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| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 345372 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | DATE SURVEY COMPLETE: 11/7/2019 |
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| NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTE | STREET ADDRESS, CITY, STATE, ZIP CODE 403 CRESTVIEW AVENUE WILSON, NC |
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| F 661 | <p>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a discharge summary for one of one residents reviewed for an anticipated discharge (Resident #76).</p> <p>Findings included:</p> <p>A review of the medical record revealed Resident #76 was admitted 7/12/2019 with diagnoses which included Congestive Heart Failure, stroke, dementia and Chronic Obstructive Pulmonary Disease.</p> <p>The care plan dated 7/14/2019 noted a focus of the resident desired to return home upon completion of rehab therapy. The goal was the resident would verbalize understanding of the discharge plan and describe the desired outcome by the next review date. Interventions included establish a pre-discharge plan with resident/family/resident representative/caregiver. Evaluate progress and revise plan as needed upon discussion/input from resident.</p> <p>The 60-day scheduled Minimum Data Set (MDS) assessment dated 9/12/2019 indicated Resident #76 participated in the discharge planning and was cognitively intact.</p> <p>The discharge instructions and Plan of Care dated 9/26/2019 contained a referral for Home Health Services for PT (Physical Therapy)/OT (Occupational Therapy)/Certified Nursing Assistant/Nursing-medication management & disease process education on Durable Medical Equipment.</p> <p>A review of the Resident's Discharge Summary dated 9/26/2019 revealed the following areas were not completed; diagnoses on admission, recent lab work and pertinent clinical findings relevant to discharge.</p> |
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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

The above isolated deficiencies pose no actual harm to the residents

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| F 661 | Continued From Page 1 In an interview on 11/7/2019 at 10:45 AM, the Nurse Supervisor stated the floor nurse who was assigned to a resident being discharged was responsible for completing the resident's discharge summary. The regional nurse consultant stated on 11/7/2019 at 11:45 AM, the discharge summary for Resident #76 had not been completed. |
| F 695 | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and observations, the facility failed to post an oxygen in use sign for 2 of 2 residents being observed for oxygen use. (Resident #2, #69) Findings included: 1. Resident #2 was readmitted to the facility on 10/28/19. The resident's current diagnosis included Super Ventricular Tachycardia, Acute and Chronic Respiratory Failure with Hypercapnia. The Minimum Data Set (MDS) dated 10/23/19 indicated resident needed extensive assistance with bed mobility and total dependence with toilet use. Transfers did not occur and eating only occurred once or twice. Resident #2 had a care plan which included Potential for Ineffective Breathing Pattern related to congestive heart failure and shortness of breath on exertion, at rest, and while lying flat, chronic obstructive pulmonary disease and history of pneumonia. The goals were the resident will demonstrate effective respiratory pattern of rate, rhythm, and depth. The interventions included oxygen therapy via nasal canula. Record review revealed physician orders dated 10/30/19 to check oxygen saturations every shift and 3 liters per minute continuous oxygen via nasal canula. Observations on 11/05/19 and 11/6/19 revealed no "oxygen in use" sign on resident's door. Resident #2 was receiving oxygen via nasal canula. A review of the facility's Oxygen Therapy Policy stated to place "OXYGEN IN USE" sign outside the room of the resident. 2. Resident #69 was readmitted to facility 10/8/19. The resident had a diagnosis of Acute on Chronic |

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| F 695 | <p>Continued From Page 2</p> <p>Diastolic Congestive Heart Failure, Atrial Fibrillation, Acute Respiratory Failure with Hypoxia, Acute Respiratory Failure with Hypercapnia, and Chronic Obstructive Pulmonary Disease.</p> <p>The quarterly Minimum Data Set (MDS) dated 10/14/19 revealed resident #69 needed extensive assistance with bed mobility, transfers, and toilet use and was independent with eating requiring set up help only.</p> <p>Resident #69 had a care plan which included Potential for Ineffective Breathing Pattern related to diagnosis of congestive heart failure. The goal was the resident will demonstrate effective respiratory pattern of rate, rhythm, and depth with oxygen saturation levels within normal limits. The interventions included oxygen therapy 2 liters per minute via nasal canula as ordered.</p> <p>Record review revealed physician orders dated 10/8/19 to check oxygen saturations every shift and for resident to be on 2 liters continuous oxygen every shift.</p> <p>Observations on 11/05/19 and 11/6/19 revealed no "oxygen in use" sign on resident's door. Resident #69 was receiving oxygen via nasal canula.</p> <p>A review of the facility's Oxygen Therapy Policy stated to place "OXYGEN IN USE" sign outside the room of the resident.</p> |
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