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 02/16/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/13/23 through 2/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #46G111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/13/23 through 2/16/23. Event ID# 46G111. The following intakes were investigated NC00190468, NC00190472, NC00193426, and NC00189231. Please select one of the followings: 1 of the 5 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		3/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/12/2023

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.

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 02/16/2023

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews the facility failed to treat a resident with dignity and respect by speaking harshly to her and asking the resident if she had been "playing in her poop" for 1 of 5 residents reviewed for dignity (Resident #346). Findings included: Resident #346 was admitted to the facility on 01/30/23 with diagnosis of hypertensive chronic kidney disease Stage 5 and a history of falls. Review of an admission Minimum Data Set (MDS) assessment dated 02/05/23 documented	F 550	F 550 Dignity and Respect Wilson Pines Nursing and Rehabilitation 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. Wilson Pines Nursing and Rehabilitation response to this Statement of Deficiencies	

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 02/16/2023

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 550	Continued From page 2 Resident #346 had moderately impaired cognition. She required extensive assistance from staff with toileting. She was frequently incontinent of bowel and bladder. Review of the care plan dated 02/10/23 for Resident #346 included, in part, the following focal area: At risk for unmet needs and/or compromised dignity. The goals for Resident #346 were to maintain dignity and have decreased episodes of anxiety. Interventions included, in part, to talk with resident in a low pitch, calm voice. In an interview with Resident #346 on 2/14/23 at 2:30 PM she stated a nurse aide came in on third shift to answer her call bell and she took the residents hands and said, "Let me see your hands. Are you playing in your poop?" The resident stated the nurse aide spoke harshly to her, made her feel like a child, and she felt humiliated. She said she felt like the nurse aide on third shift was "aggravated" when she provided care to her and spoke harshly to her. She did not know the name of the staff member but commented it was only one nurse aide who spoke harshly to her, and the rest of the staff were sweet. She stated when that nurse aide was on, she would try to hold her bowel movements and not ring the bell, but she couldn't. She described the nurse aide as "small and cute" and "not someone you would think was mean because she was so small and cute." She could not recall the exact date when the nurse aide asked her if she had been "playing in her poop" but she noted it was after the day she had fallen (01/31/23) and it was not on a dialysis day, so it had to have been on a Tuesday, Thursday, or weekend night shift.	F 550	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 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. On 2/16/2023, the Social Worker completed a grievance for Resident #346 regarding staff speaking harshly, resulting in Resident #346 feeling humiliated. Resident unable to identify which staff or date event allegedly occurred. Resident denies any further concerns. On 3/7/2023, the Social Worker and Administrator in Training (AIT) initiated interviews with all alert and oriented residents regarding Dignity and Respect to identify any concerns related to staff speaking harshly and/or not being treated with dignity and respect. The Social Worker will address all concerns identified during the interviews to include notification of the administrator and/or Director of Nursing (DON) and completion of grievance and re-education. Interviews will be completed by 3/16/2023. On 3/10/2023, the Director of Nursing (DON) initiated an audit of all residents to include Resident #346 for incontinent care. This audit is to ensure all residents had been provided incontinent care timely. The audit will be completed by 3/16/2023.	

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 02/16/2023

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 550	Continued From page 3 In an interview with a family member on 2/14/23 at 4:00 PM she stated the resident had told her a nurse aide spoke harshly to her. She said she had not reported it to the facility because she had already complained 3 times about [Resident #346] not getting lunch on dialysis days and she didn't want her to be tagged by staff as a "problem resident." In an interview with the QA Nurse on 02/15/23 at 8:15AM she reported facility staff had met after the survey team left the day before, and it was decided to discontinue some of the fall interventions for Resident #346 because her cognition had improved since admission. On 02/15/23 at 3:36 PM a telephone interview was conducted with Nurse Aide #6. She confirmed she had cared for Resident #345 on 3rd shift on 02/01/23 as documented on the working schedule. She stated she had never spoken harshly to Resident #346 or asked her if she had been playing in her poop. She had never heard any other staff member speak harshly to residents. She stated she would tell the nurse if she did. On 02/15/23 at 4:00 PM a telephone interview was conducted with Nurse Aide #4. She confirmed she had cared for Resident #346 on 3rd shift on 02/03/23, 02/07/23, 02/09/23 and 02/12/23 as documented on the working schedule. She stated she had never spoken harshly to Resident #346 or asked her if she had been playing in her poop. She reported she had never heard any staff speak harshly to Resident #346 or any other resident. She concluded if she ever did, she would call the administrator on call	F 550	On 2/15/2023, the DON initiated an in-service with all nurses and nursing assistants regarding Dignity and Respect with emphasis on dignity with incontinent care and not speaking harshly or in a demeaning manner to residents. The in-service will be completed by 3/16/2023. After 3/16/2023, any nurse or nursing assistant who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced on the Dignity and Respect during orientation. The resource nurses, Quality Improvement (QI) nurses, and/or the staff facilitator (SF) will complete 10 Resident Care Audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure all residents to include resident #346 are treated with dignity and respect and care for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, including providing timely incontinence care. The resource nurses, Quality Improvement (QI) nurses, and/or the staff facilitator (SF) will address all concerns identified during the audit to include notification of the Administrator and/or the DON and completion of grievance and/or re-education when indicated. The DON will review the Resident Care Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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 02/16/2023

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 550 Continued From page 4
or the supervisor.

