STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on physician interview, staff interview, and record review the facility failed to further assess 1 of 1 sampled residents (Resident #1) who experienced an elevated blood pressure which flagged in the electronic medical record's alert system. Findings included: Record review revealed Resident #1 was admitted to the facility on [DATE]. The resident's documented [DIAGNOSES REDACTED]. A 05/14/20 physician order [REDACTED]. Administration Instructions documented, For systolic blood pressure greater than or equal to 170 or diastolic blood pressure greater than or equal to 100. Recheck blood pressure 1 hour after [MEDICATION NAME] is given. If blood pressure is still elevated, notify physician. Resident #1's 05/22/20 quarterly minimum data set (MDS) documented she had impaired short and long term memory, she was severely impaired in decision making, she exhibited no behaviors including rejection of care, she was dependent on the staff for all of her activities of daily living (ADLs), and she received at least 51% of her calories and at least 501 cubic centimeters (cc)/day of fluid from her tubefeeding. Resident #1's vital signs record documented her blood pressure was 157/105 at midnight on 06/27/20 (the blood pressure reading triggered the electronic medical record's alert system and flagged in red with an exclamation point beside it). Review of Resident #1's June 2020 electronic medical administration record (e-MAR) revealed the resident did not receive prn [MEDICATION NAME] on 06/27/20 even though her diastolic blood pressure exceeded 100. Review of the resident's progress notes and vital sign record revealed no further blood pressure readings were documented for Resident #1 after midnight on 06/27/20. In a 06/27/20 8:25 AM progress note Nurse #1 documented, During morning med pass at (5:45 AM) walked by room and noted emesis down the front of elder's gown and in her open mouth. Head of bed was elevated 45 degrees. Elder is a tube feeder and had (Glucerna 1.5) infusing at rate of 55 mL (milliliters)/hr with 180 mL flushes every 4 hours. Upon entering room suctioned elder's mouth out and got back about 100 mL of yellowish brown colored liquid noted her not to be responsive. Checked pulse and noted to be pulseless with no rise and fall of chest noted, no heart tones heard or lung sounds auscultated. Elder is AND (allow natural death) code status During a telephone interview with Nurse #1 on 07/07/20 at 3:56 PM (phone) he stated he did not recall seeing an alert in the e-MAR regarding Resident #1's blood pressure on 06/27/20, and he did not recall Nursing Assistant (NA) #1 telling him that Resident #1 had an elevated blood pressure on 06/27/20. He reported the facility had a double alert system for abnormal vital signs with the abnormal vital being highlighted in red in the e-MAR and the NA collecting vital signs verbal alerting the nurse about the abnormal vital sign. He commented that the parameters for prn [MEDICATION NAME] were about the same for every patient with administration warranted when the resident's systolic blood pressure was equal to or greater than 170 or 180 or when the resident's diastolic blood pressure was equal to or greater than 100. According to Nurse #1, the resident's blood pressure was supposed to be checked an hour after [MEDICATION NAME] administration, and if the resident's blood pressure was still elevated, the resident's primary physician was to be contacted for guidance. During a telephone interview with NA #1 on 07/07/20 at 5:01 PM she stated 06/26/20 - 06/27/20 was her first time caring for Resident #1. She reported she began taking vital signs in Resident #1's unit around 11:15 PM on 06/26/20, and remembered reporting to Nurse #1 that Resident #1 had a spike in her blood pressure. She commented she assumed the nurse would take follow-up blood pressure readings on the resident, but she was not sure this happened because she had other duties to perform. During a telephone interview with Resident #1's primary physician on 07/09/20 at 3:08 PM he stated Nurse #1 did not have to automatically administer the prn [MEDICATION NAME] to the resident on 06/27/20 based on one blood pressure reading, but the nurse should have taken follow-up blood pressures subsequently to determine if the elevated blood pressure was a one time fluke or the resident's blood pressure remained elevated for a more extended period of time. He commented if multiple readings were elevated then the prn [MEDICATION NAME] should have been administered, with the resident's blood pressure checked again an hour after medication administration. According to the physician, it could not be determined if the elevated blood pressure played a part in Resident #1's death. He explained the resident could have had an event that triggered vomiting, or the resident could have vomited and then there was a resulting event which contributed to her death. He commented the resident did not present with the reddish-blue coloring that was typical with aspiration. During a telephone interview with the facility administrator on 07/09/20 at 4:24 PM she stated there was a breakdown in communication between the nurse and NA on 06/27/20 regarding Resident #1's blood pressure. She reported Nurse #1 should have reassessed Resident #1's blood pressure after the elevated value of 157/105 was obtained at midnight on 06/27/20.