

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <i>OCT 17 2011</i>	(X3) DATE SURVEY COMPLETED 09/01/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to notify the attending</p>	F 157	<p>F 157</p> <p>CORRECTIVE ACTION FOR IDENTIFIED RESIDENT(S) Resident # 61 Family and Physician were notified, an X-ray of left arm, elbow, and wrist was Ordered and obtained, an orthopedic Consultant secured and an event investigation was completed. Resident# 78 MD and family were notified and antibiotics were administered per physician order.</p> <p>IDENTIFICATION OF RESIDENTS AT RISK DUE TO DEFICIENT PRACTICE: All residents are at risk.</p> <p>CORRECTIVE ACTION/SYSTEMIC CHANGES PLAN: Education was provided to the nursing staff regarding prompt notification of MD (completion date 8-31-11 and 9-15-11) and family members of any change in Resident condition or any accident/event.</p> <p>Nurses who find a problem must notify physician and RP promptly off all changes in Resident condition.</p> <p>MONITORING: 24 hour report, which denotes any change in resident condition/event, will be reviewed at ITM.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy Freeman RN</i>	TITLE <i>Director of Nurses</i>	(X6) DATE <i>10-14-11</i>
--	--	----------------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 1</p> <p>physician of edema and a reddened area for 2 of 2 sampled residents with significant changes in skin conditions. (Residents 61 and 78)</p> <p>Findings include:</p> <p>1. Resident #61 was admitted to the facility on 5/10/11 with diagnoses of Anemia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) exacerbation, Peripheral Vascular Disease (PVD), Anxiety, Hypertension, debility and a hospice patient.</p> <p>A review of his initial Minimum Data Set dated 8/5/11 revealed he was severely impaired in cognitive patterns. Review of the resident's care plan dated 5/10/11 revealed he was at risk for skin breakdown. As an approach, staff were to observe skin during activities of daily living (ADL) care and report redness, swelling, tenderness open areas, bruising, to the nurse and physician.</p> <p>Review of the resident's weekly skin assessment dated 8/4/11 revealed resident had multiple areas of " ecchymosis " (bruising) to both arms and legs.</p> <p>Review of the resident ' s weekly skin assessment dated 8/11/11 revealed there was swelling to the left lower extremity and hand. The assessment revealed the area was discolored with ongoing healing.</p> <p>Record review of the nurse's notes dated 8/1/11 at 11:30 PM, revealed Resident #61 ' s left arm was swollen from the elbow to his finger tips. Nurse #7 elevated the resident ' s arm while he was in bed. Nurse #7 further documented that</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	<p>Continued From page 2</p> <p>Nurse #3 (7am -3pm) had reported the swelling on first shift.</p> <p>During an interview on 8/31/11 at 10:10 AM Nurse #3, stated on 8/1/11 she was on the 7am to 3pm shift. She stated she did report to the charge nurse that Resident #61 ' s arm was swollen from his left elbow to his fingertips. She further stated she did not call the physician because the charge nurse was supposed to call him.</p> <p>During an interview on 8/31/11 at 10:20 AM, Nurse #1, the charge nurse, stated no one had reported to her on 8/1/11 or 8/3/11 when she did rounds with the physician the resident ' s arm was swollen. She stated the physician had not been notified because it had not been reported to her. Stated he was notified when the resident complained of pain and the physician ordered an x-ray on 8/12/11. Review of the final report revealed the resident had an old fracture with pins.</p> <p>During an interview on 8/31/11 at 10:55 AM, Nurse #3 stated she did not remember the resident having any discoloration and no complaints of pain when she assessed him on 8/1/11. Stated the only new concern was the swelling from his elbow to his finger tips.</p> <p>During an observation on 8/31/11 at 10:56 AM the resident's left arm around his elbow was observed without swelling.</p> <p>During an interview with the physician on 8/31/11 at 5:05 PM, the doctor stated he was not notified until 8/12/11 when he ordered an x-ray to rule out</p>	F 157		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 3</p> <p>a fracture. Stated he did see the resident on 8/3/11, but was not told of any swelling of the resident's arm. Stated if staff had told him about the resident's arm being swollen, he would have immediately ordered X-rays to rule out a fracture.</p> <p>During an interview on 8/31/11 at 6:10 PM with Nursing Assistant (NA#3), the resident 's NA , stated she noticed on 8/1/11 that the resident ' s left arm was swollen and bruised. She stated she went and got the nurse (Nurse #3). NA #3 stated Nurse #3 came to the resident's room and assessed him.</p> <p>During an interview on 9/1/11 at 8:45 AM, the Director of Nursing (DON) stated all nurses can call the physician when a change in condition is assessed. The DON stated the nurse should have called the physician to make him aware of the resident's left arm being swollen.</p> <p>During an interview on 9/1/11 at 2:00 PM, a family member stated she had been at the facility visiting her father around 8/1/11. The family member stated her father did not complain of pain when he was questioned about his pain level when his arm was swollen. She stated she knew her father had an old fracture but did not know why he had the swelling and bruising.</p> <p>During an interview on 9/1/11 at 3:15 PM, Nurse #7 stated she did write the entry in the Nurses ' Notes concerning Resident #61 and stated the information concerning Resident #61 ' s arm and hand being swollen was reported to her by the 7am-3pm nurse. Nurse #7 stated she did not notify the physician because she thought the 7am-3pm nurse had notified him. She stated she</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 4</p> <p>did look at the resident ' s arm and it was swollen to the fingertips.</p> <p>2. Resident #78 was admitted to the facility on 8/19/11 with diagnoses including Status post right hip fracture and surgical repair, Hypertention (HTN), Dementia and Anemia. Resident #78 was assessed as having some short term memory impairment. The Minimum Data Set Assessment and Care Area Assessment had not been completed at the time of survey.</p> <p>The initial Care Plan, dated 8/19/11, documented " Skin Condition (non-decubitus) to monitor for infection. The Care Plan, dated 8/30/11, documented that Resident #78 had a risk for skin breakdown related to needing assistance with bed mobility and having a surgical site on her right hip. Listed under Approaches related to the risk was to monitor recent surgical site to the right hip for signs/symptoms of infection and report to the physician as needed.