On 02/15/23 at 4:16 PM a telephone interview was conducted with Nurse Aide #5. She confirmed she had cared for Resident #346 on 3rd shift on 02/10/23 as documented on the working schedule. She stated she had never spoken harshly to Resident #346 or asked her if she had been playing in her poop. She reported she had never heard other staff members speak harshly to Resident #346 or any other resident. She concluded she would tell the nurse if she ever did.

On 02/15/23 at 4:20 PM a telephone interview was conducted with Nurse Aide #8. She stated she worked at the facility through an agency. She confirmed she had cared for Resident #346 on 3rd shift on 02/04/23. She stated she had never spoken harshly to Resident #346 or asked her if she had been playing in her poop. She reported she had never heard any other staff member speak harshly to Resident #346 or any other resident. She concluded she would report it immediately to the nurse if she ever did.

On 02/15/23 at 4:47 PM a telephone interview was conducted with Nurse Aide #7. She stated she worked at the facility through an agency. She confirmed she had cared for Resident #346 on 3rd shift on 02/02/23, 02/05/23, and on 02/08/23 as documented on the working schedule. She stated she had never spoken harshly to Resident #346 or asked her if she had been playing in her poop. She reported she had never heard any other staff speak harshly to any resident. If she ever did, she would tell the nurse.

In an interview with the Administrator on 02/15/23

F 550

The Administrator will forward the results of Resident Care Audit Tool to the Quality Assurance (QA) Committee monthly x 2 months. The QA Committee will meet monthly x 2 months and review the Resident Care Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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 02/16/2023

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 550	Continued From page 5 at 4:10 PM he stated it was never acceptable for a staff member to speak harshly to any resident. He declared no resident at the facility had ever been branded as a "problem resident" for reporting a concern and never would be.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		3/16/23

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 02/16/2023

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 582	Continued From page 6 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice and CMS-10123 Notice of Medicare Non-Coverage (NOMNC) (Resident #65) and failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (Resident #15) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review. The findings included: 1. Resident #65 was admitted to the facility on 10/5/21.	F 582	F 582 Liability Notice Wilson Pines Nursing and Rehabilitation 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. Wilson Pines Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it	

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 02/16/2023

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 582

Continued From page 7

Resident #65's Medicare Part A skilled services ended on 12/9/22. She remained in the facility.

Record review revealed that Resident #109 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) or CMS-10123 Notice of Medicare Non-Coverage (NOMNC).

During an interview with the Business Office Manager on 2/13/23 at 3:04 PM she reported she was unable to locate the required forms for Resident #65.

An interview was conducted with the Administrator on 2/13/23 at 3:30 PM who indicated Resident #65 should have received the CMS-10555 and CMS-10123 as required by Federal guidelines.

2. Resident #15 was admitted to the facility on 8/30/21.

Resident #15 received Medicare Part A skilled services beginning on 10/6/22 and ending on 11/18/22 . She remained in the facility.

Record review revealed that Resident #427 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN).

During an interview with the Business Office Manager on 2/13/23 at 3:04 PM she reported the facility was not using the correct form. She stated she had was notified a few weeks ago the facility was using the wrong form and was now using the correct form.

F 582

constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation 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.

On 3/13/23, the Social Worker completed and provided a liability notice to resident #65 and/or resident representative.

On 3/13/2023 the Social Worker completed and provided a Beneficiary notice to resident #109 and/or resident representative.

On 3/9/23, the Social Worker and Business Office Manager, initiated an audit of all Medicare “A” discharges for the past 30 days. This audit was to ensure all Notifications of Medical Non-Coverage (NOMNC) was completed appropriately and provided to the resident and/or resident representative. All areas of concern were addressed by the Accounts Receivable to include issuing appropriate notification of non-coverage is provided to the resident/resident representative. The audit will be completed by 3/16/2023.

On 3/9/23, Social Worker and Business Office Manager, initiated an audit of all Beneficiary notices for discharges for the past 30 days. This audit was to ensure a Beneficiary Notice was completed appropriately and provided to the resident and/or resident representative. All areas

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 02/16/2023

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 582	Continued From page 8 An interview was conducted with the Administrator on 2/13/23 at 3:30 PM who indicated Resident #15 should have received the CMS-10555 SNF-ABN as required by Federal guidelines.	F 582	of concern were addressed by the Accounts Receivable to include issuing appropriate notification of non-coverage is provided to the resident/resident representative. The Audit will be completed by 3/16/2023. On 3/8/2023, an in-service was initiated by the Administrator with the Accounts Receivable and Social Workers in regards to Notifications of Medical Non-Coverage (NOMNC) with emphasis on providing appropriate notification related to non-coverage of Medicare “A” and Medicare “B” residents with the appropriate box checked and signature. All newly hired Administrator, Accounts Receivable and/or Social Workers will be in-serviced during orientation regarding Notifications of Medical Non-Coverage (NOMNC). 10% audit of all Medicare “A” discharges will be reviewed by the DON weekly x 4 weeks then monthly x 1 month utilizing the NOMNC and Beneficiary Notice Audit Tool to ensure the appropriate notification of medical non-coverage was provided to the resident/resident representative with the appropriate box checked and signature. The Social Worker and/or Accounts Receivable staff will address all areas of concern identified during the audit. The Staff Facilitator will re-educate staff for any concerns identified. The Administrator will review and initial the NOMNC and Beneficiary Notice Audit Tool weekly x 4 weeks then monthly x 1 month	

