STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PINES RETIREMENT COMM	**1000 WESLEY PINES ROAD LUMBERTON, NC 28358**

(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 survey and complaint investigation were conducted on 04/11/22 through 04/14/22. The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID # RX8Q11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey and complaint investigation were conducted on 04/11/22 through 04/14/22. Event ID# RX8Q11. 1 of 1 complaint allegations was not substantiated. Intake #: NC00182971	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the antibiotic Doxycycline per the physician order which specified it was to be administered either 2 hours before or 2 hours after administering iron or a multivitamin for 1 of 5 residents review for unnecessary medications (Resident #42). Findings included:	F 684	Wesley Pines acknowledges receipt of the statement of deficiencies and the purpose this Plan of Correction to the extent of the summary of findings is factually correct 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.	5/6/22

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

Electronically Signed | 05/02/2022

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F 684	Continued From page 1 Resident #42 was admitted to the facility on 03/11/22 with diagnoses that included a non-pressure chronic ulcer of the left foot wound with the fat layer exposed. Review of an Admission MDS (Minimum Data Set) assessment dated 03/18/22 documented Resident #42 had intact cognition. She had one venous/arterial ulcer on admission. Review of the Physician orders for 04/01/22 revealed: Doxycycline 100mg by mouth twice a day x 30 days-take 2 hours prior/after Iron or a multivitamin (MV) left foot wound; Ferrous sulfate 325 MG (Milligrams) (65 MG Iron) by mouth twice daily for anemia; and multivitamin with iron 8 MG tablet by mouth daily for a vitamin supplement. Review of Resident #42's April 2022 eMAR (electronic Medication Administration Record) revealed the following: Doxycycline 100 MG by mouth twice a day x 30 days-take 2 hours prior/after Iron or a multivitamin in the AM, Iron 325 MG by mouth at 8:00 AM and a multivitamin with iron 8 MG tablet by mouth daily at 8:00 AM. The AM dose of Doxycycline was administered with the Iron and the multivitamin with iron on 04/01/22, 04/02/22, 04/03/22, 04/04/22, 04/05/22, 04/06/22, 04/07/22, 04/08/22, 04/09/22, 04/10/22, 04/11/22, 04/12/22, and 04/13/22 (a total of 13 doses). In an interview on 04/13/22 at 8:05 AM with the DON (Director of Nursing) she explained she was passing medications that morning because two nurses had called in sick. She stated she had administered medications to Resident #42 that morning. She indicated she had administered the	F 684	Preparation and submission of this Plan of Correction is in response to CMS 2567 from April 11-14, 2022. Wesley Pines response to this statement of deficiencies and plan of correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wesley Pines reserves the right to refute any deficiency on this statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative of legal procedures. F684 Quality of Care I. Resident #42 experienced no harm. Medical team in collaboration with the pharmacist and nurse management team reviewed antibiotic order for resident and clarified order and expectations for administration of antibiotics and iron and/or multivitamins with iron on April 13, 2022. It is the practice of Wesley Pines to administer medications per physician order and policy. II. All residents receiving antibiotics with order to not administer within two hours of iron or multivitamins with iron, have the potential to be affected. An audit of all the residents currently receiving antibiotics was completed. Five resident s charts with antibiotics reviewed and found to be in compliance. III. The Administering Medications Policy was reviewed and found to meet clinical standards.	

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F 684	Continued From page 2 Doxycycline, Iron and multivitamin with iron at the same time. She stated after she given Resident #42 her medication, she returned to the cart to sign them off as given and noticed the parameters documented for the Doxycycline. She knew at that point she had administered the Doxycycline incorrectly. In a second interview on 04/13/22 at 11:50 AM with the DON she reviewed the administration times for the Doxycycline from 04/01/22 through 04/13/22 and realized every morning dose had been documented as given at the same time as the Iron and multivitamin with iron. The evening doses had been given as ordered by the physician. She stated she would change the administration time for the Doxycycline to ensure it would not be given within 2 hours before or after the Iron or the multivitamin with iron. In an interview on 04/14/22 at 11:00 AM with Nurse #5 she stated she worked full time and was routinely assigned to care for Resident #42. She reported she had given the Doxycycline every morning at the same time as the Iron and the multivitamin with iron. She had not realized the Doxycycline was to be given either 2 hours before or 2 hours after the Iron and the multivitamin with iron. She explained she had received education that morning on how to give the medication. In a telephone interview on 04/14/22 at 11:13 AM with Nurse #6 she stated she realized there was supposed to be a 2- hour gap between the Doxycycline and the Iron and the multivitamin with iron. She explained she gave Resident #42 the Doxycycline at 8:00 AM each day, went down the hall giving medications, then gave the Iron	F 684	Education Provided to Licensed Nurses regarding Administering Medications Policy including timing delay in administration time, when ordered by physician, for antibiotics. In addition, any new orders including antibiotics is being discussed during the daily clinical meeting to further ensure compliance. IV. Director of Nursing or designee will: Audit residents□ records for antibiotic usage with potential delay or retiming with medications per MD order, weekly x 4 weeks, biweekly x 4 weeks, and monthly x 2 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review.	