</p> <p>The Minimum Data Set Assessment and Care Area Assessment had not been completed at the time of the survey. The resident was initially assessed as having some short term memory problems and had a score of 14 on the Brief Interview for Mental Status and being cognitively intact. Resident #78 was assessed as needing extensive assistance in activities of daily living, with the exception of eating where she was set-up only.</p> <p>During medication pass on 8/29/11 at 7:45pm, resident #78 ' s right hip was observed by Nurse #4. Nurse #4 placed her gloved hand over the</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 5</p> <p>resident ' s right hip area and stated that the area was not only red, but very warm to touch. There was a reddened, circular area approximately 5 cm x 5cm in diameter surrounded by an area that was a lighter shade of pink over the right hip area. A healing incision was noted also on the right hip area.</p> <p>Review of the Nursing notes dated 8/29/11 for 7AM-3PM shift documented that the resident had a reddened area on her right hip that blanched easily, was cool to touch, and " has not been there before, after surgery. "</p> <p>Review of the Nursing notes dated 8/29/11 for the 3PM-11PM shift documented that the resident had a reddened area noted to the upper incision area on her right hip that was blanchable.</p> <p>Review of the 24-hour report log showed that Nurse #3 documented an entry on the 7AM-3PM day shift for 8/29/11 a reddened area on resident #78 ' s right hip.</p> <p>Review of the 24-hour report log did not document any entry from 8/29/11 evening shift of any reddened area for resident #78.</p> <p>Review of the Minimum Data Set (MDS) 5-day Progress note, dated 8/30/11, documented that Resident #78 ' s " surgical site being monitored. "</p> <p>Review of the Nursing Notes dated 8/31/11 at 3:25PM documented that resident #78 ' s right hip remained red and she had been put on the list for the physician to see during rounds on 8/31/11.</p> <p>During an observation of Resident #78 ' s surgical</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 6</p> <p>site on her right hip and interview with the Physician on 5/31/11 at 6:30pm he stated that the area was red and warm to touch. He stated that he would err on the side of caution and begin an antibiotic because he did not know if there was anything going on with the area. He further stated that he would have preferred to have been notified of the redness and warmth in the hip because the resident just had hip surgery and redness and warmth can be a sign of infection.</p> <p>During an interview on 9/1/11 at 10:55am with Nurse #3, who entered documentation on 8/29/11, that resident had a new reddened area on right hip, she stated that she told the charge nurse, Nurse #1.</p> <p>During an interview on 9/1/11 at 11am with Nurse #1 she stated the she was not working on 8/29/11. She stated the nurses are not supposed to verbally communicate with the nursing supervisor but to write in the communication book. The nursing staff can call the physicians with concerns and they know this. Nurse #1 and surveyor reviewed the communication log and there was an entry for the 7AM-3PM shift regarding a new reddened hip area. There was no entry in the communication log for 3PM-11PM evening shift when the evening nurse also noted the reddened area. Nurse #1 stated that if a nurse is "bogged down" there are always other nursing supervisors to go to. Nurse #1 stated that she first learned of the redness and warmth on 8/31/11 from the therapist who had the resident in the whirlpool.</p> <p>During an interview with the Assistant Director of Nursing on 9/1/11 at 2:10pm she stated that on</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 7 8/30/11 during the IDT (Interdisciplinary Team) Meeting, the team mentioned Resident #78's reddened area on her hip but did not make and notes or report the redness to the physician because they did not think it was a problem. During an interview with the Director of Nursing (DON) on 9/1/11 at 2:15pm she stated that anytime you have redness at a surgical site that could be a warning sign and it should have been reported to the Physician.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the facility failed to assess for self-administration of medications for 2 of 2 residents observed with medications in their rooms. (Residents #78 and #50). The findings include: 1. Resident #78 was admitted to the facility on 8/19/11 with diagnoses including Status post right hip fracture and surgical repair and Dementia. Resident #78 was assessed as having some short term memory impairment. The Minimum Data Set Assessment and Care Area Assessment had not been completed at the time	F 176	F 176 CORRECTIVE ACTION FOR IDENTIFIED RESIDENT(s) Resident # 78 Cream was removed from resident room and order was written. Resident # 50 inhaler was removed from resident room and put on med cart for nurse to administer. IDENTIFICATION OF RESIDENTS AT RISK DUE TO DEFICIENT PRACTICE: All nursing residents. CORRECTIVE ACTION/SYSTEMIC CHANGES PLAN: Education was provided to staff that medications will be kept on cart or kept in a lock-box accessible to residents who have been deemed competent to administer their own meds (completion date 10-31-11).	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	<p>Continued From page 8 of survey.</p> <p>The initial Care Plan, dated 8/30/11 documented that Resident #78 was unable to self-administer her own medications and her level of assistance may fluctuate related to her diagnosis of Dementia.</p> <p>Review of the medical record revealed Resident #78 had no physician orders for Performin cream and no assessment for self administration of any medication or treatment.</p> <p>During initial tour on 8/29/11 at 7:45PM a medication administration was observed. During the medication pass, Resident #78 was noted to have a tube of Performin (pain relieving gel cream comprised of Menthol 3.1%) on her bedside table. The instructions on the tube read in part, " do not apply to wounds, damaged or irritated skin, do not use with other ointments or creams and to wash hands after use. " The resident stated that her family member brought the cream from home and she uses the cream on her back for back pain. Nurse #4 asked the resident if therapy knew she was using the cream and the resident stated that she thought she told the therapy department, but was not sure. The nurse left the room after the resident ' s medications were given. The tube of cream was left on the resident ' s bedside table.</p> <p>The tube of Performin remained on the bedside table during observations on 8/30/11 at 11:00AM.</p> <p>During an observation on 8/31/11 at 6:30PM with the physician and Nurse #1 the tube of Performin was observed to be sitting on the resident ' s</p>	F 176	<p>MONITORING: Will obtain MD order and use medication self-administration evaluation form which will be reviewed at ITM. On going assessments will be reviewed monthly as part of QA and reported quarterly.