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 02/16/2023

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 582	Continued From page 9	F 582	to ensure all areas of concern were addressed. The Administrator will forward the NOMNC and Beneficiary Notice Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC and Beneficiary Notice Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for isolation (Resident #243), use of a wander guard (Resident #6), diagnosis of dementia (Resident #58) and discharge status (Resident #90) for 4 of 25 residents whose MDS assessments were reviewed. Findings included: 1. Resident #243 was admitted to the facility on 1/30/2023. Nursing documentation dated 1/30/2023 at 9:37	F 641	F 641 Accuracy of Assessments Wilson Pines Nursing and Rehabilitation 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. Wilson Pines Nursing and Rehabilitation response to this Statement of Deficiencies	3/16/23

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 02/16/2023

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

Continued From page 10

p.m. revealed the physician and the Resident #243's representative was notified Resident #243 tested positive for COVID-19.

Resident #243's care plan dated 1/30/2023 included a focus for an infection related to COVID-19 that was resolved on 2/13/2023.

Physician notes dated 1/31/2023 indicated Resident #243 was diagnosed with COVID-19.

An infection note documented in Resident #243's medical record dated 1/31/2023 at 9:40 a.m. indicated the day of onset for COVID-19 was 1/30/23, and the type of transmission based precautions (isolation) required was contact and droplet precautions.

A COVID-19 laboratory test collected at 11:00 p.m. on 1/31/2023 reported Resident #243 tested positive for COVID-19 on 1/31/2023 at 11:15 p.m.

The 5-day admission MDS assessment dated 2/5/2023 indicated Resident #243 was cognitively intact and diagnoses included COVID-19. There was no indication on the MDS Resident #243 was on isolation.

Signage for special droplet and contact precautions was observed on 2/13/2023 at 10:47 a.m. outside Resident #243's door.

In an interview with MDS Nurse #1, she stated the look back period for Resident #243's MDS assessment was from 1/30/2023 to 2/5/2023. She said the resident had tested positive for COVID-19, and the 5-day MDS did not reflect he was on isolation. She implied isolation was marked on the MDS assessment when

F 641

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 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.
On Resident # 243 no longer resides in the facility.

On 03/07/23, The MDS Coordinator completed a modification to prior comprehensive assessment for Resident # 6 to reflect accurate coding of a wander guard.
On 03/07/23, the MDS Coordinator completed a modification to prior comprehensive assessment for Resident # 58 & # 90 to reflect accurate coding of discharge status.

On 03/07/23, the resource nurse, Quality Improvement (QI) nurse, and MDS nurse initiated an audit for all isolation residents to include resident #243 to ensure all MDS assessments completed were coded accurately for isolation status. The MDS Coordinator will complete modifications for all concerns identified during the audit. The audit will be completed by 03/16/22.

On 03/07/23, the resource nurse, Quality Improvement (QI) nurse, and MDS nurse initiated an audit for all wander guard residents to include resident #6 to ensure all MDS assessments completed were

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 02/16/2023

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

Continued From page 11

documentation reflected residents were provided all services in the room. She further stated at the time of the completion of Resident #243's MDS assessment, COVID-19 restricted Resident #243 to his room, and he should have been coded for isolation.

In an interview with the Administrator on 2/16/2023 at 3:46 p.m., he did not have an explanation for why Resident #243 was not coded for isolation on the 5-day MDS assessment and stated Resident #243 should have been coded for isolation.

2. Resident #6 was admitted to the facility on 6/4/21 with diagnoses that included dementia.

A progress note dated 10/28/22 revealed Resident #6 was found propelling to the door of the facility and a wander alarm was placed on her ankle.

Resident #6's quarterly Minimum Data Set (MDS) assessment dated 11/24/22 indicated she did not use a wander alarm.

During an interview with the MDS nurse on 2/15/23 at 1:22 PM she stated Resident #6's assessment should have been coded to reflect her use of a wander alarm and the error was an oversight.

An interview was conducted with the Administrator on 2/16/23 at 3:24 PM. He stated Resident #6's MDS assessment should have been coded accurately to reflect her use of a wander alarm.

F 641

coded accurately for use of a wander guard. The MDS Coordinator will complete modifications for all concerns identified during the audit. The audit will be completed by 03/16/22.

On 03/07/23, the the resource nurse, Quality Improvement (QI) nurse, and MDS nurse initiated an audit for all residents' most current MDS assessment, to include resident #58 and #90 to ensure all MDS assessments completed are coded accurately for discharge status. The MDS Coordinator will complete modifications for all concerns identified during the audit. The audit will be completed by 3/16/22.

On 3/07/23, the regional nurse consultant completed an in-service with the MDS Coordinator and MDS nurse regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely to include isolation, use of a wander guard, discharge status, and a diagnosis of dementia. All newly hired MDS Coordinators and/or MDS nurses will be in-serviced by the Director of Nursing during orientation regarding MDS Assessments and Coding.

