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 02/13/2014

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 2/13/14. Event ID# G4JF11.	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure pressure relieving measures were in place for 1 of 3 residents (Resident #25) who had pressure ulcers. Findings included: The facility's Pressure Ulcer Prevention policy, version date 01/10, noted that residents who had been assessed at moderate to high risk for pressure ulcer development may be placed on a preventative program. It was noted that the incidence of pressure ulcers could be dramatically reduced and/or prevented by implementing a preventative program. It was noted to "use positioning devices and protective devices as needed to protect susceptible areas from breakdown."	F 314	Plan of Correction Corrective Action for Resident Affected Resident #25 - discharged to Assisted Living facility on 1-20-14 Corrective Action for Residents Potentially Affected On 2-12-14 and 02-26-14 all residents to include residents that receive oxygen who have the potential for skin breakdown were assessed to ensure all pressure relieving measures were in place including oxygen tube ear padding by the Nurse Supervisor, QI Nurse, Staff facilitator	3/13/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2014

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F 314	Continued From page 1 Resident #25 was admitted to the facility on 10/12/13 and discharged on 01/20/14. Cumulative diagnoses included hypertension and a closed femur fracture of 10/12/13. A physician's telephone order of 10/14/13 indicated Resident #25 was to have oxygen via nasal cannula at 2 liters per minute as needed to keep oxygen saturation greater than 92%. The Admission Minimum Data Set (MDS) of 10/19/13 indicated Resident #25 was cognitively impaired. The resident required extensive assistance from staff for bed mobility, toilet use and hygiene. The resident required total assistance with transfers. Oxygen therapy was noted. According to the Care Area Assessment (CAA) of 10/19/13, the care plan would address the risk for development of pressure areas. A wound ulcer flow sheet of 11/13/13 indicated Resident #25 had a stage 3 pressure ulcer to the right ear which occurred in house. It measured 0.9 centimeters by 0.5 centimeters with 60% pink tissue and 40% necrosis of white/yellow slough. A physician's telephone order of 11/14/13 indicated to cleanse the right ear with normal saline daily, apply santyl (an enzymatic debriding agent) and cover with a non-adhesive dressing. A physician's telephone order of 11/15/13 indicated Resident #25 had continuous oxygen via nasal cannula. A wound ulcer flow sheet of 11/18/13 for Resident #25 indicated there was a stage 3 pressure area to the right ear which measured 0.3 centimeters by 0.3 centimeters with 80% pink tissue and 20%	F 314	Nurse, MDS Nurses and Treatment Nurse. Any identified concerns were immediately corrected by Nurse Supervisor, QI Nurse, Staff Facilitator Nurse, MDS Nurse and Treatment Nurse. On 02-14-14 □ 02-21-14 a 100% head to toe assessment was completed on all residents to ensure there were no newly identified pressure ulcers by the Nurse Supervisor, QI Nurse, Staff Facilitator Nurse, MDS Nurses, and Charge nurse. There were no new areas identified. 2-12-14 an in-service was initiated to all licensed nurses and c.n.a.□s by the Staff Facilitator. The In-service included s/s of skin breakdown and padding of ear pieces on oxygen tubing. On 02-26-14 in-service was initiated on ensuring all identified pressure relieving measures are in place, including oxygen tube ear padding as identified per the resident care guide by the Staff Facilitator. All newly hired licensed nurses and c.n.a.□s will be in-serviced by the Staff Facilitator on s/s of skin break down , padding of ear pieces on oxygen tubing and pressure relieving measures on orientation. Systemic Changes Q.I. Tool for monitoring pressure relieving measures to include padding oxygen tubing was initiated on 02-26-14. The DON, Nurse Supervisor, QI Nurse, Staff Facilitator Nurse, MDS Nurses and Treatment Nurse will observe each	