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 176	<p>Continued From page 9</p> <p>bedside table. Nurse #1 asked the resident if that was her cream and the resident stated yes. When Nurse #1 asked where she got the cream the resident stated she bought it at a local store. Resident #78 stated that she uses the cream on her back because her back always hurts. Nurse #1 stated that the cream was considered a medication and the physician would need to write an order for the cream and the nurses would keep the medication in the medication cart and the resident would need to ask the nurse for the cream. The cream was removed from the resident ' s room.</p> <p>During an interview with Nurse #1 on 8/31/11 at 6:50PM, she stated that she was unaware that Resident #78 had any pain relieving cream at her bedside.</p> <p>During an interview with the Physician on 8/30/11 at 6:55PM, he stated that although the medication is relatively benign and only containing Menthol, the resident has been very confused since her hip surgery.</p> <p>During an interview with the Director of Nursing on 9/1/11 at 11:30am she stated that it was expected that medications be kept in the medication cart until the resident was assessed to self-administer medications. She stated that the facility does have wandering residents and medications need to be accounted for.</p>	F 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 176	<p>Continued From page 10</p> <p>2. Resident #50 was admitted to the facility on 4/27/11 with diagnoses of Chronic Persistent Bronchitis and Asthma.</p> <p>Review of the resident's quarterly Minimum Data Set with the Assessment Reference Date (ARD) of 8/4/11 revealed she was cognitively intact.</p> <p>Record review of the care plan held 8/5/11 read, "Resident unable to self-administer own meds."</p> <p>Review of physician ' s orders for the Month of August 2011, revealed Resident #50 was prescribed a Ventolin inhaler and was to receive 2 puffs twice daily.</p> <p>During a med pass observation on 8/30/11 at 9:54 AM, Resident #50 ' s ventolin inhaler was missing from the med cart. During an interview with Nurse #5, she stated Resident #50's Ventolin inhaler usually was found in the resident's room. Nurse #7, training with Nurse #5, found the resident's inhaler in her room and was observed returning the inhaler to Nurse #5.</p> <p>During an interview on 8/31/11 at 9:15 AM, Nurse #7 stated she did find the inhaler in Resident # room on 8/30/11 and gave the inhaler to Nurse #5.</p> <p>During an interview on 8/31/11 at 9:10 AM, Resident #50 stated that staff leave the inhaler in</p>	F 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 11 her room most of the time. Resident #50 stated the nurses just get busy and walk off and leave the inhaler in her room.	F 176		
F 309 SS=E	<p>During an interview on 9/1/11 at 8:45 AM, the Director of Nursing (DON) stated staff should have medications secured and should have assessed and care planned Resident #50 before leaving her inhaler in her room.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and family interviews, the facility failed to provide the necessary care for residents with a change in skin condition for 2 of 4 sampled residents (Residents 61 and 78) and failed to monitor bowel movement records for 3 of 3 residents that had no bowel movements recorded for over 3 days (Residents 50, 55, and 25).</p> <p>The findings include:</p> <p>1. Resident #61 was admitted to the facility on 5/10/11 with diagnoses of Anemia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) exacerbation,</p>	F 309	<p>F 309 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS AT GREATEST RISK DUE TO DEFICIENT PRACTICE:</p> <p>Upon discovery of resident #61 increased swelling and discoloration of arm and hand, MD was notified and orders were given. An abuse investigation was initiated due to injury of unknown origin. Resident # 78 MD notified and he evaluated on his next rounds. Resident was started on ABT. Resident #50, #55, #25 Laxatives administered per MD order and bowel movements monitored.</p> <p>IDENTIFICATION OF RESIDENTS AT GREATEST RISK DUE TO DEFICIENT PRACTICE: All residents.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 12</p> <p>Peripheral Vascular Disease (PVD), Anxiety, Hypertension, debility and a hospice patient.</p> <p>A review of his Minimum Data Set dated 8/5/11 revealed he was severely impaired in cognitive patterns. Review of the resident's care plan dated 5/10/11 revealed he was at risk for skin breakdown. As an approach, staff were to observe skin during activities of daily living (ADL) care and report redness, swelling, tenderness open areas, bruising, to the Nurse and physician.</p> <p>Review of the resident's weekly skin assessment dated 8/4/11 revealed resident had multiple areas of " ecchymosis " (bruising) to both arms and legs.</p> <p>Review of the resident ' s weekly skin assessment dated 8/11/11 revealed there was swelling to the left lower extremity and hand. The assessment revealed the area was discolored with ongoing healing.</p> <p>Record review of the Nurse ' s notes dated 8/1/11 at 11:30 PM, revealed Resident #61 ' s left arm was swollen from the elbow to his finger tips. Nurse #7 elevated the resident ' s arm while he was in bed. Nurse #7 further documented that Nurse #3 (7am -3pm) had reported the swelling on first shift.</p> <p>During an interview on 8/31/11 at 10:10 AM Nurse #3, stated on 8/1/11 she was on the 7am to 3pm shift. She stated she did report to the charge nurse (Nurse #1) that Resident #61 ' s arm was swollen from his left elbow to his fingertips. She further stated she did not call the physician because the charge nurse was</p>	F 309	<p>CORRECTIVE ACTION/SYSTEMIC CHANGES PLAN:</p> <p>Standing order in place for residents not having bowel movement in 3 days. Bowel movement reports from Care Tracker reviewed daily on 3-11 shift and appropriate action taken.</p> <p>All nurses to promptly notify MD and RP for all changes in resident condition (Completion Date 9-15-11).</p> <p>MONITORING:</p> <p>DON collects reports and these are reviewed at ITM as part as part of an on-going QA (Completion Date 9-15-11).</p> <p>Staff Trained (Completion Date 9-5-11).</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 13 supposed to call him.</p> <p>During an interview on 8/31/11 at 10:20 AM, Nurse #1, the charge nurse, stated no one had reported to her on 8/1/11 or 8/3/11 when she did rounds with the physician the resident ' s arm was swollen. She stated the physician had not been notified because it had not been reported to her. Stated he was notified when the resident complained of pain and the physician ordered an x-ray on 8/12/11. Review of the final report revealed the resident had an old fracture with pins.