10% audit of all resident's most recent MDS assessments for accuracy to include isolation, dementia diagnosis, wandering, and/or discharge planning will be completed by the Director of Nursing, QI nurse, and/or the resource nurse, utilizing the MDS Coding Accuracy Tool weekly x 4

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 02/16/2023

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

Continued From page 12

3. Resident #58 was admitted to the facility on 5/22/22.

Review of Resident #58's medical record showed a nurse practitioner's note dated 6/20/22. The note indicated Resident #58 had been seen by a neurologist and was reportedly diagnosed with early symptoms of dementia.

Review of Resident #58's medical record showed a psychiatry progress note dated 7/18/22. The note read "Dementia: patient seen by neuro since last visit and diagnosed with MNC (Mild Neurocognitive disorder) due to Alzheimer's dementia."

Review of the quarterly Minimum Data Set (MDS) dated 8/1/22 did not include or Alzheimer's Disease or Non-Alzheimer's Dementia diagnoses.

An interview was conducted on 2/16/23 at 9:43 A.M. with the MDS Nurse. During the interview the MDS nurse reviewed her worksheet she used to complete Resident #58's quarterly MDS, the medical record, physician progress notes, and the MDS assessments dated 8/1/22. The MDS nurse indicated she had noted Resident #58 had a diagnosis for dementia, the MDS should have been marked to include the dementia diagnosis, and this had been overlooked.

An interview was conducted on 2/16/22 at 2:24 P.M. with the Administrator. The Administrator indicated he was told by the MDS nurse Resident #58's dementia diagnosis was not marked when it was identified during the survey. He further indicated the MDS nurse made a mistake and overlooked the diagnosis when she completed the MDS assessment.

F 641

weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment. The MDS Coordinator, and/or Director of Nursing will address all areas of concern identified during the audit to include completion of resident assessment and/or retraining of the MDS Coordinator or MDS nurses when indicated.

The administrator will review and initial the MDS Coding Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The Quality Improvement (QI) nurse will forward the results of the MDS Coding Accuracy Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Coding Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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 02/16/2023

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	Continued From page 13	F 641		

4. Resident #90 was admitted to the facility on 11/02/22. She was discharged on 01/03/23.

Review of a progress note written on 01/03/23 documented Resident #90 was discharged at 5:30 PM and left the facility by wheelchair with her husband. Discharge instructions, medication administration, and medications were sent with the resident.

Review of the facility Discharge Instructions and Plan of Care Report dated 01/03/23 documented the resident was discharged to home.

Review of the discharge MDS assessment dated 01/03/23 documented Resident #90 was discharged from the facility to an acute hospital, Line A2000.

In an interview with MDS Nurse #3 on 02/16/23 at 11:13 AM she stated, after reviewing the records, the MDS assessment should have been coded as the resident went home, not to the hospital. She thought she just clicked on the wrong button when completing the assessment.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/16/23

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent

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 02/16/2023

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 689 Continued From page 14

accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review the facility failed to implement interventions for fall prevention for a resident with a history of falls for 1 of 2 residents reviewed for accidents (Resident #346).

Findings included:

Resident #346 was admitted to the facility on 01/30/23 with diagnoses that included falls, osteoarthritis, and restless leg syndrome.

Review of a health status note written on 01/31/23 at 12:52 AM documented: "PT [Physical Therapy] walked past resident's room and found resident on the bathroom floor ... [Resident #346 was] reeducated to use call bell when needing to ambulate, to lock (wheelchair) when transferring, and to wear non-skid footwear."

Quality Assurance-Falls Review (at risk for or actual) dated 2/2/23 was reviewed and documented Resident #346 had a fall on 01/03/23. Resident had non-skid (gripper) socks to feet when she fell. She was reminded to call for assistance. Interventions included to place call bell within reach, place bed in lowest position, and continue current fall interventions.

Review of an admission Minimum Data Set (MDS) assessment dated 02/05/23 documented Resident #346 had moderately impaired cognition. She required extensive assistance with most activities of daily living. She required limited assistance from staff with walking in room using a walker or a wheelchair. She had a fall

F 689

F 689 Free of Accident Hazards/ Supervision/ Devices

Wilson Pines Nursing and Rehabilitation 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.

Wilson Pines Nursing and Rehabilitation 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 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.

On 2/14/2023, Resident #346 bed was placed into lowest position after care, roll guard (bolster) on bed, and non-skid socks were applied on both feet.

On 3/10/2023, an audit was initiated by the Director of Nursing (DON) and Quality Improvement (QI) nurses, Minimum Data

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 02/16/2023

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 689 Continued From page 15

prior to admission and fell after admission to the facility with injury (not major).

Review of the care plan for Resident #346 dated 02/10/23 documented a focal area of: Risk for falls characterized by history of falls multiple risk factors related to, in part, weakness, impaired balance, impaired vision, disrobing, removal of brief, frequent incontinence of bowel and bladder, impaired short and long term memory. The goal was for Resident #346 to be free of falls through the next review. Interventions included, in part, bed in lowest position and ensure roll bolster (roll guard) is in place to outer edge of bed.

An observation of fall precautions in place was made at 2:30 PM on 02/14/23. Resident #346 was laying on her bed awake. She had socks on that were not non-skid, the roll guard was standing in the corner of the room, and the bed was in a high position (chest high). The resident revealed a large healing skin tear on her left leg and on her left arm she had sustained from a fall at the facility.

