STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING ______ B. WING ______	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	**403 CRESTVIEW AVENUE WILSON, NC 27893**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 1/8/15. Event ID# 24XG11.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to remove a topical analgesic patch as ordered to prevent	F 329	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	1/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/14/2015

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.

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F 329	Continued From page 1 over-medication for 1 of 1 resident, Resident #41, who was observed for topical pain medication administration. Findings included: Review of the Resident #41's Quarterly Minimum Data Set (MDS) Assessment dated 12/14/2014 revealed the resident was severely cognitively impaired and had diagnoses which included, but were not limited to, diabetes mellitus, hypertension, heart failure, renal disease, and history of a stroke. Per the same MDS assessment, the resident was receiving a scheduled pain medication. Resident #41's Nursing Care Plan last updated 12/26/2014 included a goal and interventions to address the resident's potential for pain in the shoulder region. Some of the interventions included on the nursing care plan were to administer pain medication as ordered by the physician and to monitor for side effects. A review of the physician's orders revealed there was an order in place to administer a Lidoderm Transdermal Patch 5% every 12 hours to the right shoulder, and to remove the patch after 12 hours. The same order also stated that each patch should remain in place no more than 12 hours per 24 hour period. (A Lidoderm Transdermal Patch 5% is a local anesthetic lidocaine patch which is applied topically to provide pain relief.) A review of the Medication Administration Record (MAR) revealed the Lidoderm Transdermal Patch 5% was to be applied daily at 9:00 AM, and was to be removed at 9:00 PM. There were initials on the MAR to indicate the lidocaine patch was applied as ordered on 01/06/2015 at 9:00 AM. There were also initials present to indicate the	F 329	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of resident. The Plan of Correction is submitted as a written allegation of compliance. Wilson Pines Nursing and Rehabilitation CenterKs response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution formal appeal procedure and/or any other administrative or legal proceeding. F329 Criteria One: On 1/7/15, Lidoderm patch was removed immediately from resident #41 by the assigned medication aide under the direction of the Licensed Practical nurse. Criteria Two: By 1/14/15, a 100% audit of all residents who had an order for any type of transdermal patches was completed by the Treatment nurse to include Lidoderm patches. The treatment nurse verified appropriate placement, removal, and documentation in the Medication Administration Record. No further issues were observed during this audit. Criteria Three: On 01/07/15, a 100% in-service to all medication aides and license nurses, (to	

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F 329	Continued From page 2 lidocaine patch was removed from Resident #41's right shoulder on 01/06/2015 at 9:00 PM. During a medication administration observation on 01/07/2015 at 8:20 AM, Medication Aide (MA) #1 exposed Resident #41's right shoulder to apply the Lidoderm Transdermal patch 5%. As the resident's right shoulder was exposed to apply the patch, a lidocaine patch was observed to be in place. MA #1 removed the lidocaine patch from Resident #41'sright shoulder, then applied the new lidocaine patch to the same shoulder. In an interview with MA #1 on 01/07/2015 at 9:00 AM, she stated the lidocaine patch that was already in place on the resident's right shoulder must have been present from the evening before. MA #1 stated that the initials were present to indicate the evening nurse had removed the patch on 01/06/2015 at 9:00 PM, but the lidocaine patch obviously was still in place. In an interview with Nurse #1 on 01/08/2015 at 2:45 PM, she stated that she initialed that she removed the lidocaine patch from Resident #41's shoulder on 01/06/2015 at 9:00 PM, but that she forgot to actually remove it. Nurse #1 explained that when she entered Resident #41's room to remove the lidocaine patch, she assessed and provided care for the resident's renal shunt sight, and then she just forgot to also remove the lidocaine patch. In an interview with the Director of Nursing and the Administrator on 01/08/2015, the DON stated that the lidoderm patch should have been removed as ordered on 01/06/2015 at 9:00 PM, and that it was unfortunate that this occurred.	F 329	include the Registered nurse on 1/6/15), was initiated on application, removal, and documentation of all transdermal patches to include Lidoderm patches by the Staff Facilitator and will be completed by 1/15/15. All newly hired nurses and medication aides will be in-serviced during orientation on appropriate application, removal, and documentation of transdermal patches to include Lidoderm patches and correct procedure for medication administration to include removing patches per the MAR and MD order in orientation by the Staff Development Coordinator. On 1/9/15, the Licensed Pharmacist completed the Medication pass audit education and administration for the Director of Nursing and LPN-Staff Facilitator. On 1/9/15 a 100% medication pass audit was initiated with all medication aides and licensed nurses by the DON and LPN-Staff Facilitator assure each hall nurse and medication aide is in compliance with medication administration by having an error rate of less than 5% during the observation. The Medication Pass Audits will be completed by 1/19/15. Nurses who have not had a medication administration pass reviewed by an Administration nurse will not be allowed to work until the medication pass audit is completed. The Director of Nursing or Licensed Nurse will conduct medication pass audits 3 times a week for 8 weeks, and then 2 times a week for 4 weeks to include observation of nurse from 1/6/15 to assure the transdermal patched are	