</p> <p>During an interview on 8/31/11 at 10:55 AM, Nurse #3 stated she did not remember the resident having any discoloration and no complaints of pain when she assessed him on 8/1/11. Stated the only new concern was the swelling from his elbow to his finger tips. She further stated the resident ' s elbow and arm no longer had the swelling.</p> <p>During an observation on 8/31/11 at 10:56 AM the resident's left arm around his elbow was observed with a dark purple area. When the nurse lifted the resident's left arm he did not complain of pain and had no facial grimace.</p> <p>During an interview with the physician on 8/31/11 at 5:05 PM, the doctor stated he was not notified until 8/12/11 when he ordered an x-ray to rule out a fracture. Stated he did see the resident on 8/3/11, but was not told of any swelling of the resident's arm. Stated if staff had told him about the resident's arm he would have immediately ordered X-rays to rule out a fracture.</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 14</p> <p>During an interview on 8/31/11 at 6:10 PM with Nursing Assistant (NA#3), the resident ' s NA , stated she noticed on 8/1/11 that the resident ' s left arm was swollen and bruised. She stated she went and got the nurse (Nurse #3). NA #3 stated Nurse #3 came to the resident's room and assessed him.</p> <p>During an interview on 9/1/11 at 8:45 AM, the Director of Nursing (DON) stated all nurses can call the physician when a change in condition is assessed. The DON stated the nurse should have called the physician to make him aware of the resident's left arm being swollen.</p> <p>During an interview on 9/1/11 at 2:00 PM, a family member stated she had been at the facility visiting her father around 8/1/11. The family member stated her father did not complain of pain when he was questioned about his pain level when his arm was swollen. She stated she knew her father had an old fracture but did not know why he had the swelling and bruising.</p> <p>During an interview on 9/1/11 at 3:15 PM, Nurse #7 stated she did write the entry in the Nurses ' Notes concerning Resident #61 and stated the information concerning Resident #61 ' s arm and hand being swollen was reported to her by the 7am-3pm nurse. Nurse #7 stated she did not notify the physician because she thought the 7am-3pm nurse had notified him. She stated she did look at the resident ' s arm and it was swollen to the fingertips. She stated she did elevate the resident's arm and he finally got an X-ray ordered.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 15</p> <p>2. Resident #78 was admitted to the facility on 8/19/11 with diagnoses including Status post right hip fracture and surgical repair, HTN, Dementia and Anemia. Resident #78 was assessed as having some short term memory impairment. The Minimum Data Set Assessment and Care Area Assessment had not been completed at the time of survey.</p> <p>The initial Care Plan, dated 8/19/11, documented " Skin Condition (non-decubitus) to monitor for infection. On the Care Plan dated 8/30/11 documented showed that Resident #78 had a risk for skin breakdown related to needing assistance with bed mobility and having a surgical site on her right hip. Listed under Approaches related to the risk was to monitor recent surgical site to the right hip for signs/symptoms of infection and report to the physician as needed.</p> <p>The Minimum Data Set Assessment and Care Area Assessment had not been completed at the time of the survey. The resident was assessed as having some short term memory problems and had a score of 14 on the Brief Interview for Mental Status and being cognitively intact. Resident #78 was assessed as needing extensive assistance in activities of daily living, with the exception of eating where she was set-up only.</p> <p>During medication pass on 8/29/11 at 7:45pm, resident #78 ' s right hip was observed by nurse #4. Nurse 4 placed her gloved hand over the resident ' s right hip area and stated that the area was not only red, but very warm to touch. There was a reddened, circular area approximately 5 cm x 5cm in diameter surrounded by an area that</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 16</p> <p>was a lighter shade of pink over the right hip area. A healing incision was noted also on the right hip area.</p> <p>Review of the Nursing notes dated 8/29/11 for 7-3 shift documented that the resident had a reddened area on her right hip that blanches easily, was cool to touch, and " has not been there before after surgery. "</p> <p>Review of the Nursing notes dated 8/29/11 for the 3-11pm shift documented that the resident had a reddened area noted to the upper incision area on her right hip that was blanchable.</p> <p>Review of the 24-hour report log for the 7AM-3PM shift on 8/29/11 did document an entry of a reddened area on residnet #78's right hip by Nurse #3.</p> <p>Review of the 24-hour report log did not document any entry from 8/29/11 evening shift of any reddened area for resident #78.</p> <p>Review of the Minimum Data Set (MDS) 5-day Progress note, dated 8/30/11, documented that Resident #78 ' s " surgical site being monitored. "</p> <p>Review of the Nursing Notes dated 8/31/11 at 3:25PM documented that resident #78 ' s right hip remained red and she had been put on the list for the physician to see during rounds on 8/31/11.</p> <p>During an observation of Resident #78 ' s surgical site on her right hip and interview with Dr. Hardin on 5/31/11 at 6:30pm he stated that the area was red and warm to touch. He stated that he would err on the side of caution and begin an antibiotic</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 17</p> <p>because he did not know if there was anything going on with the area. He further stated that he would have preferred to have been notified of the redness and warmth in the hip because the resident just had hip surgery and redness and warmth can be a sign of infection.</p> <p>During an interview on 9/1/11 at 10:55am with Nurse #3, who entered documentation on 8/29/11, that resident had a new reddened area on right hip she stated that she told the charge nurse, Nurse #1.</p> <p>During an interview on 9/1/11 at 11am with Nurse #1 she stated she was not working on 8/29/11. She stated the nurses are not supposed to verbally communicate with the nursing supervisor but to write in the communication book. The nursing staff can call the physicians with concerns and they know this. Nurse #1 and surveyor reviewed the communication log and there was an entry for the 7-3 shift regarding a new reddened hip area. There was no entry in the communication log for 3-11pm evening shift when the evening nurse also noted the reddened area. Nurse #1 stated that if a nurse is "bogged down" there are always other nursing supervisors to go to. Nurse #1 stated that she first learned of the redness and warmth on 8/31/11 from the therapist who had the resident in the whirlpool.</p> <p>During an interview with the Assistant Director of Nursing on 9/1/11 at 2:10pm she stated that on 8/30/11 during the IDT (Interdisciplinary Team) Meeting, the team mentioned Resident #78's reddened area on her hip but did not make and notes or report the redness to the physician because they did not think it was a problem.