The Quality Assurance (QA) Nurse was interviewed in the resident ' s room on 02/14/23 at 3:05 PM. She stated the resident should have had the bed in the lowest position and acknowledged it was in a high position, the roll guard should have been on the bed and it was not, and the resident should have had non-skid socks on and she did not. She opened the resident ' s closet door and pointed out the Care Kardex that listed instructions for caregivers that included non-skid socks, bed in lowest position and roll guard to edge of bed. During the interview the QA Nurse lowered the resident ' s bed to a low position and the resident sat up and

F 689

Set (MDS) nurses to review all residents at high risk of falls, including Resident #346, to ensure all interventions are in place to include roll bolsters on bed, beds put into lowest position after care provided, and non-skid socks worn per the care plan and care guide. The audit will be completed by 3/16/2023. Any concerns identified during the audit will immediately be addressed by the MDS nurses, the QI nurses, treatment nurse, or DON to include implementing intervention as documented on care plan and care guide, as well as providing re-education.

On 2/14/2023, the DON and staff facilitator initiated an in-service for 100% of nursing assistants and nurses to ensure fall interventions are in place in residents' rooms per the care plan and care guide. The in-service will be completed by 3/16/2023. Any nursing assistant for nurses that has not received the in-service by 3/16/2023 will receive it prior to the next scheduled shift. All newly hired nursing assistants and nurses will receive the in-service on fall interventions during the orientation process.

10% of residents to include Resident # 346 will be monitored by the QI nurses and resource nurses weekly x 4 weeks, then monthly x 1 month to ensure fall interventions are implemented in the resident's room per the care plan and care guide utilizing the Fall Intervention Monitoring tool. Any concerns identified during the monitoring process will be addressed by the MDS nurses, the QI

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 02/16/2023

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 689	Continued From page 16 put her legs over the side of the bed. She stated she would put non-skid socks on the resident. A follow-up observation on 02/14/23 at 3:30 PM revealed the resident was lying in bed that was in the lowest position, non-skid socks were on the resident's feet and the roll guard was on the outside edge of the bed.	F 689	nurses, and/or the treatment nurse. The DON will review and initial the Fall Intervention Monitoring tool weekly x 4 weeks, then monthly x 1 month to ensure compliance. The DON will present the findings of the Fall Intervention Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI committee will meet monthly for 2 months and review the Fall Intervention Monitoring 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.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interviews and record review, the facility failed to provide a lunchtime meal to a dialysis resident on 02/01/23, 02/03/23, 02/06/23, 02/08/23, 02/10/23 and 02/13/23 for 1 of 2 residents reviewed for dialysis (Resident #346). Findings included: Resident #346 was admitted to the facility on	F 698	F 698 Dialysis Wilson Pines Nursing and Rehabilitation 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	3/16/23

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 02/16/2023

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 698

Continued From page 17

01/30/23 with diagnoses that included hypertensive chronic kidney failure Stage 5.

Review of an admission Minimum Data Set (MDS) assessment dated 02/05/23 documented Resident #346 had moderately impaired cognition. She received hemodialysis.

In an interview with Resident #346 on 02/14/23 at 2:30 PM she stated she had not gotten a lunch meal either at the facility or boxed to go since her admission on 01/30/23. She reported she went to dialysis every Monday, Wednesday, and Friday. She explained her chair time at dialysis was 11:30 and she was usually transported between 10:30 and 11:00 each dialysis day. She reported her family had told staff she was not receiving a lunch on dialysis days, but she still had not gotten a box lunch to take with her. She complained she was already weak from dialysis but going from breakfast to dinner without any food made her feel weaker.

In a telephone interview with a family member on 02/14/23 at 4:00 PM she stated she had told 3 separate staff members on 3 separate occasions that her mom was very hungry when she returned from dialysis because she was not being provided a lunch on dialysis days and went from 7:00 AM to after 5:00 PM without any food. She reported she had a care plan meeting at the facility earlier that day and told the Social Worker again that her mom was not being fed lunch on dialysis days. She stated the Social Worker told her it was not appropriate to go without lunch.

In an interview with the Social Worker on 02/15/23 at 2:36 PM she stated she had a two week care plan meeting on 02/14/23 with the

F 698

submitted as a written allegation of compliance.

Wilson Pines Nursing and Rehabilitation 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 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.

On 2/17/2023, Resident #346 received a bagged lunch and snack prior to her dialysis appointment.

On 3/6/2023, the resource nurse received and entered an order into the medical record for Resident #346 to receive early lunch tray or bag lunch prior to dialysis appointments.

On 2/15/2023, the Director of Nursing (DON) and resource nurses completed an audit of all residents receiving dialysis for the month of February to ensure dialysis residents had a meal/snack provided prior to leaving the facility for dialysis appointments. Any concerns identified during the audit were immediately addressed by the DON and resource nurses to include providing re-education.

On 2/15/2023, the Staff Facilitator (SF) initiated an in-service for 100% of dietary

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 02/16/2023

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 698

Continued From page 18

family of Resident #346. She acknowledged she had been told by the family the resident had not been receiving lunch on dialysis days. She stated she had attempted to call the Kitchen Manager twice on 02/14/23 who didn ' t answer or call her back and as the day went on she forgot about it. She did not process the concern.