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on physician interview, staff interview, and record review the facility failed to carry out a psychiatry order to recheck the functionality of a hearing aid for 1 of 1 sampled residents (Resident #2) who depended on the use of a hearing aid to communicate with staff. Findings included: Record review revealed Resident #2 was admitted to the facility on [DATE]. Her documented [DIAGNOSES REDACTED]. Record review revealed Resident #2 received a notice on 07/25/19 that her telecoil hearing aid had been approved. A 01/07/20 psychiatry consult documented, Pt. (Patient) is accompanied by the social worker (SW) from (the facility). Per SW, patient's behavior has improved since she received her hearing aides but at times continues to 'holler out', may be due to patient not being able to hear During the visit patient appears to be hard of hearing and answers one word sentences to questions. Pt. has a hearing aid noted to her left ear A 01/07/20 order written by Nurse Practitioner (NP) #1, who worked for psychiatry services, documented to have the audiologist re-evaluate Resident #2's hearing aid. On 02/20/20 the facility's former SW documented in her spiral notebook that she had identified the company which provided Resident #2 with her hearing aid, and noted that need to take hearing aide to office. Resident #2's 05/19/20 annual minimum data set (MDS) documented her cognition was severely impaired, she was dependent on the staff for all of her activities of daily living, she experienced moderate difficulty hearing with the speaker having to increase their volume and speak distinctively, she utilized a hearing aid, and she sometimes understood others. A 05/27/20 Care Plan note documented, She (Resident #2) is alert and oriented to person. Her speech is clear, and she is sometimes understood and sometimes understands. She is moderately hard of hearing requiring speaker to use loud tone of voice or staff will write out questions. She has a hearing aid in left ear and staff still must raise voice or repeat several times to be heard. She can answer simple direct questions or follow simple commands when she understands and/or hears what is being ask. Will often furrow brow and have puzzled look on her face when she does not hear what is said or understands. Will yell out loudly 'what did you say' or 'I can't hear you.' During a 07/08/20 3:03 PM interview with Nurse #2 who cared for Resident #2 she stated she did not always think that the resident's hearing aid was effective in enhancing her communication. During a 07/08/20 3:57 PM interview with Nursing Assistant (NA) #4 who cared for Resident #2 she stated she was not sure the resident's hearing aid was working correctly because it did not seem to help the resident hear any better. During an interview with Resident #2's Unit Manager on 07/08/20 at 4:04 PM she stated the hall nurse should have noted the 01/07/20 order and followed up to obtain an appointment to get Resident #2's hearing aide serviced. She reported the hall nurse should have input the appointment date into the facility's electronic medical record system. During an interview with

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

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F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the facility's current SW on 07/08/20 at 4:15 PM she stated she just made contact with the company which furnished Resident #2's hearing aid, and the company reported the hearing aid had not been brought back in for follow-up service since it was furnished. She reported the person she talked with stated it was past time to check the tube in the hearing aid which could effect the amplification. During an interview with Resident #2's primary physician on 07/09/20 at 3:08 PM he stated hearing aides should be taken periodically for servicing so that they continued to work at peak proficiency. He commented not being able to communicate with staff effectively could affect resident quality of life. During a telephone interview with the facility administrator on 07/09/20 at 4:24 PM she stated there was a problem in getting Resident #2's hearing aid serviced because the psychiatric NP did not have rights to place orders into the facility's electronic medical record system, and the order was placed in the resident's paper chart after hours. She explained that normally the unit secretary would have scanned the order into the electronic medical record, and the SW would have followed up to make sure an appointment was secured.