</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 18</p> <p>During an interview with the Director of Nursing (DON) on 9/1/11 at 2:15pm she stated that anytime you have redness at a surgical site that could be a warning sign and it should have been reported to the Physician.</p> <p>3. The facility Admitting/Standing Orders read as follows: 21. Constipation Protocol: If no bowel movement in 3 days give Milk of Magnesia 30cc with 4 ounces of water or fluids PO (by mouth) and G-tube (Gastrostomy tube). If no results by the next shift may give Glycerin or Dulcolax Suppository rectally. If no results by next shift give (name of enema) enema rectally. If still no results call physician.</p> <p>Resident #55 was admitted to the facility on 11/09/09 and re-admitted 6/29/11 with diagnoses including Dysphagia, CVA with right sided hemiparesis, History of Constipation, Dementia, and Seizures.</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment dated 8/1/11 documented the resident as scoring 13 on the BIMS (Brief Interview for Mental Status), having unclear, mumbled speech and sometimes understanding. The resident was assessed as needing extensive assistance with bed mobility and total dependence for toileting. The resident was also assessed and incontinent for bowel and bladder. The resident uses a communication board.</p> <p>Review of the most recent Care Area Assessement (CAAs), dated 5/16/11, documented that Nutrition triggered related to a diagnosis of Dementia, Dysphagia and recent</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 19</p> <p>Cerebrovascular Accident with right sided hemiplegia. Dehydration did not trigger.</p> <p>Review of the most recent Care Plan dated 5/19/11 for Dehydration/Fluid Maintenance and updated on 8/4/11 read in part, Problem: History of Constipation with Goals being: will have bowel movement (BM) at least every 3 days x 90 days. Approaches listed in meeting this goal were to observe for BM QS, document, to encourage food and fluids, to assist out of bed to wheelchair daily, to report decreased bowel sounds, abdominal pain, and abdominal distention to the physician and to use medications as ordered (laxative, stool softeners and enemas).</p> <p>Review of the Medication Administrative Record for the months of May 2011 and June 2011 documented that resident # 55 received Enulose 30ml (milliliters) PO (by mouth) at bedtime and beginning on 6/15/11 received Colace (stool softener) twice daily.</p> <p>Review of the Physician Progress notes dated 5/25/11 read in part that the resident had complained of rectal pain and was probably constipated.</p> <p>Review of the Nursing note, dated 5/25/11 documented that the staff nurse was notified of the resident 's complaints of difficulty with a bowel movement.</p> <p>During an interview with Nurse #1 on 8/31/11 at 11:30am she stated that if she wrote in her nursing note of 5/25/11 that she notified the staff nurse that the resident was having bowel</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20</p> <p>difficulties than she did. The rounds were done on the evening shift on 8/25/11 and that nurse was Nurse #6 and she no longer is employed here. She said oftentimes the physician will check the residents bowels if there is a concern or complaint from the resident.</p> <p>Further review of the Physician Progress notes dated 6/15/11 read in part that the resident complained of abdominal pain but was not nauseated. The Physician documented that the resident ' s abdomen was distended and bowel sounds hyperactive. He recommended continuing the Lactulose 30ccs at bedtime and starting Colace 100mg BID (twice daily).</p> <p>Review of the Nursing Notes, dated 6/15/11, read that the physician was in for a routine visit and to note new orders.</p> <p>Review of Physician orders dated 6/15/11 documented that Colace (stool softener) was started.</p> <p>In reviewing the monthly Bowel Movement records for May 2011 and June 2011, the resident had two episodes recorded of not having a bowel movement for 4 consecutive days and 5 consecutive days on 5/21/11-5/24/11 and 6/8/11-6/12/11. Further documentation revealed that the resident had a bowel movement on 5/25/11 and on 6/13/11.</p> <p>During an interview with Nurse #2 on 8/31/11 at 10:55am she stated that the Nursing Assistants (NA ' s) will go to the care tracker and chart if the resident had a bowel movement (BM) during their shift and the details of the bowel movement (soft,</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 21</p> <p>large, formed, and loose). The NA ' s should let the nurse know if the resident has not had a BM on their shift. However, ultimately, she stated it is the nurses responsible to make sure that their resident ' s are not constipated. We have a bowel protocol and after three days of no BM we are to check for constipation and impaction. The nurses can check on the care tracker to see what the NA ' s have documented. I do not usually read the physician ' s progress notes. If a physician wants a resident checked for impaction he/she will write an order or let the charge nurse know; however, after three days we have a protocol to follow.</p> <p>During an interview on 8/31/11 at 12:00PM with nurse # 2 who worked 5/24/11 on the day shift from 7am-3pm and on 6/11/11, she stated that because the resident is alert and oriented she did not look at the care tracker, but asked the resident if she was having any problems. She further stated that if a resident is not alert and oriented then she has to trust the care tracker. She further stated that she did not make any notes in the nursing notes regarding the resident ' s bowel movements. She stated that if the resident would have stated she was having problems, then I would have initiated our bowel protocol.</p> <p>During an interview with Director of Nursing (DON) on 8/31/11 at 11:10am she stated that the facility does have a bowel protocol and after day 3 the nursing staff institute the protocol or new physician ' s orders. The DON further stated that she would expect that the nursing staff look at the 3 day BM on the care tracker. Even if a resident is alert and oriented, they sometimes forget or a BM might be small or a smear, which could</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 22</p> <p>indicate a problem. If a resident is on pain medications they are that much more susceptible to having bowel difficulties.</p> <p>During an interview with the Physician on 8/31/11 at 5:10pm he stated that the facility should be monitoring the residents for BM ' s every 3 days. It ' s important to make sure there is not a problem. If I wrote in my progress notes to check for constipation and I checked, I would write the results of the check. If something is not documented, it is not done. I would expect that the nursing checks the resident ' s bowel if the resident has had three days of no bowel movements.