In an interview with Resident #346 on 02/15/23 at 10:25 she stated she went to the nurse ' s station and got a bag of chips and a pack of peanut butter crackers out of the snack box to take to dialysis with her. She had not been provided a box lunch to go. She revealed the chips and crackers when she opened her dialysis duffle bag. There was no other food observed in her dialysis bag. The resident was observed from 10:25 AM to 11:40 AM and no lunch bag was brought to the resident. The transport company was late to pick her up for dialysis. At 11:40 AM Nurse #4 brought the resident a lunch tray.

In an interview with Nurse #1 on 02/15/23 at 11:45 AM she stated she walked past Resident #346 ' s room and noticed she had not left for dialysis, so she asked the resident if she had had lunch. She went to the kitchen and got a lunch tray for the resident and also had asked the kitchen staff for a sandwich the resident could take with her. She stated it was her understanding no box lunches went with dialysis residents because the dialysis center would not let them eat there anymore. She stated she did not think the kitchen made box lunches anymore.

In an interview with the Kitchen Manager on 02/15/23 at 12:15 PM she stated the kitchen made generic box lunches with no names on them each day for residents to use. She reported

F 698

staff, nursing assistants, and nurses regarding ensuring dialysis residents have a meal/snack provided prior to leaving the facility for dialysis appointments. The in-service will be completed by 3/16/2023. Any dietary staff, nursing assistant, or nurse that has not received the in-service by 3/16/2023 will receive the in-service prior to the next scheduled shift. All newly hired dietary staff, nursing assistants, and nurses will receive the in-service during orientation.

The resource nurses, Quality Improvement (QI) nurses, and/or the SF will monitor all dialysis residents to include resident #346 once weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Meal Audit Tool. This audit is to ensure each resident receiving dialysis is provided with an early meal tray or bag lunch prior to dialysis appointments. All concerns identified during the audit will be addressed by the resource nurses, QI nurses, and/or the SF to include providing the resident with a meal/bag lunch and/or re-education of staff. The DON will review the Dialysis Meal Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.

The DON will forward the results of Dialysis Meal Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Dialysis Meal Audit Tool to determine trends and / or issues that may

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 02/16/2023

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 698	Continued From page 19 she had made 3 box lunches that day and none had been used. She explained each box lunch contained a sandwich, chips, and a drink. The box lunches were available for nurse aides to pick up and give to any resident going to dialysis. She stated it was the responsibility of the nurse aides to come to the kitchen and get a box lunch if a resident needed one. In an interview with Nurse Aide #1 on 02/15/23 at 12:30 PM she stated she provided care to Resident #346 on day shift. She reported she had never gone to the kitchen to get a box lunch for the resident and didn ' t know she was supposed to get the box lunch from the kitchen. In an interview with the Administrator on 02/15/23 at 4:15 PM he stated all dialysis residents were to receive a box lunch to take to dialysis if gone during a meal time. He explained there was a period when the dialysis center would not allow the facility to send food but that was a while ago and no longer applied. He reported he didn ' t realize Resident #346 was going from breakfast to supper with no lunchtime meal. He stated he would look at the process and fix it immediately.	F 698	need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals	F 761		3/16/23

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 02/16/2023

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 761	Continued From page 20 §483.45(h)(1) 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. §483.45(h)(2) 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 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep medications secured by storing opened and unlabeled medications in four different medications cups in the medication cart on the 600 hall for 1 of 2 medication carts inspected. Findings included: An inspection of the 600 hall medication cart on 02/16/23 at 9:45 AM revealed four separate medications cups stored in a drawer on the cart that contained the following unlabeled items: a cup containing 9 pills, a cup of a white liquid, a cup with brown applesauce, and a cup of clear gel. In an interview with Medication Aide #1 on 02/16/23 at 9:45 AM she stated she had opened some of the medications to administer to a resident who refused to take the medications at	F 761	F761 Label/Store Drugs and Biologicals Wilson Pines Nursing and Rehabilitation 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. Wilson Pines Nursing and Rehabilitation 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 reserves the right to refute any of the deficiencies	

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 02/16/2023

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 761 Continued From page 21

that time. She reported the resident had told her he was going to the store and would be back in a minute. She stated she finished opening the rest of the medications due at that time and placed the unlabeled mediations in the drawer to administer when the resident returned. She was not able to identify the pills in the cup without looking at the Medication Administration Record in the computer. She explained the applesauce had the medication, Revela, mixed in it. She noted she knew she was supposed to dispose of the medications when the resident refused to take them, and she knew it was not alright to store unlabeled medications in a medication cart, but she thought the resident was coming right back. She took the unlabeled medications to the medication storage room and properly disposed of them.

In an interview with the 600 Hall Resource Nurse on 02/16/23 at 9:50 AM she stated it was not acceptable to store unlabeled medications in a medication cart. She noted she would have tried to encourage the resident to take the medications that had been prepared and if unsuccessful, she would have destroyed them.

F 761

on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

On 2/16/2023, Medication Aide #1 was re-educated by the Staff Facilitator on the medication storage policy to include storage of pre-poured medications as unacceptable. The Medication Aide discarded the resident's medications after the resident declined to take the medications. Medications were re-pulled by Medication Aide #1 and administered to the resident upon returning to room.

On 2/16/2023, the Director of Nursing (DON) completed and 100% audit of all medication carts to include the 600-hall medication cart to ensure no pre-poured medications were present. No further concerns were noted during the audit.

