| 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 01/31/2019 |

| 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 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to accurately code the area of behaviors on the Minimum Data Set assessment for 1 of 3 sampled residents reviewed for behaviors (Resident #1).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 7/26/16 with diagnoses that included: dementia, hypertension and anemia.<br><br>Review of a progress note dated 12/24/18 revealed Resident #1 refused care and continued to yell no one was going to touch him.<br><br>Review of a progress note dated 12/27/18 indicated Resident #1 threw his breakfast tray after finishing his meal.<br><br>Review of Resident #1's minimum data set (MDS) assessment dated 12/28/18 revealed the resident was assessed in section E, question E0200 as having no behaviors during the 7 day look back period of the assessment.<br><br>During an interview on 1/31/19 at 11:07 AM the MDS Coordinator stated Resident #1 had behaviors during the look back period and question E0200 was coded incorrectly.<br><br>An interview was conducted on 1/25/19 at 11:00 | F 641 | Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes 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 provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>Wilson Pines Nursing and Rehabilitation Center's 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 proceed.<br><br>The Minimum Data Set (MDS) assessments for resident #1 was reviewed and proper modifications were made to sections E so that the coding would accurately reflect the residents' condition by the MDS Coordinator on | 2/12/19 |

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

Electronically Signed — 02/12/2019

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 641 | Continued From page 1<br>AM with the Administrator who stated it is his expectation that MDS assessments are coded accurately to reflect behavior. | F 641 | 1/31/19.<br><br>A 100% audit of the last completed MDS assessment for section E for all residents to include resident # 1 was conducted by an MDS trained licensed staff nurse and completed on 2/8/19 to ensure coding of the minimum data set accurately reflects the residents to include behaviors. Modifications were completed by the MDS nurses during the audit for any identified areas of concern with the oversight from the Registered Nurse (RN) Supervisor completed on 2/11/2019.<br><br>The MDS Coordinator, MDS Nurse and RN Supervisor were in-serviced on proper coding of section E of the MDS assessments per the Resident Assessment Instrument (RAI) Manual by the Facility Consultant on 2/12/19. The MDS Nurses were in-serviced on the use of the Point Click Care online RAI resource manual to ensure accuracy in coding by the Facility Consultant on 2/12/19.<br>25% of all completed Minimum Data Set (MDS) assessments to include resident # 1 will be audited by the RN Supervisor weekly x 8 weeks, then monthly x 1 months utilizing an MDS Audit Tool to ensure compliance and accuracy of coding MDS assessment to include behaviors. All identified areas of concern will be addressed immediately by the MDS Coordinator with modification of the MDS assessment. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks, then monthly x 2 | |

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| F 641 | Continued From page 2 | F 641 | months to ensure all areas of concern were addressed.<br><br>The Administrator will present the findings of the MDS audit tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the MDS audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. | |