</p> <p>During an interview with NA#1 on 9/1/11 at 3:25pm she stated that she worked on 6/11/11 and 6/12/11 on 3-11 shift. She stated that she only documents for the shift that she works and cannot see what the previous days in the care tracker read. She stated that the nurses are supposed to check to see if the resident's have had a BM within three days. She also stated that if a resident complains of pain or not being able to use the bathroom, then she will let the nurse know. She stated that resident #55 can let you know if she needs something but it is very difficult to understand her. She stated you basically have to just name what you think she is saying and she will shake her head yes or no and then you just keep naming things.</p> <p>During an interview with the Administrator on 9/1/11 at 3:45pm he stated that it is expected that the nursing assistants accurately document in the care tracker and that the nursing staff check to make sure a resident has had a bowel movement</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 23 within three days.</p> <p>4. The facility Admitting/Standing Orders read as follows: 21. Constipation Protocol: If no bowel movement in 3 days give Milk of Magnesia 30cc with 4 ounces of water or fluids PO (by mouth) and G-tube (Gastrostomy tube). If no results by the next shift may give Glycerin or Dulcolax Suppository rectally. If no results by next shift give (name of enema) enema rectally. If still no results call physician.</p> <p>Resident #50 was originally admitted to the facility on 7/9/10 with diagnoses including Mental Status Changes, Bladder and Rectal Prolapse, Osteoporosis and Large Hiatal Hernia. According to the most recent Annual Minimal Data Set dated 5/16/11, Resident #50's memory was intact. She required support or was independent in most areas of activities of daily living. Resident #50 was independent in toileting. She was always continent of bladder but was occasionally incontinent of bowel.</p> <p>Review of Resident #50's bowel movement record dated 8/7/11 through 8/11/11, revealed there were no bowel movements recorded for four consecutive days.</p> <p>Review of Nursing notes dated 8/11/11 revealed no entries or intervention for Resident #50's lack of bowel movements for four days.</p> <p>During an interview with the Physician on 8/31/11</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 24</p> <p>at 5:10pm he stated that the facility should be monitoring the residents for BM's every 3 days. It's important to make sure there is not a problem. If I wrote in my progress notes to check for constipation and I checked, I would write the results of the check. I would expect that the nursing checks the resident's bowel if the resident has had three days of no bowel movements.</p> <p>During an interview on 9/1/11 at 11:40AM, Staff Nurse #2 stated Resident #50 was capable of letting someone know when she didn't have a bowel movement. She revealed the care tracker, used by Nursing Assistants to record daily care, was not always accurate. She stated Nurses relied on either alert and oriented residents to tell them or Nursing Assistants.</p> <p>During an interview on 9/1/11 at 11:40AM, Staff Nurse #5 stated Resident #50 was alert and oriented and would tell them if she felt she needed a laxative and she was also monitored. She revealed the facility implemented a policy for the 2nd shift Nurse to print the care tracker report and the first shift Nurse would check it. Staff Nurse #5 stated if a resident was not alert and oriented the Nurse's would ask the Nursing Assistants. She revealed the facility had standing orders to intervene when residents did not have a bowel movement after three days.</p> <p>During an interview on 9/1/11 3:35PM, the Director of Nursing (DON) revealed Nursing Assistants put information into a care tracker. She stated bowel movements would be placed on the Medication Administration Record (MAR). The DON explained that by Nurses asking about resident's bowel movements, they would be able</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 25</p> <p>to use the BM protocol. She stated Resident #50 would tell staff when she had a bowel movement. The DON revealed for a while they were not able to pull care tracker up. Now they are able to pull up Care Tracker. Nurses would be able pull up the care tracker at night to determine which had or had not had a BM. The DON further stated BMs would be taken off the care tracker so there would not be any conflicting information.</p> <p>During an interview on 9/1/11 at 3:40PM, Nursing Assistant #4 stated she was usually assigned to Resident #50 on 2nd shift. She stated Resident #50 would tell someone if she needed something. Nursing Assistant # 4 stated when she was working she would tell Nurses who had or had not had a bowel movement. However, she stated Nurses would check on bowel movements in the care tracker themselves.</p> <p>During an interview with the Administration on 9/1/11 at 3:45pm he stated that it is expected that the nursing assistants accurately document in the care tracker and that the nursing staff check to make sure a resident has had a bowel movement within three days.</p> <p>The facility Admitting/Standing Orders read as follows: 21. Constipation Protocol: If no bowel movement in 3 days give Milk of Magnesia 30cc with 4 ounces of water or fluids PO (by mouth) and G-tube (Gastrostomy tube). If no results by the next shift may give Glycerin or Dulcolax Suppository rectally. If no results by next shift give (name of enema) enema rectally. If still no results, call physician.</p> <p>5. Resident #25 was admitted to the facility on</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 26</p> <p>7/22/2010 with diagnoses of chest pain, hypertension, type 2 diabetes, cerebral vascular accident, right sided hemiplegia, and a history of colon cancer.</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment dated 8/29/11 documented the resident as scoring 15 on the BIMS (Brief Interview for Mental Status) meaning the resident was cognitively intact and had no communication problems. The resident was assessed as needing extensive assistance with transfers and two person assistance with toileting. The resident was also assessed as always continent for bowel and occasionally incontinent of bladder.</p> <p>Review of the most recent Care Plan dated 6/9/11 for constipation read: "Problem: History of constipation and history of colon cancer. Goals: Will have bowel movement (BM) at least every 3 days x 90 days. Approaches listed in meeting this goal were to observe for BM QS (every shift), document stools, to encourage food and fluids at mealtimes, to offer water when in room on rounds, to assist out of bed to wheelchair daily as tolerated, to report abdominal pain, blood in stool, bloating, nausea, and vomiting to the physician, and to administer medications as ordered (laxative, stool softeners and enemas)."