician or their designee to respond to her recommendations and if the physician did not want to change a resident's medication that the rationale would be documented in the resident's medical record or on the communication form.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007 Based on record review and staff interviews the facility failed to administer significant medications to 4 out of 16 residents (Resident #1, #18, #21, and #48) reviewed for medication administration. The facility also failed to follow medication administration guidelines for not crushing certain medications for 1 out of 16 residents reviewed for medication administration (Resident #42). Findings included: 1a) Resident #1 was admitted originally into the facility 01/31/22 and was readmitted on [DATE] with the diagnoses of cerebral infarction, chronic systolic congestive heart failure, hypothyroidism, hypertensive heart and chronic kidney disease with heart failure, epilepsy, and type 2 diabetes mellitus. A review of Resident #1's quarterly Minimum Data Set, dated dated dated [DATE]included that she is severely cognitively impaired, has diagnoses of heart failure, diabetes mellitus, stroke, dementia, seizure disorder, and schizophrenia. It further revealed that she had received insulin injections on 7 days and was taking high risk drug classifications of a diuretic and antidepressant. A review of Resident #1's comprehensive care plan initiated on 3/24/23 included the focus and interventions of a seizure disorder with a risk for injuries, the interventions included give seizure medication as ordered by doctor and to monitor/document the side effects and effectiveness. The focus and interventions of she used an antidepressant medication and had an increased risk for adverse side effects, the interventions included giving the antidepressant medication as ordered by the physician and to observe for/document side effects and effectiveness. The focus and interventions of the potential for dehydration or fluid volume deficit related to status post gastrostomy tube hydration and oral medications the interventions included to administer medications as ordered and monitor/document side effects and effectiveness. A focus and interventions of she had diabetes mellitus with risk for complications interventions included to administer diabetes medication as ordered by the doctor and to monitor/document for side effects and effectiveness, and to monitor blood glucose levels as ordered by the physician. A review of Resident #1's November 2023 Medication Administration Record revealed no documentation of her medications scheduled for 9:00 AM on 11/29/23. These medications included: furosemide 40 mg daily for heart failure, phenobarbital 30 mg twice a day for seizures, and her blood sugar was not documented at 8:00 AM or 11:00 AM which determined if she received any human insulin per sliding scale. A review of Resident #1's facility record did not indicate adverse effects were noted by the medications not being administered. b) Resident #18 was admitted into the facility on [DATE] with the diagnoses of dementia, schizophrenia, sick sinus syndrome, hypertensive heart, and chronic kidney disease without heart failure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #18's quarterly Minimum Data Set, dated dated dated [DATE] indicated that he was moderately cognitively impaired, and had diagnoses of hypertension, dementia, schizophrenia, renal insufficiency, and coronary artery disease. A review of Resident #18's comprehensive care plan dated 8/2/21 and revised 8/1/24 included the focus he received antipsychotic medication related to a diagnosis of paranoid schizophrenia with a risk of adverse side effects, the interventions included administer medication as ordered by the physician and discuss possible side effects with the resident and his responsible party. A review of Resident #18's Medication Administration Record revealed no documentation of his scheduled medications scheduled for 9:00 AM on 11/29/23. These medications included haloperidol 5 mg daily for schizophrenia, amlodipine besylate 5 mg daily for hypertension, and carvedilol 3.125 mg daily for hypertension. A review of Resident #18 medical record did not indicate adverse effects were noted from the medications not being administered. c) Resident #21 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses of cerebrovascular accident, hypertension, and seizures. A review of Resident #21 quarterly Minimum Data Set, dated dated dated [DATE] included he was cognitively intact and had diagnoses of a stroke, hypertension, and seizures. A review of Resident #21's comprehensive care plan included a focus initiated on 2/22/16 that he was receiving an antiseizure medication with risk for toxic side effects and was at risk for injury due to seizure activity with interventions to administer medication as ordered by the physician. A focus initiated on 1/26/18 that he had hypertension with interventions to give antihypertensive medications as ordered and monitor for side effects including orthostatic hypotension and increased heart rate and effectiveness. A review of Resident #21's Medication Administration Record revealed no documentation of his scheduled medications for 9 AM on 11/29/23. These medications included levetiracetam 1000mg twice a day for seizures, hydralazine hydrochloride 100 mg three times a day for hypertension, and labetalol hydrochloride 200 mg three times a day for hypertension. An interview conducted with Resident #21 on 5/2/24 at 1:00 PM indicated that he was not aware of ever missing any medications since his admission into the facility. A review of Resident #21's medical record did not indicate adverse effects were noted from the medications not being administered. d) Resident #48 was admitted into the facility on [DATE] with diagnoses of cerebral vascular accident, diabetes mellitus, hypertension, and hyperlipidemia. A review of Resident #48's quarterly Minimum Data Set, dated dated dated [DATE] included that she was moderately cognitively impaired. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #48's Comprehensive Care Plan dated initiated 5/12/21 included a focus of diabetes mellitus with a risk for complications with interventions of administer sliding scale insulin as ordered and give diabetes medications as ordered by the physician. A focus of at risk of complication of coronary artery disease related to hyperlipidemia with interventions of to give medications to control cholesterol level as ordered by the physician. A review of Resident #48's Medication Administration Record revealed no documentation of her scheduled medications for 9:00 AM on 11/29/23. These medications included insulin glargine inject 24 units subcutaneously one time a day for diabetes mellitus, metoprolol tartrate 25 mg daily for hypertension, amlodipine besylate 10 mg daily for hypertension, and a blood glucose check one time a day and to notify the physician if the blood glucose is less than 70 milligrams per deciliter or greater than 220 mg per deciliter. A telephone interview was conducted on 5/6/24 at 10:07 AM with Nurse #12 who was scheduled on 11/29/23 to pass the 9:00 AM medications. She indicated she was not sure what time she had arrived at work on 11/29/23 however the facility was notorious for calling her in at the last minute. She further indicated that when she arrives late, she walks into several things requiring her immediate attention. She further stated that if the medications were not documented then the medications were not passed by her due to other issues, she was taking care of. A review of Nurse #12's timecard indicated that she clocked in for work at 8:00 AM. An interview was conducted on 5/6/24 at 10:33 AM with Medication Aide #12 who was originally scheduled to pass medications on 11/29/23 at 9:00 AM. She revealed that her job duties had been switched from a medication aide to nursing assistant duties due to call-ins on 11/29/23 and that she had not passed any medications prior to her job duties being changed. An interview was conducted on 5/6/24 at 11:09 AM with the Director of Nursing revealed that she could not say if she was aware of the 9:00 AM medications not being administered on 11/29/23. She indicated that the normal procedure was for the nurse to notify the unit supervisor who then notified the Director of Nursing if there was an issue with the nurse passing medications to ensure the medications were given. An interview with the Unit Supervisor could not be completed as he was out of the country. An interview was conducted on 5/6/24 at 12:45 PM with the Physician who stated that there was a potential for harm if blood glucose were not obtained as ordered and if diabetic, antihypertensive, heart failure, antiseizure medications were not administered to Residents as prescribed. He was unaware of any increased monitoring or adverse effects related to the residents not being administered these types of medications the morning of 11/29/23. He stated that he was not aware of the medications not being administered on 11/29/23 which he expected to take place when these types of medications were not administered. An interview was conducted on 5/6/24 at 1:30 PM with the Interim Administrator revealed that if there was an issue with administering medications that the nurse should have notified the unit supervisor so that arrangements to ensure the medications were administered could be accomplished. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #42 was admitted into the facility on [DATE] with multiple diagnoses including atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), gastroesophageal reflux disease, and arthritis. A review of Resident #42's admission Minimum Data Set, dated dated dated [DATE] revealed she was moderately cognitively intact, had loss of food or fluids while drinking or eating, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complained of difficulty or pain with swallowing, she had no weight loss and was on a mechanically altered diet. A review of Resident #42's comprehensive care plan initiated on 3/18/24 included that she needed to be set up and supervised during meals and that she was on a mechanically altered diet. A review of Resident #42's admission Physician orders for March 2024 included the following: Cardizem(used to treat high blood pressure) Controlled Delivery 120 milligrams (mg) daily , enteric coated aspirin (used to lower the risk of a heart attack, stroke and blood clots) 81 mg daily, Protonix (used to treat gastroesophageal reflux disease (GERD) and a damaged esophagus (the tube that allows food and liquid from the throat to pass to the stomach) delayed release 40 mg tablet daily, Tylenol 8 hour extended release one tablet every 8 hours as needed for pain, and pentoxifylline (used to treat poor blood circulation) extended release 400 mg tablet twice daily. A review of Resident #42's Pharmacy Consultant review dated 3/21/24 included the following: the electronic medical record indicates medications are crushed. Please consider the following alternatives: 1) Change Cardizem CD 120 milligram (mg) capsule daily to diltiazem 30 mg (work with cardiology for change). 