STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	**523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/11/22 through 10/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1Z2B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 10/11/22 through 10/14/22. Event ID#1Z2B11. The following intakes were investigated NC00192863 and NC00192721. Three of the 3 complaint allegation(s) was/were not substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		11/1/22

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

Electronically Signed | 10/31/2022

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F 636	Continued From page 1 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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F 636	Continued From page 2 Based on record review and staff interviews, the facility failed to accurately code a resident's Minimum Data Set (MDS) assessment for 1 of 17 assessments reviewed (Resident #26). The findings included: Resident #26 was admitted to the facility on 02/19/2020 with diagnoses that included, in part, bipolar disorder, insomnia due to other mental disorder ad unspecified dementia with behavioral disturbance. A review of Resident #26's significant change MDS, dated 08/29/22, revealed the facility had indicated Resident #26 had not been evaluated for a level II Preadmission Screening and Resident Review (PASSR) for question A1500. A review of Resident #26's medical record revealed a PASSR Level II Determination Letter Notification, dated 07/27/2021, with no expiration date. During an interview with the MDS Coordinator on 10/14/22 at 11:10 a.m., the coordinator stated Resident #26 was assessed as a PASSR Level II. The coordinator explained due to human error she had answered "no" to the question (A1500) on the assessment when she should have answered "yes." The coordinator stated she had submitted a corrected assessment after it was brought to her attention. During an interview with the Administrator on 10/14/22 at 11:06 a.m., the Administrator explained the assessment had been coded incorrectly possibly due to "human error." The Administrator stated it was her expectation that	F 636	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice • Pre-Admission Screening and Resident Review (PASRR) level for resident #26 was inaccurately coded on the Minimum Data Set (MDS) for Assessment Reference Date (ARD) 8/29/2022 by the MDS Coordinator. MDS Coordinator submitted a correction for this error on 10/11/22. Assessment for Resident #26 is accurate and correct. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: • 100% audit was completed of PASRR for all residents by the MDS Coordinator on 10/13/22. The following were reviewed for resident's who were identified as a Level II PASRR: MDS assessment, diagnosis list, and PASRR letter to ensure coding accuracy. • Any inaccuracies identified on the assessments during the audit were corrected by the MDS Coordinator on 10/21/22. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur • The MDS Coordinator will ensure that assessments accurately reflect the resident's status. • The MDS coordinator received in-service training by the DCR (Director of Clinical Reimbursement) on the MDS	

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F 636	Continued From page 3 residents' MDS assessments are coded accurately.	F 636	Coordinator requirements to ensure compliance with MDS accuracy on 10/11/22. • The MDS coordinator will participate in daily administrative nurse and IDT meetings to monitor changes in condition or change in resident diagnosis that would warrant changes to the MDS assessment. If the need arises for a new MDS assessment, changes will be reflected in the assessment appropriately and accurately. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained • An audit tool titled MDS Coordination/Certification and Accuracy Audit, has been developed to monitor performance. Audits will be conducted by the DCR/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with accuracy. • Audit Compliance will be discussed weekly by the Executive Director (ED)/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. • The ED/designee will bring results of MDS Coordination/Certification and Accuracy Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and	

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F 636	Continued From page 4	F 636	monitoring to begin again at the weekly audits until compliance is met.	