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F 314	Continued From page 2 yellow/white slough. A wound ulcer flow sheet of 11/25/13 for Resident #25 indicated the pressure area to the right ear was unstageable and measured 0.5 centimeters by 0.5 centimeters with 90% necrosis of yellow/white adherent slough and 10% pink tissue. The physician had assessed the wound and no new orders received. Resident #25's care plan which was last revised on 12/09/13 included a problem with ulceration or interference with structural integrity of layers of skin due to a stage 3 wound to the right ear. It was noted that it was caused by prolonged pressure related to impaired mobility and hip pain. Staff members were to report any reddened or open areas to the nurse. The interventions did not include anything to address the pressure of the oxygen tubing on the resident's ear. A wound ulcer flow sheet of 12/16/13 for Resident #25 indicated the pressure ulcer to the right ear was now a suspected deep tissue injury (SDTI) measuring 0.5 centimeters by 0.3 centimeters with 50% smooth pink tissue and 50% necrosis of yellow adherent slough. There was a scant amount of serosanguinous drainage present. The treatment was santyl. The wound physician had assessed the area and no new orders were received. The quarterly MDS of 01/06/14 indicated Resident #25 was at risk for pressure ulcers and had a stage 3 pressure ulcer which measured 0.5 centimeters by 1.0 centimeters by 0.2 centimeters. Oxygen therapy was noted. A Quality Improvement (QI) note of 01/10/14 at	F 314	resident weekly to ensure pressure relieving measures are in to place per the resident care guide, including oxygen tube ear padding 3 times a week times 4 weeks, then weekly times 3 weeks utilizing the Q. I. tool for monitoring pressure relieving measures. Any areas identified will be corrected immediately by the DON, Nurse Supervisor, QI Nurse, Staff Facilitator Nurse, MDS Nurses and Treatment Nurse. Quality Assurance The Administrator will review and initial the Q. I. tool for monitoring pressure relieving measures to include padding oxygen tubing weekly for 4 weeks, then monthly for completion and compliance. The QI tools will be reviewed in the Executive QI Committee monthly time 2 months for additional recommendations as appropriate and continued compliance in this area.	

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F 314	Continued From page 3	F 314		

2:54 PM indicated the wound to Resident #25's right ear was stable and being treated with antibiotic ointment daily and left open to air. Ear cushions were applied to her oxygen tubing.

According to a wound ulcer flow sheet of 01/16/14 the area to the right ear had healed.

During an interview with Nurse Aide #1 (NA#1) on 02/12/14 at 11:12 AM, she stated Resident #25 required total care for bathing. NA #1 stated she wasn't sure when the gray pads were placed on the oxygen tubing. She also stated she did not remember seeing any open areas on her skin but she didn't always look at her ears when she provided personal care. She commented she did wear oxygen continuously. NA #1 reported that she had been taught to report any open or reddened areas to a resident's skin.

During an interview with NA #2 on 02/12/14 at 11:24 AM, she stated Resident #25 was alert but confused. She stated Resident #25 wore oxygen. NA #2 stated she would remove the oxygen tubing during her bath to wash her face. She stated Resident #25 preferred bed baths instead of showers. When questioned about skin issues, NA #2 reported she did not remember any open areas to Resident #25's ears. She commented she would wash her ears but couldn't say that she observed them daily. NA #2 reported she had been taught to look at the resident's skin daily during the bath and report any redness, skin tears or open areas to the nurse.

Nurse #1 was interviewed on 02/12/14 at 12:05 PM. She stated residents who have oxygen have padding on their tubing unless they refused it. She commented the area to the ear was more

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F 314	Continued From page 4 prone to breakdown due to the absence of fatty tissue. When questioned about skin checks, Nurse #1 reported the nurse aides were responsible for observing the resident's skin during bathing and were to report any changes in the skin to the hall nurse. She stated when an area was identified a skin referral was made to the treatment nurse for assessment. Nurse #1 commented there were no skin checks performed by the nurses. Nurse #1 stated she had not observed Resident #25's pressure ulcer and the treatment nurse who worked with the resident was no longer employed. Staff #1 was identified as assisting with treatments with the previous treatment nurse. During an interview with her on 02/12/14 at 12:45 PM she stated she had worked with Resident #25 when she had the pressure ulcer to her right ear. She stated Resident #25 usually slept on that side causing added pressure to the ear area. She stated she did develop an open area on the top part of her ear where the oxygen tubing was placed. She stated the open area initially appeared as a red open slit on the top of her ear next to her scalp. Staff #1 stated Resident #25's oxygen tubing was not padded prior to the area developing. After the area formed, she had pads added to her oxygen tubing. During an interview with the Director of Nurses (DON) on 02/13/14 at 4:10 PM, she stated the nurse aides observed the resident's skin daily during care and were instructed to report any changes in the skin to the nurses. The DON reported once the changes were noted in the electronic chart an alert was sent to the nurse. The DON reported she would not expect to find pressure ulcers on the ear since they have	F 314		

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F 314	Continued From page 5 several options for prevention. She stated there were specialty pillow cases available for protection as well as gray padding that attached to the oxygen tubing.	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345372	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/07/2014

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. Building 0102 is Type III construction, one story, with a complete automatic sprinkler system. Building 0202 is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Wilson Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/7/2014 at approximately noon the hazardous area was non-compliant, specific findings include; the door to soiled linen side of laundry did not close and latch tightly in it's frame.	K 029	**K 029** **Corrective Action** The door to the soiled linen side of laundry room was repaired on 03/10/14. **Corrective Action for other areas potentially Affected** All rooms with doors in facility that protect hazardous areas were examined to ensure that they closed and latched properly by the maintenance director on 03/13/14 **Systemic Changes** An in-service was conducted with the maintenance staff 03/13/14 by the Administrator to ensure understanding that the rooms with doors protecting hazardous areas close and latch tightly in it frame. **Quality Assurance** The Maintenance Supervisor will monitor all doors monthly times 3 months to ensure compliance using the QI monitoring tool for doors that protect hazardous areas. The Administrator will check the QI monitoring tool for doors that protect hazardous areas monthly times 3 months to ensure compliance and completion.	04/21/14
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy W Bullock RN | TITLE: Administrator | (X6) DATE: 3-14-14

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DRW

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	345372	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/07/2014

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K 052 SS=D	Continued From page 1 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/7/2014 at approximately noon the fire alarm system was non-compliant, specific findings include; the duct detector labeled "D9" did not function properly when tested.	K 052	The Safety committee will review the QI door lock monitoring tools monthly times 3 months, any recommendations for further monitoring will be determined at that time to ensure compliance. **K052** **Corrective Action** The duct detector (D9) was replaced on 03-11-14. **Corrective Action for other areas potentially affected** All duct detectors were tested by C.T.E. Inc. on 03-11-14 to ensure they were in proper working order. **Systemic Changes** An in-service was conducted with the maintenance staff 03/13/14 by the Administrator to ensure understanding of monitoring schedule for fire system and duct detectors. **Quality Assurance** The maintenance director will ensure the facility is scheduled for the duct detectors to be checked and cleaned by a contracted electrical/fire safety company annually. The safety committee will review the service records yearly and make recommendations for monitoring.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/7/2014 at approximately noon the electrical code item was non-compliant, specific findings include; a multi outlet power strip was found in room 219 to the refrigerator.	K 147	**K-147** **Corrective Action** The multi outlet power strip was removed from room 219 **Corrective Action for Residents Potentially Affected** A 100% room audit was performed by the Maintenance Director from 3-11-14 – 3-13-14 to ensure that any multi outlet power strips were not being utilized. Residents that had these power cords in their rooms were re-educated and the cords were removed. **Systemic Changes** An in-service was conducted by the Administrator with the Maintenance Director on 03-13-14 to ensure proper monitoring of residents rooms were being observed for the use of multi power strips. Maintenance Director was in-serviced on the QI Monitoring Tool for use of Multi power strips.	

Quality Assurance

The Maintenance Director will audit 10% of all residents rooms weekly times 3 months, then monthly times 3 months to ensure residents are not utilizing multi power strips utilizing the QI Monitoring Tool for use of Multi Power Strips.

The Administrator will review and initial the QI Monitoring Tool for use of Multi Power Strips to ensure compliance weekly times 3 months and then monthly times 3 months.

The Safety committee will review the QI Monitoring tools for use of Multi Use Power Strips monthly times 6 months, any recommendations for further monitoring will be determined at that time to ensure compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345372	A. BUILDING 02 - BUILDING 02 B. WING _____	03/07/2014

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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000	MAR 24 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy W Bullock RN | TITLE: Administrator | (X6) DATE: 3-14-14

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