2) Change aspirin enteric coated 81 mg daily to aspirin chewable 81 mg daily. 3) Change protonix 40 mg delayed release to protonix 40 mg granule packet daily. 4) Change Tylenol 8 hour extended release 650 mg give one tablet every 8 hours as needed for pain to Tylenol 325 mg give 2 tablets as needed for pain. 5) Evaluate pentoxifylline extended release 40 mg tab twice a day for alternative as this extended release should not be crushed An interview with the Pharmacy Consultant on 5/7/24 at 10:22 AM indicated that the aspirin was enteric coated to reduce the risk of stomach irritation, the protonix, pentoxifylline and Tylenol were designed to be released into the resident's system slowly and by crushing the medication the delayed release was compromised. An interview was conducted on 5/7/24 at 10:31 AM with Nurse #13 indicated that she crushed Resident #42's medication prior to giving it to her. She further indicated that she does not remember if the medications are flagged on the electronic record not to be crushed and does not remember if there is a list of do not crush medications on the medication cart. She stated that she was aware of only the enteric coated medications were not to be crushed but not the other medications. An interview was conducted on 5/7/23 at 3:11 PM with Nurse # 14 revealed that she crushed Resident #42's medication. She indicated that there is a list of do not crush medications on the medication cart but does not remember if the medications are flagged in the electronic record to not crush. She stated that she knew the enteric medications should not be crushed and she thought the pentoxifylline was not to be crushed. An interview was attempted with the physician, but he was unavailable.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 43798 Based on record review and staff interviews the facility failed to maintain documentation of current Covid-19 vaccination status, eligibility screening, education, and offering of Covid-19 vaccination for facility staff. The failures regarding education, offering the vaccine, and maintaining records were found for 4 of 12 facility staff (Staff #1, Staff #2, Staff #3, and Staff #4) reviewed for infection control. The findings included: Facility Covid-19 Staff Vaccination Policy last revised 8/2023 indicated all newly hired employees will be offered the Covid-19 Vaccine. Current employees will be offered the vaccine when there is a change in the vaccine content or if they previously refused and now would like to obtain the vaccine. The facility Staff Vaccination Policy also indicated a master tracker would be created to list all current staff who routinely enter the facility and updated on an ongoing basis as new staff are onboarded. The tracker will include vaccination status and proof of vaccination will be maintained in a secured location. Review of facility records revealed Staff #1 was hired 2/9/2024, Staff #2 was hired 1/29/24, Staff #3 was hired 1/16/24 and Staff #4 was hired 4/25/24. The facility records revealed no documentation of the facility screening the four staff members for Covid-19 vaccine eligibility, offering the vaccine and educating the staff on the benefits, risks, and potential side effects of the vaccine. An interview was conducted with the facility Infection Preventionist (IP) on 5/3/24 at 9:12 AM. The IP explained she started working at the facility end of January 2024 and she could not find any records of employee Covid-19 vaccination documentation. The IP indicated she started looking for the staff Covid-19 vaccine tracking and documentation when the survey team asked for the information on 4/29/24 which she could not locate, and she started keeping the staff vaccination records straight on 5/2/24. She verbalized she was not made aware during hire that the staff vaccination records were not kept and that she needed to track it, screen, offer and provide education on Covid-19 vaccines to staff. During an interview on 5/3/24 at 9:30 AM with the Director of Nursing (DON), she stated she thought the previous Infection Preventionist (IP) was keeping track of staff Covid-19 vaccination status and offering education regarding Covid-19 vaccination. The DON stated going forward the current IP was going to keep track of employee vaccination status, screen, educate and offer Covid vaccines to facility staff. An interview was conducted on 5/3/24 at 10:11 AM with the facility Interim Administrator. She stated going forward all new hired employees would be screened for Covid-19 vaccination eligibility, offered the vaccine, and educated on the benefits, risks, and potential side effects of the vaccine. The Administrator further stated going forward, the IP or designee would ensure staff Covid vaccination status, screening and education was tracked and documented accurately.