</p> <p>A review of Resident #25's monthly Bowel Movement records for August 2011 revealed the resident had no bowel movements from 8/2/2011 - 8/11/2011. Documentation indicated no bowel movements for 9 consecutive days.</p> <p>A review of the Nursing notes for the time period of 8/2/2011 - 8/9/2011 showed no documentation</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 27 of bowel movements or interventions for constipation for Resident #25.</p> <p>A review of the Medication Administration Record (MAR) for Resident #25 indicated the resident was not given any medications per the facility Constipation Protocol until August 10, 2011. Documentation on the MAR revealed the resident was given 30 cc of Milk of Magnesia for constipation on the 10th and the Bowel Movement daily tracker recorded a bowel movement on August 11th.</p> <p>An interview was conducted with the first shift Nursing Assistant (NA) who was a main care giver for Resident #24 on 9/1/2011 @ 3:14 pm. The NA stated he could record on the care tracker daily but he did not have clearance to look back three days to verify if the residents had gone 3 days without a bowel movement.</p> <p>During an interview with Nurse #2 on 8/31/11 at 10:55am she stated that the Nursing Assistants (NA's) will go to the care tracker and chart if the resident had a bowel movement (BM) during their shift and the details of the bowel movement (soft, large, formed, and loose). She stated the NA's should let the nurse know if the resident has not had a BM on their shift. However, ultimately, she stated it is the nurse 's responsibility to make sure that their resident's are not constipated. Nurse #2 stated the facility had a bowel protocol and after three days if no BM was recorded staff were to check for constipation and impaction. She indicated nurses can check on the care tracker to see what the NA's have documented.</p> <p>During an interview on 8/31/11 at 12:00PM with</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 28</p> <p>Nurse # 2 she stated if the resident was alert and oriented she did not look at the care tracker, but asked the resident if he was having any problems. She further stated that if a resident is not alert and oriented then she has to trust the care tracker. She further stated that she did not make any notes in the nursing notes regarding the resident's bowel movements. She revealed that if the resident stated he was having problems, she would have initiated the bowel protocol.</p> <p>During an interview with the Director of Nursing (DON) on 9/1/2011 @ 4:15 pm she stated that the facility does have a bowel protocol and after day 3 the nursing staff should institute the protocol. The DON further stated she would expect the nursing staff to look at the 3 day BM documentation on the care tracker. The DON indicated all nursing staff had been trained on the care tracker should be able to pull up their assigned residents to review their daily bowel movements. It was her expectation that even if a resident was alert and oriented staff would track their BMs.</p> <p>During an interview with the Administrator on 9/1/11 at 4:00pm he stated it was his expectation nursing assistants would accurately document in the care tracker and nursing staff would review the care tracker to ensure residents had a bowel movement every three days per protocol.</p>	F 309		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371	<p>F 371 CORRECTIVE ACTION FOR IDENTIFIED RESIDENT(S): No negative outcome to Residents</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 29 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to date and discard outdated food in 2 of 5 refrigerators and failed to properly store dry ingredients in 4 of 5 bins.</p> <p>Observations of foods stored inside of refrigerators and dry ingredients stored in bins revealed the following:</p> <p>An observation of the main refrigerator in the kitchen on 8/29/2011 at 7:05 pm revealed 5 individual use containers of sour cream with the date of 7/11/2011. A five pound tub of cottage cheese was observed in the refrigerator with a use by date of 8/19/2011. Two salad prep station containers were noted to be in the refrigerator. One of the units had a red dressing in it and 1 unit had egg salad. Neither container was dated to indicate when the food was prepared or stored.</p> <p>Observations of the walk in refrigerator revealed 2 five pound containers of sour cream. The manufacturer had a best use by date of 8/14/2011 stamped on the container. A clear plastic 2 ½ quart container of pineapple rings in juice was noted on the second shelf. The container had not been dated to indicate when it was prepared or used.</p>	F 371	<p>IDENTIFICATION OF RESIDENTS AT RISK DUE TO DEFICIENT PRACTICE: All residents could be at risk.</p> <p>CORRECTIVE ACTION/SYSTEMIC CHANGES PLAN: The Dietary Manager checked all refrigeration for unlabeled or out dated food products. All unlabeled or outdated food products were discarded immediately. All Dietary employees were in serviced on correct labeling and dating procedures. Date monitoring has also been added to the daily check off list to ensure all food items are properly labeled and in date. The Dietary Manager immediately removed all scoops from dry storage bins and instructed employees to discontinue leaving scoops in bins. The Dietary Manager had already ordered scoop holders and have been installed. The Dietary Manager has in serviced all Dietary employees on proper procedures for using and storing scoops and service ware.</p>	
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 30</p> <p>Dry good storage was observed in the main kitchen. Four bins containing rice, seafood breader, sugar, and chicken breader were noted to have scoops stored inside the bins with the food item.</p> <p>An interview was conducted with Nutsing Assistant #3 (NA) during the initial kitchen tour on 8/29/11. NA #3 opened the kitchen for the initial observation because kitchen staff had gone home. She indicated she had worked in the kitchen before the move to the new building in April. She revealed some of the food items had a coded manufacturers' date. She indicated that the staff was not always able to read the coded dates but the Kitchen Manager had a card to assist staff with decoding the dates.