STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 02/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An announced recertification and complaint investigation survey was conducted on 02/12/24 through 02/16/24. The facility was found in compliance with the Requirement CFR 483.73, Emergency Preparedness. Event ID #2W6Y11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/12/2024 through 02/16/2024. Event ID# 2W6Y11. The following intakes were investigated NC00212240, NC00208511, NC00211454, NC00213152, NC00204914, NC00201055, NC00201119, NC00200497, NC00198364, NC00207468, NC00213108, and NC00213336. 3 of the 33 allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner, and staff interviews, the facility failed to provide care safely when Nursing Assistant (NA) #1 and NA #2	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/01/2024

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transferred a resident who was dependent on staff assistance and unable to bear weight from his bed to chair by holding the resident under his arms. Resident #62 sustained an acute displaced left humeral (long bone in the arm between shoulder and elbow) neck fracture requiring use of a sling, orthopedic follow up, and resulted in pain for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #62).

Findings included:

Resident #62 was admitted to the facility on 10/14/19 and his most recent re-admission to the facility was on 1/23/23. His diagnoses included dementia, heart failure, osteoarthritis, and Parkinson's disease.

Resident #62's Care Guide summary (no date) indicated he was totally dependent with transfers; he was non weight bearing and he required a sling lift for transfers.

Resident #62's care plan initiated 1/23/23 indicated he was at risk for falls related to history of falls, increased weakness/decreased endurance, safety/impaired or decreased safety awareness. He displayed poor safety awareness and insight and was very impulsive in behavior. History of falls: 12/3/19 fall with no injury, 12/9/19 fall with no injury, 12/17/19 fall with no injury, 2/3/20 fall with no injury, 2/8/20 fall with no injury, 11/15/21 fall with no injury, 12/5/21 fall with no injury, and 3/20/23 fall with no injury. Interventions included: before transfers ensure floor surrounding bed is free from obstacles, whether in bed or chair ensure proper and safe body alignment, positioning and parameters for resident to maximize safety, assist to change

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position frequently for comfort.

Resident #62's quarterly Minimum Data Set (MDS) assessment dated 6/8/23 revealed he was assessed as cognitively intact. Resident #62 was dependent for transfers and required the assistance of 2 or more people. Resident #62 was coded as not exhibiting behavioral symptoms and not exhibiting rejection of care behaviors. He was coded as utilizing a manual wheelchair and was dependent on staff to utilize the wheelchair. He had no pain and was not receiving opioids. He was coded as having had a fall without injury.

During an interview on 2/14/24 at 1:52 PM with NA #1, she stated she was told by Nurse #1 to transfer Resident #62 from the bed to the chair since his feet were hanging off the bed on 9/1/23 during the third shift that began at 11:00 PM and ended on 9/2/23 at 7:00 AM. She transferred Resident #62 from the bed to the chair with NA #2 without using the mechanical lift. She (NA #1) indicated she stood on one side of Resident #62 and NA #2 stood on the opposite side and they supported him by the arms and transferred him to the chair. NA #1 stated Resident #62 did not bear any weight or assist with the transfer. NA#1 verbalized she was aware based on Resident #62's Care Guide that he required a mechanical lift for transfers, but they went ahead with the transfer without obtaining the lift anyway since Resident #62's feet were off the bed. NA #1 verbalized Resident #62 did not complain of any pain during the transfer or after the transfer on 9/1/23 during the third shift that began at 11:00 PM and ended on 9/2/23 at 7:00 AM.

Attempts to interview NA #2 were unsuccessful.

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During an interview on 2/15/24 at 8:07 AM with Nurse #1, she stated she had asked NA #1 and NA#2 on 9/1/23 11:00 - 7:00 AM shift to transfer Resident #62 to the chair since he had his foot hanging out of the bed. She stated they got Resident #62 out of bed because he was agitated and had his foot hanging off the bed. Nurse #1 verbalized she realized NA #1 and NA #2 had not used the mechanical lift to transfer Resident #62 out of bed because there was no sling under him when she came back to check on him shortly after he was transferred. She explained that he was seated at the Nurse's station. He did not complain of pain on 9/1/23 during the 11:00 PM - 7:00 AM shift.

During an interview on 2/15/24 at 8:07 AM with Nurse #1 she stated she became aware of pain/injury on 9/2/23 during the shift that began at 11:00 PM and ended on 9/3/23 at 7:00 AM when Resident #62 reported 4 out of 10 pain level to the right shoulder. Tylenol was administered for pain and was effective. An x-ray was done on 9/3/23 and showed he had a fracture to the left humerus.