On 2/16/203, the Staff Facilitator and DON initiated an in-service required for 100% of all nurses and medication aides addressing the medication storage policy to include storage of pre-poured medications as unacceptable. After 03/16/2022, any nurse or medication aide who has not received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation by the Staff Facilitator regarding the medication storage policy to include storage of pre-poured medications as unacceptable.

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 02/16/2023

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 761	Continued From page 22	F 761	The resource nurse, Quality Improvement (QI) nurses, and/or staff facilitator will audit all medication carts/medication storage rooms weekly x 4 weeks, then monthly x 1 month utilizing the Medication Storage Audit Tool. This audit is to ensure that ensure no pre-poured medications are stored on the medication carts. The resource nurse, Quality Improvement (QI) nurses, and/or staff facilitator will address all concerns identified during the audit to include immediately discarding pre-poured medications and providing re-education. The DON will review Medication Storage Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Medication Storage Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Storage 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.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		3/16/23

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 02/16/2023

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 812	Continued From page 23 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to (1) label foods items with an open and expiration date and discard expired food items stored for use in 1 of 1 walk-in refrigerator for 1 of 2 kitchen observations and (2) label food items with an open and expiration date stored for use in 1 of 1 walk-in freezer. These practices had the potential to affect food served to 99 of the 99 residents. Finding included: 1. On 2/13/2023 at 9:48 a.m. in the initial tour of the kitchen accompanied by Dietary Manager (DM), the following items were observed in the walk-in refrigerator: " Two containers of frozen solid puree bacon in a box with no date indicating when opened or an expiration date. The Dietary Manager discarded the item. " A large, opened container of ranch buttermilk dressing dated open 12/1/2022. There was no expiration date on the manufacture's label or the container. The Dietary Manager stated	F 812	F 812 Food Procurement, Store/Prepare/Serve- Sanitary Wilson Pines Nursing and Rehabilitation 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. Wilson Pines Nursing and Rehabilitation 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 reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal	

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 02/16/2023

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 812

Continued From page 24

opened containers of dressing expired one month after opening and discarded the ranch buttermilk dressing.

" An unopened 12-pack of boiled eggs indicating no date indicating delivery or an expiration date. The Dietary Manager stated the unopened 12-pack of boiled eggs was pulled out of a box and should have been labeled with the date the box was opened. Dietary Manager discarded the unopened 12-pack of boiled eggs.

In an interview with Dietary Aide #1 on 2/16/2023 at 2:20 p.m., she stated she helped put up the food items in the walk-in refrigerator when delivered. She stated food boxes were rotated to the back of the shelves and dated when the box was opened. Boxes of food items without a date were to be discard. She said when she found food boxes without a date, she would write a date on the food item box.

In an interview with Assistant Dietary Supervisor on 2/16/2023 at 2:28 p.m., he stated he was responsible for placing new stock on the shelves in walk-in refrigerator. He explained food boxes were to be dated when opened. He further stated dietary staff should relabel any food items removed from the box since those food items need to be used within seven days. He was unable to give a reason why food boxes were found not labeled with dates.

2. On 2/13/2023 at 10:03 a.m. in the initial tour of the kitchen accompanied by the Dietary Manager, the following items were observed in the walk-in freezer:

" Frozen sliced ham in a box with no date on the box or package indicating delivery or an expiration date.

F 812

appeal procedure and/or any other administrative or legal proceeding.

On 2/13/2023, the Dietary Manager discarded all items in the walk-in refrigerator that expired and/or not dated when opened to include that were not dated when opened or expired to include two containers of frozen solid puree bacon in a box, a large open container of ranch buttermilk dressing, and an unopened 12 pack of boiled eggs.

On 2/13/2023, the Dietary Manager discarded all items in the walk-in freezer that expired and/or were not dated when opened to include a box of frozen sliced ham, two unopened packages of frozen waffles, an open box of frozen puree deli meat, and an unopened package of frozen hotdogs.

On 3/10/2023, the dietary manager and administrator completed an audit of all items in the walk- in freezer, walk in refrigerator. This audit ensured all items were labeled with an “open date,” a “use by date” when opened and no expired food items were present. No further concerns were noted during the audit.

On 3/7/2023, the administrator initiated an in-service with the dietary manager and dietary staff “Labeling and Storage of Food Items When Opened and Expired Food Items” with emphasis on labeling all food items and discarding expired food items in the walk-in freezer and walk in refrigerator per protocol to ensure food

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 02/16/2023

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 812 Continued From page 25

" Two unopened packages of frozen waffles with no date indicating a delivery, opening or expiration date.
" An open box of frozen puree deli meat trays with no date on the package or box indicating the delivery, open or expiration date.
" An unopened package of frozen hot dogs with no date on the package indicating a delivery date, open date or expiration date.
The Dietary Manager discarded the unlabeled items in the freezer and stated staff were to date the boxes of food items when delivered and opened.

In an interview with Dietary Aide #1 on 2/16/2023 at 2:20 p.m., she stated she helped put up the food items in the walk-in freezer when delivered. She stated food boxes were rotated to the back of the shelves when delivered and were to be dated when the box was opened. Boxes of food items without a date were to be discard. She said when she found food boxes without a date, she would write a date on the food item box.

In an interview with Assistant Dietary Supervisor on 2/16/2023 at 2:28 p.m., he stated he was responsible for placing new stock on the shelves in walk-in freezer. He explained food boxes were to be dated when opened. He further stated dietary staff should relabel any food items removed from the box since those food items need to be used within seven days. He was unable to give a reason why food boxes and packaged were found not labeled with dates.