</p> <p>An interview was conducted with the Kitchen Manager on 9/1/2011 at 10:50 am. He stated facility policy was to not have leftovers. He stated new menus were prepared daily and it was the kitchen policy to store ingredients no longer than 48 hours after they were opened. He indicated he expected his staff to quick chill, date, cover, label, and store all ingredients in the appropriate place. The Manager stated staff knew scoops were not to be left in dry ingredient bins. He revealed his expectations were for staff to clean and store scoops outside of those bins. The Kitchen Manager indicated all his food came from one manufacturer. He revealed that manufacturer uses a code on some of their food products. He stated he does have a card provided by the manufacturer listing all codes and how to read them. He reported his staff is familiar with the codes because they work with</p>	F 371	<p>MONITORING:</p> <p>The Dietary Manager will check all check off lists on a daily basis to ensure employees are completing the task. The Dietary Manager will also physically inspect all food items weekly to ensure proper dating and labeling procedures are being followed for four consecutive weeks. After four consecutive weeks, the Dietary Manager will spot check all food items to ensure all food items are in date and labeled correctly. If any issues arise the Dietary Manager will retrain all Dietary employees to follow correct procedures.</p> <p>The Dietary Manager will monitor that scoops are placed in the provided holders daily for four consecutive weeks then the Dietary Manager will spot check there after. If any issues arise the Dietary Manager will retrain all Dietary employees to follow correct procedures.</p>	
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 371	Continued From page 31 them everyday. He indicated it was his expectation that staff would ask if they had any questions about the dating on the food products. An interview was conducted with the Administrator on 9/1/2011 at 4:00pm. The Administrator indicated it was his expectation that all food in the facility would be labeled, dated, and stored correctly per policy.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F 431 CORRECTIVE ACTION FOR IDENTIFIED RESIDENT(S) The undated vials of PPD were disposed of immediately (completion date 9-1-11). IDENTIFICATION OF RESIDENTS AT RISK DUE TO DEFICIENT PRACTICE: All residents were at risk. CORRECTIVE ACTION/SYSTEMIC CHANGES PLAN: A thorough audit of all medication storage areas was conducted to ensure that no other drugs/biological had been opened and not dated(effective 9-2-11). A daily audit will be conducted to ensure all opened multi-dose vials of biologicals have a date opened on the vial. In services regarding the proper handling of multi-use vials, were held with all licensed staff with emphasis given to the fact that multi-use drugs		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28368
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431	<p>Continued From page 32</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove opened, undated multi-dose vials of a tuberculin diagnostic agent from 2 of 2 medication rooms. Findings include:</p> <p>1. An inspection of the medication room refrigerator on Lantana Hall on 9/1/11 at 11:15AM revealed one opened, undated multi-dose vial of Tuberculin Purified Protein Derivative (PPD). PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results.</p> <p>In an interview on 9/1/11 at 11:20AM, nurse #1 confirmed the vial of PPD had not been dated when opened. Nurse #1 stated the vial should have been dated when it was opened.</p> <p>In an interview on 9/1/11 at 11:35AM, the Assistant Director of Nursing (ADON) stated the staff is supposed to date all injections when</p>	F 431	and/or biological must be dated when first opened. Effective 9-2-11 a daily audit will be conducted to ensure adherence to policy, that all biological must have a date opened displayed on container/vial.	
-------	---	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 33 opened.</p> <p>During an interview on 9/1/11 at 11:45AM with the Director of Nursing (DON) she stated that it is expected that all multi-dose vials of medication be dated with an open date.</p> <p>2. An inspection of the medication room refrigerator on the Wisteria Hall on 9/1/11 at 11:30AM revealed one opened, undated multi-dose vial of Tuberculin Purified Protein Derivative (PPD). PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results.</p> <p>In an interview on 9/1/11 at 11:35AM with the ADON, she confirmed the vial of PPD had not been dated when opened. The ADON stated the vial should have been dated when it was opened.</p> <p>In an interview on 9/1/11 at 11:45AM, the DON stated that it was expected that all multi-dose vials of medication be dated with an open date.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - REPLACEMENT FACILITY B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p>	K 027	<p>Cross corridor doors have been repaired and provide a smoke tight seal on activation of fire alarm. All other corridor doors were tested to ensure they closed and sealed appropriately. Going forward all corridor doors will be checked monthly to ensure proper operations. The Plant Director or his designee will perform the door checks and document the results. Repairs will be performed as necessary.</p>	11/10/11
<p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 1:00 am onward, the following item were noncompliant; specific findings include: cross corridor doors coming into Wistera Way Hall did not close for smoke tight seal on activation of fire alarm test.</p> <p>42 CFR 483.70(a)</p> <p>K 038 SS=F</p>	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Wade Rogers* TITLE *Exec. Dir.* (X6) DATE *10/20/11*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - REPLACEMENT FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 1:00 am onward, the following items were noncompliant; specific findings include: door to all Med. rooms requires two motion of hand to open door to exit egress. Also, gates leading from courtyard did not release when release switch was tested at nurse station.	K 038	Deadbolt locksets were removed from Med Room doors. Med rooms now meet the requirement of single motion egress to exit. All other facility doors will be checked to ensure no other double lock situations exist. Corrections will be made as necessary. No further action is required. A qualified electrical contractor assessed and repaired the gate locking devices. Gates leading from the courtyards will now release upon emergency switch activation. No further action is required.	11/10/11
K 144 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 1:00 am onward, the following item were noncompliant; specific findings include: generator did not crank and transfer within 10 seconds when test was conducted.	K 144	A qualified service technician from Power Secure assessed and adjusted the emergency generator transfer switch to ensure proper starting and power transfer within 10 seconds. The Plant Director or his designee will test the cranking and power transfer monthly. Results will be documented and system repairs/adjustments made as necessary.	11/10/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - REPLACEMENT FACILITY B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER WESLEY PINES RETIREMENT COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 2 42 CFR 483.70(a)	K 144		