Resident #62 no longer resided at the facility and was unavailable for interview.

A physician's order dated 9/3/23 indicated order stat (immediate) x-ray, 2 view of the left shoulder.

Resident #62's x-ray radiology interpretation dated 9/3/23 findings indicated a fracture involving left humeral neck with slight medial displacement and mild osteoporosis. The impression was acute displaced left humeral neck fracture.

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A physician's order dated 9/3/23 indicated place arm in a sling and refer to Orthopedist next week.

Nursing progress note dated 9/3/23 indicated Resident #62 requested pain medication, Tylenol (acetaminophen) was given and was effective.

Resident #62's September 2023 Medication Administration Record (MAR) indicated a pain evaluation on a scale of 0 to 10 was conducted on each shift. Resident #62's pain level on 9/3/23 7:00 AM - 3:00 PM shift was documented as 4 out of 10, 3:00 PM - 11:00 PM shift was documented as 3 out of 10 and 11:00 PM - 7:00 AM shift was 0 out of 10. On 9/5/23 at 9:03 AM pain level was documented as 7 out of 10 and 650 milligram acetaminophen was administered. The pain level was documented as 0 or 1 out of 10 all the other days in September 2023.

Resident #62's Emergency Department (ED) after visit Summary dated 9/5/23 indicated Resident #62 was seen at the ED for a shoulder injury. The diagnosis was encounter for closed fracture of left humeral head. Discharge instructions were to follow up with bone doctor, continue to use sling in place to avoid further bone injury and use over the counter pain medication.

A physician's order dated 9/7/23 indicated to monitor sling in place to Resident #62's left arm every shift.

Resident #62's Orthopedics assessment plan dated 9/27/23 indicated initial encounter for nondisplaced fracture of upper end of left humerus. The note stated he will continue with sling for comfort, extra strength Tylenol 2 tablets 3 times a day can be used for pain, follow up in 3

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weeks.

The physician's order dated 9/7/23 related to sling monitoring every shift was discontinued on 10/25/23.

Facility Investigative Summary Review submitted on 9/7/23 by facility Administrator for Resident #62 indicated the resident complained of pain in his right shoulder on 9/3/23 at approximately 6:00 AM and he had swelling to the right shoulder. The resident stated the pain began about two days ago. An in-house x-ray was performed on 9/3/23 at approximately 4:05 PM, the x-ray report revealed a fracture involving the left humeral neck with slight medial displacement. Resident #62 was ordered a sling and ordered to follow up with orthopedic doctor. Staff investigations indicated Resident #62 was agitated on the night of 9/1/23 and Nurse #1 noted him with his foot hanging off the bed. Nurse #1 told Nursing Assistant #1 (NA #1) and Nursing Assistant #2 (NA #2) to get Resident #62 out of bed. NA #1 and NA #2 transferred Resident #62 from bed to chair without the lift. Facility actions indicated staff were in-serviced on transfer policy-not lifting/handling resident limbs, kardex following completing transfers and reporting incidents/accidents. On 9/2/23 education was initiated by the charge nurse with the nursing assistants (NA #1 and NA #2) who transferred the resident without the lift. Re-education again on 9/3/23 and on 9/7/23 one on one return demonstration and re-education was completed by the Director of Nursing with the two nursing assistants who provided the wrong transfer ensuring they check the Kardex before transfers and they must follow the plan of care.

An interview was conducted with the Nurse

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Practitioner on 2/14/24 at 12:43 PM. She stated that an x-ray was ordered when Resident #62 complained of right shoulder pain (9/3/23) which showed a fracture to the left humerus. An order was given for the Resident to wear a sling. Pain was managed with Tylenol, and he was sent to the ED when he had increased pain (9/5/23). The ED and orthopedics discharge indicated to continue with same treatment, to wear sling and pain medication as needed. The NP stated NA #1 and NA #2 should have used the lift to transfer Resident #62 on 9/1/23 to ensure it was a safe transfer.