F 812

service safety. In-service will be completed by 3/16/2023. All newly hired dietary staff will be in-serviced during orientation regarding “Labeling and Storage of Food Items When Opened and Expired Food Items.”

The administrator and/or designee will complete an audit of the walk-in freezer and the walk-in refrigerator weekly x 4 weeks, then monthly x 1 month, utilizing the Kitchen Audit Tool. This audit is to ensure all items in the walk-in freezer and walk in refrigerator are labeled with an “open date” or an “use by date” when opened and that expired food items in the walk- in freezer, walk in refrigerator and the each in refrigerator per facility protocol. The dietary manager will address all concerns identified during the audit to include discarding items not labeled per facility protocol and re-education of staff. The administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed.

The administrator will present the findings of the Kitchen Audit Tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months. The QAPI committee will meet monthly for 2 months and review the Kitchen 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.

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 02/16/2023

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 867	Continued From page 26	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		3/16/23

§483.75(c) Program feedback, data systems and monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the

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 02/16/2023

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 867	Continued From page 27 facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and	F 867		

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 02/16/2023

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 867	Continued From page 28	F 867		

implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented

Provider's Plan of Correction:

F 867 QAPI/QAA Improvement Activities

Wilson Pines Nursing and Rehabilitation

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 02/16/2023

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 867

Continued From page 29

procedures and monitor interventions that the committee had previously put in place following the recertification and complaint survey of 8/27/21. The deficiencies are in the areas of Accuracy of Assessments (641), Accidents (689), Label/Store Drugs and Biologicals (761), and Food Procurement (812). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referenced to:
F641: Based on record review, observations and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for isolation (Resident #243), use of a wander guard (Resident #6), for dementia (Resident #58) and discharge status (Resident #90) for 4 of 25 residents whose MDS assessments were reviewed.
During the recertification and complaint survey of 8/27/21, the facility was cited for accurately coding an admission Minimum Data Set for smoking.
F689: Based on observation, staff interview and record review the facility failed to implement interventions for fall prevention for a resident with a history of falls for 1 of 2 residents reviewed for accidents (Resident #346).

During the recertification and complaint survey of 8/27/21, the facility was cited for failing to implement interventions to prevent a resident for smoking in his room and failed to complete a smoking evaluation.
F761: Based on observation and staff interviews the facility failed to keep medications secured by

F 867

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.

Wilson Pines Nursing and Rehabilitation 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 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.

On 3/10/2023, the administrator initiated an audit of previous citations and action plans from 8/27/2021 to 2/16/2023 including F 641 Minimum Data Set (MDS) Coding Accuracy, F 689 Accidents/Hazards, F 761 Medication Storage, and F 812 Food Procurement/ Storage to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by Quality Improvement (QI) Nurse for any concerns identified. The Regional Nurse Consultant will address all concerns identified during the audit to

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 02/16/2023

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 867	Continued From page 30 storing opened and unlabeled medications in four different medications cups in the medication cart on the 600 hall for 1 of 2 medication carts inspected. During the recertification and complaint survey of 8/27/21, the facility was cited for not discarding expired medications and failing to keep topical medications contained in a resident's room. F812: Based on record review, observations and staff interviews, the facility failed to (1) label foods items with an open and expiration date and discard expired food items stored for use in 1 of 1 walk-in refrigerator for 1 of 2 kitchen observations and (2) label food items with an open and expiration date stored for use in 1 of 1 walk-in freezer. These practices had the potential to affect food served to 99 of the 100 residents. During the recertification and complaint survey of 8/27/21, the facility was cited for failing to maintain sanitary conditions in the kitchen by: failing to ensure the dishwasher was rinsing dishes at the correct temperature to sanitize the dishes; by failing to discard expired food and to date opened resealable food items stored in the walk-in refrigerator; by not properly storing and dating open dry food items and by failing to store food items off the floor. An interview with the Administrator was conducted on 10/16/23 at 3:24 PM. He reported the facility attempted to correct any on-going issues that were identified. The Administrator further stated the facility had some turnover in staff which may have contributed to the repeated citations.	F 867	include but not limited to education of staff. This audit will be completed by 3/16/2023. On 3/7/2022, the regional nurse consultant initiated an in-service with the administrator and Director of Nursing (DON), Quality Improvement (QI) Nurses regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include pharmacy services and infection control. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 3/15/2023. All newly hired administrators, DONs, and QI nurses will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include F 641 Minimum Data Set (MDS) Coding Accuracy, F 689 Accidents/Hazards, F 761 Medication Storage, and F 812 Food Procurement/ Storage will be taken to the Quality Assurance committee for review monthly x 3 months by the QI Nurse. The Quality Assurance committee will review the data and determine if plan of corrections is being followed, if changes in plans of action are required to improve outcomes,	

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 02/16/2023

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 867	Continued From page 31	F 867	if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QI Nurse. The regional nurse consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F 641 Minimum Data Set (MDS) Coding Accuracy, F 689 Accidents/Hazards, F 761 Medication Storage, and F 812 Food Procurement/ Storage and all current citations and QA plans are followed and maintained quarterly x2. The Regional Nurse Consultant will immediately retrain the Administrator, DON, and QI nurse for any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the QI nurse to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	