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F 329	Continued From page 3	F 329	removed per the MD order. This med pass observation will include observations of removing transdermal patches to include resident #41. The audit will include conduction observations with medication aides and license nurses on all three shifts and weekends. Any license nurse or medication aide with an error rate of greater than 5% will be immediately retrained on the correct procedure for medication administration by the Staff Facilitator or DON. The DON or LPN-Staff Facilitator will review and monitor the Medication Pass QI audit tool for completion and accuracy 2 times a week for 8 weeks, and then weekly for 4 weeks. Criteria Four: The DON or LPN-Staff Facilitator will review and monitor the Medication Pass QI audit tool for completion and accuracy 2 times a week for 8 weeks, and then weekly for 4 weeks with the Administrator for further recommendations if indicated. The Quality Improvement Committee will review the QI audit tool for transdermal patches weekly for 8 weeks and then monthly for 4 months for recommendations, take action as appropriate, and monitor continued compliance in this area	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		1/20/15

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F 371	Continued From page 4 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sanitizing solution in 1 of 4 sanitizer buckets at the proper strength which resulted in meal carts, which had been out on the floor in resident care areas, not being sanitized. Findings included: At 3:28 PM on 01/05/15 the administrator stated two residents had confirmed cases of the flu. Therefore, she reported she was posting signs requesting no current visitation, there would be no group activities, and all residents would be eating in their rooms. At 9:35 AM on 01/07/15 a dietary employee wiped down the outside and inside of a meal cart, which was previously in resident care areas, with cloths from the green dishwashing bucket and then the red sanitizer bucket. At 9:53 AM on 01/07/15 a dietary employee wiped down the outside and inside of another meal cart, which was previously in resident care areas, with cloths from the green dishwashing bucket and then the red sanitizer bucket. At 10:07 AM on 01/07/15 a dietary employee wiped down the outside and inside of another meal cart, which was previously in resident care areas, with cloths from the green dishwashing	F 371	F371 Criteria One: The corrective action for the sanitization solution in bucket #4 was to reconstitute to 50 ppm (parts per million) bleach solution on 1/7/15 by the Dietary Manager. Criteria Two: All meal carts were properly sanitized on 01/07/215 with the correct bleach solution that had tested at 50 ppm by the Dietary Manager. The dietary staff was in-serviced by Dietary Manager on 01/07/2015 on assuring the bleach solution is maintained at 50 ppm for proper sanitization of the meal carts. Criteria Three: The dietary staff was in-serviced by the Dietary manager on 01/07/15 on assuring the bleach solution is maintained at 50 ppm for proper sanitization of the meal carts. The Dietary Manager will conduct sanitization audits 3 times a week for 8 weeks, and then 2 times a week for 4 weeks to include testing the sanitization solution to assure the solution is testing at 50 ppm. Any identified area of concern will be re-sanitized upon identification and prior to use.	

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F 371	Continued From page 5 bucket and then the red sanitizer bucket. At 10:20 AM on 01/07/15 a dietary employee wiped down the outside and inside of another meal cart, which was previously in resident care areas, with cloths from the green dishwashing bucket and then the red sanitizer bucket. At 10:22 AM on 01/07/15 a strip used to measure the strength of the bleach-based sanitizing solution in the red bucket in the dish machine area registered 0 - 10 parts per million (PPM) hypochlorite. At this time the dietary manager (DM) stated the solution should register at least 50 PPM hypochlorite, and a dietary employee reported she made the solution in the dish machine bucket up at approximately 8:00 AM that morning. At 4:45 PM on 01/07/14 the DM stated she was unsure why the bleach-based sanitizing solution at the dish machine was not strong enough. She reported it was possible too many rags or lack of a dedicated rag had weakened the solution. She also commented it was possible that someone had added dishwashing liquid to the sanitizer bucket by mistake. The DM remarked it was the responsibility of the cooks to prepare red buckets of sanitizing solution. According to the DM, the dietary staff was in-serviced about sanitizing solutions about a month ago followed a corporate mock survey. She stated during this in-service staff were instructed to fill the sanitizer buckets with bleach solution which had been prepared in the sanitizing sink of the three-compartment sink system. The DM reported the dietary staff was instructed to change the sanitizer buckets out about every six hours, and check the strength of fresh buckets with strips which should register at	F 371	The Dietary Manager will review and monitor the Sanitization QI Audits with the Administrator weekly for completion and accuracy 2 times a week for 8 weeks, and then weekly for 4 weeks. Criteria Four: The Dietary Manager will review and monitor the Sanitization QI audit tool for completion and accuracy 2 times a week for 8 weeks, and then weekly for 4 weeks with the Administrator for further recommendations if indicated. The Quality Improvement Committee will review the Sanitization QI audit tool weekly for 8 weeks and then monthly for 4 months for recommendations, take action as appropriate, and monitor continued compliance in this area	

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

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F 371	Continued From page 6 least 50 PPM hypochlorite. However, she commented with the flu currently in the facility it would probably be better to change sanitizer buckets out every four hours. At 4:52 PM on 01/07/14 the PM cook stated the dietary staff was in-serviced about sanitizing solutions about a month ago. She reported cooks made up the sanitizer buckets using bleach, and they were instructed that the sanitizing solutions could be drawn from the sanitizing sink of the three-compartments sink system or could be made up at individual buckets. The cook commented the strength of the solution in the red buckets was checked about every two hours with strips which should register at least 50 PPM hypochlorite. If the solutions were too weak, the cook stated a little bleach was added to the buckets.	F 371		