An interview was conducted with the facility Administrator and Corporate Consultant on 2/15/24 at 2:20 PM. The Administrator stated Resident #62 complained of right shoulder pain on 9/3/23 and an X-ray was done on 9/3/23 which showed an acute fracture to the left humeral neck. The doctor gave an order to place the arm in a sling, pain medication and follow up with orthopedics the following week. The Administrator verbalized the facility completed a 24-hour report on 9/3/23 and conducted an investigation. The investigation revealed NA #1 and NA #2 had transferred Resident #62 from the bed to the chair on 9/1/23 during the third shift that began at 11:00 PM and ended on 9/2/23 at 7:00 AM without utilizing the mechanical lift. The Administrator explained, the 2 NAs stood on each side of Resident #62 and supported the Resident under his arms and transferred the Resident to the chair, Resident #62 did not bear any weight during the transfer. Resident #62 was sent to the Emergency Department (ED) on 9/5/23 due to increased pain. Diagnosis at the ED on 9/5/23 was closed fracture of the left humeral head. The Administrator stated under no circumstances

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should facility staff transfer Residents by their body limbs such as arms or legs. She further stated NA #1 and NA #2 should have used the lift to transfer Resident #62 on 9/1/23.

The facility provided the following plan of correction with a compliance date of 9/8/23:

1. Corrective action for resident(s) affected:
- On 9/3/23, Resident complained of pain to right shoulder pain. Nurse notified the doctor of the pain and an order was received for an x-ray to the left shoulder. The nurse instructed staff to get Resident out of bed to prevent him from trying to get up on his own. The two nursing assistants were interviewed, and they did get resident up into the chair without the mechanical lift, shortly after coming onto shift on 9/1/23 at approximately 11:20 pm. Staff got resident up and placed at the nurse's station. Resident had snack and was placed back to bed by the nursing assistants and the nurse using the mechanical lift. Charge Nurse verbally educated nursing assistants that they were supposed to use the lift. Charge Nurse did demonstrate proper use of the lift and assisted the nursing assistants with safe transfer of the resident back into bed according to the Resident's plan of care on 9/2/23 when the resident was put back to bed.
- On 9/3/23 X-ray revealed fracture to the left shoulder. The doctor was notified of the results of x-ray and ordered sling to the left arm and Tylenol.
- On 9/5/23 Resident reported increased pain and the doctor gave the order to send to the Emergency Room (ER) for evaluation. ER report stated closed fracture of humeral head, no dislocation on 9/5/23 x-ray, and no new orders were given from previous facility doctor's orders.

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F 689	Continued From page 8 ER stated to follow-up with orthopedics doctor. 2. Corrective action for resident(s) with the potential to be affected. - On 9/2/23, education began by the charge nurse with the nursing assistants who transferred the resident without the lift. Reeducation again on 9/3/23, and on 9/7/23, one on one return demonstration and re-education was completed by the Director of Nursing with the two nursing assistants who provided the wrong transfer ensuring they check the Kardex before transfers and they must follow the plan of care. - In-service was conducted with all other staff beginning 9/3/23 on the no-lift policy (no lifting residents by body parts such as arms, legs) and additional in-servicing was added on 9/7/23 checking the Kardex before transfers, and incident/accident reporting and protocols. 3. What measures/systems will be put into place to ensure the deficient practice does not occur again? - Facility implemented a Transfer Audit tool to monitor compliance with resident transfers to ensure residents are transferred according to the plan of care. 4. How will performance be monitored and how often? - Transfer audit log audits will be completed weekly x4 and monthly x3 thereafter by the Executive Director and quarterly thereafter to ensure compliance. Findings of the transfer audit compliance will be presented to the Quality Assurance Committee quarterly. Any non-compliance will be addressed by the QA Committee and the plan will be modified as needed. Compliance Date: 9/8/23	F 689		

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F 689	Continued From page 9 On 2/16/24 the facility's plan of correction was validated by the following: Audits conducted by the facility were reviewed and were found to be completed according to the plan of correction. Auditing started 9/3/23 and was completed on 12/27/23. Staff interviews with NAs and nurses verified education was provided on reviewing the kardex prior to providing care for residents. The training content included: locate and identify transfer status for resident, demonstrate proper mechanical pad placement, demonstrate proper use of mechanical lift from bed to chair/chair to bed, demonstrate proper stand and pivot technique with one/two person using gait belt and education on importance of facility no lift policy. The Director of Nursing (DON), Quality Assurance Nurse and Corporate Consultant verbalized they had conducted the initial training. Training check off sheets were noted to have DON's signature as the instructor. In-service for all facility staff started 9/3/23 and was completed on 9/7/23. The facility Executive Director (Administrator) stated she was responsible for ensuring all new hires were in-serviced. The Director of Nursing or Designee was responsible for transfer audits and monitoring compliance to ensure residents are transferred according to the plan of care. Transfer audits were noted to have been completed by DON and Quality Assurance Nurse. On 2/16/24 at 12:01 PM NA #3 and NA #4 were observed transferring a resident utilizing the mechanical lift according to the plan of care. The facility's plan of correction was validated to be completed as of 9/8/23.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867		3/1/24

