

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

PRINTED: 02/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	F 000			
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to draw a follow-up potassium lab on the morning specified in a physician order in response to a critically high</p>	F 329	The follow up potassium lab was drawn for resident #16 on 1/27/16 by the lab technician. The results of the follow up potassium lab was reviewed by the	2/19/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/24/2016

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: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329	<p>Continued From page 1</p> <p>potassium level obtained the day before for 1 of 5 sampled residents (Resident #16) reviewed for unnecessary medications. Findings included:</p> <p>Resident #16 was admitted on 11/08/11 and readmitted on 06/11/14. Her documented diagnoses included congestive heart failure, history of cerebrovascular accident, hypertension, and orthostatic hypotension.</p> <p>The resident's 12/04/15 quarterly minimum data set (MDS) documented her cognition was intact, she was dependent on the staff for dressing and bathing, and she only required supervision from the staff with her other activities of daily living (ADLs).</p> <p>A 01/20/16 physician order documented, "Obtain CBC (complete blood count), CMP (comprehensive metabolic profile), for baseline prior to starting radiation."</p> <p>01/20/16 lab results documented Resident #16's potassium was elevated at 5.3 millimoles per liter (mmol/L), with the normal range being 3.5 - 5.0 mmol/L.</p> <p>01/22/16 lab results documented Resident #16's potassium was critically high at 6.1 milliequivalents per liter (MEq/L), with the normal range being 3.5 - 5.5 MEq/L. The date stamp on the faxed results was 01/22/16 at 10:02 PM.</p> <p>A 01/22/16 physician order documented "Kayexelate 30 grams po (by mouth) x 1 now, Kayexelate 30 grams at 4 AM, repeat K (potassium) in AM."</p> <p>Record review revealed there was no lab result</p>	F 329	<p>Physician Extender on 1/29/16. No new orders received.</p> <p>100% audit of labs within the past 30 days to include labs for resident #16 was completed by the Resource Nurse on 2/12/16 to ensure that labs were drawn per MD specification to include the date ordered. The MD was notified of any identified areas of concern by the resource nurse during the time of the audit.</p> <p>All licensed nurses to include nurse #1, #2, and #3 were in serviced by the Staff Development Coordinator on the lab procedure to include all labs to be drawn per physician specifications; Notify the MD of ordered labs that haven't been drawn to receive orders; If a critical lab is ordered to be drawn on weekend a lab requisition will be placed on the mar to notify the nurse of the need to draw the lab; All critical labs on weekend need to be drawn as ordered and taken to Wilson Medical Center; Results need to be called to MD or Physician Extenders timely for further orders.; On Friday, Saturday, and Sunday 11-7 shift nurse will review that days physician orders for any lab orders, lab requisition will be completed and placed on the Medical Administration Record. A new lab company starts on 4/4/16. Completion Date for the inservice is 2/19/16.</p> <p>The DON and administrative nurses will conduct an audit of all physician ordered labs 3x per week x 4 weeks, weekly x 4</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329	<p>Continued From page 2</p> <p>for the 01/23/16 follow-up potassium lab draw in Resident #16's medical record. Record review also revealed the resident was not receiving a diuretic or potassium supplement in January 2016.</p> <p>A 01/23/16 6:11 AM nursing progress note document, "Pt (patient) in bed, skin warm and dry. Kayexelate given x 1 tolerated well. Pt. has had some loose stools. No complaints of pain."</p> <p>Record review revealed there were no more progress notes for Resident #16 until 01/29/16.</p> <p>At 10:12 AM on 02/11/16 the director of nursing (DON) provided a copy of the follow-up potassium lab for Resident #16 which was drawn on a "stat" (at once) basis on 01/27/16. The result documented the resident's potassium was within normal limits at 4.3 mmol/L, with the normal range being 3.5 - 5.0 mmol/L.</p> <p>At 10:42 AM on 02/11/16 Nurse #1 (charge nurse) stated she took over the responsibility of labs from the ward clerks about 6 - 7 months ago. She reported the 01/22/16 (Friday) potassium draw for Resident #16 was a scheduled lab which was recorded in the lab book and initialed off as being completed. She commented a physician order was generated in response to Resident #16's critically high potassium level which was received at 10:02 PM on 01/22/16. She stated part of this order was to draw a follow-up potassium on the morning of 01/23/16 (Saturday). Nurse #1 explained normally this would not pose a problem because contracted laboratory services was available to draw labs on the weekend. However, the nurse explained there was inclement weather the weekend of 01/23/16 -</p>	F 329	<p>weeks then monthly x 2 months to include labs ordered on the weekend using a Laboratory Monitoring Tool to ensure labs have been drawn per MD specification to include the date ordered. All areas of concern will be immediately addressed by the DON and or QI nurse by contacting the physician and providing retraining. The DON and/ or QI nurse will review and initial the results of the Laboratory Monitoring Tool Weekly x 8 weeks then monthly x 2 months for completion and to ensure all identified areas of concern have been addressed.</p> <p>Results of the Laboratory Monitoring Tool will be forwarded to the facility's Quality Improvement committee by the DON and/ or the Administrator monthly for 4 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.</p>		

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

PRINTED: 02/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329	<p>Continued From page 3</p> <p>01/24/16, and contracted lab services had already informed her on Friday that they would not be drawing labs over the weekend. According to Nurse #1, she posted on a communication board that staff would have to draw all labs on 01/23/16 - 01/24/16 and take them to the local hospital themselves. She explained this would entail staff completing lab slips and recording the weekend labs by hand in the lab notebook. The nurse also commented if labs were not able to be collected and delivered to the hospital over this weekend, her expectation would be for the staff to contact the primary physician to get guidance about how to proceed. Nurse #1 reported on Monday, 01/25/16, there was no record of a follow-up potassium level for Resident #16 in the lab notebook. On Tuesday, 01/26/16, Nurse #1 commented Nurse #2 (the quality improvement nurse) brought her the pink copy of the 01/23/16 physician order requesting a follow-up potassium for Resident #16. According to Nurse #1, she made contact with the hospital which confirmed no follow-up potassium had been drawn. She explained she immediately called contracted lab services on 01/26/16 to request a potassium level be drawn for Resident #16 "stat". However, the nurse stated when she arrived at work on 01/27/16 (Wednesday) she realized the resident's "stat" lab still had not been drawn. Once again, she reported calling lab services who reported they had no record of her request for a "stat" lab on 01/26/16. Nurse #1 commented Resident #16's follow-up potassium level was drawn on 01/27/16.</p> <p>At 11:27 AM on 02/11/16 Nurse #2 stated during the time of Resident #16's delayed follow-up potassium lab the administrative nurses were not checking the pink copies of physician orders daily</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329	<p>Continued From page 4 to make sure nothing got missed.</p> <p>At 12:05 PM on 02/11/16 during a telephone interview with Nurse #3 she stated she was the nurse working second shift on 01/22/16 when a physician order was generated to draw a follow-up potassium lab for Resident #16. She reported she did write up a lab slip for the follow-up lab, but forgot to punch holes in it so it may have fallen out of the notebook. She commented she was not aware that the lab company was not coming over the weekend of 01/23/16 - 01/24/16 to draw resident labs. Since she completed the lab slip, Nurse #3 explained she just assumed that the lab was drawn on 01/23/16, and the follow-up value was within normal limits.</p> <p>At 12:12 PM on 02/11/16 the DON stated if there had been better communication between Nurse #1 and Nurse #2 regarding the inability of the lab company to draw labs due to inclement weather, and if there had been more timely review of the pink copies of physician orders written over the weekend, drawing the follow-up potassium for Resident #16 may not have been delayed. She reported this delay in obtaining a follow-up potassium, triggered by a critically high potassium level, had the potential for causing the resident some heart rhythm irregularities.</p> <p>At 1:03 PM on 02/11/16 during a telephone interview Resident #16's primary physician stated it was her expectation if a time frame was specified in orders for follow-up labs that the facility draw the labs within those time parameters. If the facility was not able to meet the time parameters, she reported the facility was to immediately communicate this failure to her</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 329	Continued From page 5 office so a new course of action could be determined. The physician did not recall being contacted about the facility's inability to collect Resident #16's follow-up potassium over the weekend of 01/23/16 - 01/24/16.	F 329			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's QI committee failed to update its action	F 520	The action plan was updated for the missed lab and presented to the QI	2/24/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 6</p> <p>plan for missed labs after failure to draw a follow-up potassium level was discovered for 1 of 5 residents (Resident #16) reviewed for unnecessary medications, placing other residents at risk for the same deficient practice. Findings included:</p> <p>This tag is cross-referenced to:</p> <p>F329: Unnecessary Medications, Inadequate Monitoring: Based on physician interview, staff interview, and record review the facility failed to draw a follow-up potassium lab on the morning specified in a physician order in response to a critically high potassium level obtained the day before for 1 of 5 sampled residents (Resident #16) reviewed for unnecessary medications.</p> <p>At 10:12 AM on 02/11/16 the director of nursing (DON) provided a copy of a quality improvement (QI) action plan for "STAT (at once) labs" developed on 11/17/15. She reported the action plan was designed to make sure "STAT" labs and follow-up labs were drawn on a timely basis. Solutions/interventions to the lab problem included discussion with the contracted lab service about facility concerns, switching contracted lab companies, and giving Nurse #1 the responsibility of monitoring the lab look daily to make sure "STAT" and follow-up labs were drawn as ordered. The goal date for the interventions of all these solutions was documented as 01/17/16.</p> <p>At 11:27 AM on 02/11/16 Nurse #2 (QI Nurse) provided a copy of the facility's notes from the most recent QI Executive Meeting which was held on 01/29/16. The meeting minutes documented the QI committee reviewed monthly incidents,</p>	F 520	<p>committee by the Administrator on 2/10/16.</p> <p>The Administrator, DON and QI nurse completed 100% audit of current action plans to include labs to ensure that the QI committee has revised and updated all action plans if further concerns were observed since the action plan was created to prevent placing other residents at risk for the same deficient practice on 2/16/16. Action plans were updated and present to the QI Committee by the Administrator on 2/24/16 for any concerns identified.</p> <p>Administrator, DON and or QI Nurse were educated by corporate consultant on the QA process, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the QA process, and modification and correction if needed on 2/10/16. Administrator, DON and QI Nurse were educated by the corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. Completion date 2/10/16</p> <p>The Administrator and DON will review and initial all current and newly initiated action plans weekly x 8 weeks then monthly x 2 months for needed updates to the current action plans if further concerns are noted. All implemented changes will be reviewed by the QA committee. The QA committee monthly meeting minutes</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 7</p> <p>infection logs, restraint logs, wound logs, grievances, re-hospitalizations, psychoactive medications, and audits/results from issues currently being addressed in the QI process (including labs).</p> <p>At 12:12 PM on 02/11/16 the DON stated during the 01/29/16 QI meeting the facility did not, but should have addressed the facility's failure to draw Resident #16's follow-up potassium. She explained the solutions/interventions proposed in the 11/17/15 action plan for "STAT" labs were not sufficient as evidenced by the failure to draw Resident #16's potassium on 01/23/16. The DON reported the 01/29/16 meeting would have provided an excellent opportunity to revise and add interventions to prevent further occurrence of missed labs. She commented on 01/29/16 the facility probably should have added interventions to the "STAT" labs action plan to address weekend labs and the review of pink copies of physician orders written over the weekends.</p> <p>At 1:53 PM on 02/11/16 Nurse #2 (QI Nurse) stated the QI committee used monitoring/audit tools to make sure proposed interventions were working for identified issues. She reported the sharing of audit results with the committee sometimes led the members to reassess and update interventions for QI action plans.</p>	F 520	<p>will be reviewed and initialed by the Facility Consultant to ensure implemented procedures and monitoring practices to address interventions, to include labs, are followed, maintained, and updated if further concerns are identified monthly x 4 months.</p> <p>The Executive QI committee will meet monthly to review audits and action plans and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X4 months.</p>		