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F 684	Continued From page 3	F 684		

and the multivitamin with iron to Resident #42 when she came back up the hall, but she documented all three at the same time. Record review revealed she documented she gave the Iron and multivitamin with iron on 04/09/22 at 8:27 and the Doxycycline at 8:28 AM; and on 04/10/22 she documented she gave all three at 8:56 AM not leaving a gap of two hours either day had she given the Doxycycline at 8:00 AM. When the sign off times were reviewed with Nurse #2 she had no response.

In a telephone interview on 04/14/22 at 11:40 AM with Nurse #7 she stated she had administered medication to Resident #42 on 04/04/22 on day shift but had not had time to document that the medications were given because she had to leave to pick up her children and did not return to complete her charting. She did remember a resident who had to be given an antibiotic "30 minutes before other medications and two hours before eating" but could not recall the resident. She was not aware the Doxycycline she had given was ordered to be given either 2 hours before or after the Iron and the multivitamin with iron.

In an interview on 04/13/22 at 10:42 AM with the Physician she stated she would need to review the orders because she had just taken over beginning on 04/01/22 and was not very familiar yet with the residents. She explained, in general, Doxycycline should not be given with Iron or a multivitamin with iron because the Iron decreased the effectiveness of the antibiotic and the ability to manage the infection. She stated she may have recommended the facility hold the Iron and the multivitamin with iron during the 30 days the antibiotic was to be given or had the medication

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F 684	Continued From page 4 time altered to either 2 hours before or after the other medications. She commented because the resident was ordered to receive the antibiotic for 30 days and had the rest of the month remaining the medication would be effective if the rest of the remaining prescription was given as ordered and not given at the same time as the Iron or the multivitamin with iron. In an interview on 04/13/22 at 3:27 PM with the facility Pharmacy Consultant she stated when Doxycycline was given at the same time as Iron or a multivitamin with iron, the iron bound to the Doxycycline and could decrease the effectiveness of the medication. She stated the resident would not experience any negative outcome overall but concluded the best practice was to give the Doxycycline either 2 hours before or 2 hours after giving the Iron or the multivitamin with iron. She concluded she would contact the DON and discuss the correct time to administer the Doxycycline.	F 684		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information;	F 885		5/6/22

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F 885	Continued From page 5 (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to inform resident representatives (RP) and families by 5:00 PM the next calendar day following the occurrence of sixteen confirmed staff and eleven confirmed resident COVID-19 infections from 01/05/22 through 02/03/22 for thirteen instances the facility did not contact family/RP of sixteen staff and eleven residents reviewed for COVID-19 reporting. Findings included: Review of the facility COVID-19 testing log revealed 2-staff tested positive on 01/05/22 and 01/06/22. An interview with the Administrator on 04/11/22 at 11:00 AM revealed the 2-staff who tested positive for COVID-19 on 01/05/22 and 01/06/22 were notified of positive COVID-19 status via facility-rapid test the same day. The Administrator stated he did not think about notifying residents or residents' responsible parties of the 16-staff and 6-Residents who tested positive on 01/05/22 thru 02/03/22, because he	F 885	F684 Reporting-Residents, Representatives & Families I. No residents experienced any harm. It is the practice of Wesley Pines to inform residents, their representatives, and families of COVID outbreak status per guidelines. Covid outbreak notice was provided to residents and families on February 3, 2022. II. All residents had the potential to be affected. This is being addressed by the systems described. III. Administrator, Director of Nursing, and all additional Administrative Staff educated regarding outbreak communication and QSO-20-29-NH to ensure that residents, their representatives, and families of those residing in our facility will be informed of either a single confirmed infection of Covid-19, or three or more residents and staff with new onset of respiratory symptoms occurring within 72	

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F 885	Continued From page 6 was an interim Administrator and just forgot to send a letter out to all facility's resident families until 02/03/22. The Administrator confirmed he was aware the facility was required to report subsequent confirmed COVID-19 cases, so the facility did not contact families and/or responsible parties of 2-staff who were COVID-19 positive on 01/06/22.	F 885	hours of each other. In addition, any new COVID cases triggering outbreak status and reporting will be discussed during the daily clinical meeting to further ensure compliance. IV. Administrator or designee will: Audit compliance of notification to residents, their representatives, and families regarding COVID-19 outbreak status, weekly x 4 weeks, biweekly x 4 weeks, and monthly x 2 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review.	