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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 facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and

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F 867	Continued From page 11 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 implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 12 §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, Nurse Practitioner, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the focused infection control and complaint investigation	F 867	F867: QAPI/QAA Improvement Activities • How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #62 was discharged from the facility on 1/22/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 13 survey of 8/18/22. This was for one deficiency in the area of Accidents/Hazards (F689) that was recited on the current recertification and complaint investigation survey of 2/16/24. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referenced to: F689: Based on record review, Nurse Practitioner, and staff interviews, the facility failed to provide care safely when Nursing Assistant (NA) #1 and NA #2 transferred a resident who was dependent on staff assistance and unable to bear weight from his bed to chair by holding the resident under his arms. Resident #62 sustained acute displaced left humeral (long bone in the arm between shoulder and elbow) neck fracture requiring use of a sling, orthopedic follow up, and experienced pain for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #62). During the focused infection control and complaint investigation survey of 8/18/22 the facility was cited at F689 for failing to ensure a resident, who was on an anticoagulant, did not fall from bed while care was being rendered with the bed in the elevated position. An interview was conducted on 2/16/24 at 12:59 PM with facility Administrator and Corporate Consultant. The Administrator stated the QAPI committee met monthly and committee members included: Administrator, Medical Director, Director of Nursing (DON), Nurse Manager, Dietary Manager, Dietician, Admissions Coordinator,	F 867	• How will the facility identify other residents having the potential to be affected by the same deficient practice? On 3/1/24, 100% audit of all closed and open QA/QAPI initiatives was completed by the QA committee to ensure substantial compliance. On 3/1/24, any QA/QAPI initiatives that were found to be out of compliance were reopened by the QA Committee. • What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 3/1/24, QA/QAPI team initiated an additional process review of all open initiatives to reflect confirmation of compliance by Administrator On 3/1/24, QA/QAPI team completed QAPI discussion with outcome and document by Administrator At the next QA/QAPI meeting, substantial compliance will be confirmed and documented by the Administrator. On 3/1/24 Director of Operations completed 100% education with the QA/QAPI Committee on the requirements of the quality assurance program. • How does the facility plan to monitor its performance to make sure that solutions are sustained? On 3/1/24, Administrator scheduled monthly QA/QAPI meetings x 3months and then quarterly thereafter. At each meeting the QA/QAPI team will discuss the updated initiatives implemented and document the completion by the	

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F 867	Continued From page 14 Minimum Data Set (MDS) Coordinator, Environmental Services Director, Treatment Nurse, Social Services Director, Therapy Director, and Activities Director. The Administrator stated the committee discussed ongoing identified concerns to include prevention of accidents.	F 867	Administrator.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345348	A. BUILDING: _____ B. WING _____	2/16/2024

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WHISPERING PINES NURSING & REHAB CENTER	**523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	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 and staff interviews the facility failed to code the Minimum Data Set (MDS) accurately for noninvasive ventilator use for 1 of 18 residents reviewed for accuracy of the MDS (Resident #25). Findings include: Resident #25 was admitted into the facility on 12/14/23 with diagnoses of coronary heart disease, congestive heart failure, asthma and respiratory failure. A review of Resident 25's comprehensive care plan dated 1/3/24 included she required the use of a ventilator type device (Luisa non-invasive ventilation therapy device) to maintain an adequate respiratory status. A review of Resident 25's Physician's Orders dated 1/6/24 included to apply the noninvasive ventilator as needed and remove in the morning. A review of Resident #25's significant change MDS dated 1/10/24 had not indicated Resident #25 used a non-invasive ventilator. An interview was conducted with the MDS Coordinator on 02/15/24 08:52 AM. A review of the significant change MDS dated 1/10/24 that indicated Resident #25 was not coded for noninvasive ventilator use was reviewed with the MDS Coordinator. The MDS Coordinator revealed she thought noninvasive ventilator was only coded if it was a continuous positive airway pressure machine (CPAP) or bilevel positive airway pressure machine (BiPAP) and since the noninvasive ventilator was neither she did not code noninvasive ventilator use. An interview with the Director of Nursing on 2/15/24 at 9:37 AM revealed that the noninvasive ventilator should have been coded on the MDS. An interview with the Administrator on 2/15/24 at 9:50 AM indicated that the noninvasive ventilator should have been coded on the MDS.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents