STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345332	A. BUILDING _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTHCARE AND REHABILITATION CENTER	2501 DOWNING ST SW WILSON, NC 27893

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 09/17/23 through 09/20/23. The facility was found to be in compliance with CFR 483.73, Emergency Preparedness Event ID #FOJ711.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was completed from 09/17/23 through 09/20/23. The following complaint intakes were investigated: NC00205965 and NC00194752. 4 of the 4 allegations did not result in deficiency. Event ID #FOJ711.	F 000		
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 and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessments for 4 of 30 residents reviewed in the areas of dialysis, wandering, weight, and discharge (Resident #145, Resident #91, Resident #33, and Resident #94). Findings included: 1. Resident #145 was admitted to the facility on 09/07/23. Diagnoses included, in part, end stage renal disease (ESRD) with hemodialysis. Review of a physician order dated 09/07/23	F 641	Please accept this Plan of Correction as Wilson Healthcare and Rehabilitation Center's credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by Federal and State laws, which requires an acceptable Plan of Correction as a condition of continued certification. Resident # 94 Discharge MDS	10/3/23

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

Electronically Signed | 10/03/2023

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F 641	Continued From page 1 revealed an order for dialysis treatments on Tuesday, Thursday, and Saturday for Resident #145. A nursing progress note written on 09/09/23 at 7:38 AM revealed Resident left the facility via wheelchair to go to dialysis. Resident was alert and verbal and vital signs were stable. The MDS 5-day admission assessment dated 09/13/23 revealed Resident #145 was moderately cognitively impaired and was not coded as receiving dialysis. Review of Resident #145's care plan dated 09/13/23 revealed a plan of care for hemodialysis related to ESRD. Interventions included after returning from dialysis check for thrill and bruit 2 times per shift on dialysis days Tuesday/Thursday and Saturday and daily. An interview was conducted with the MDS Nurse #1 on 09/20/23 at 12:30 PM. MDS Nurse #1 revealed when she completed the MDS assessments she reviewed the electronic medical record (EMR) to include the discharge summary, the nursing progress notes and physician orders to determine how to accurately code for dialysis residents. She stated she should have coded Resident #145 for receiving dialysis services and added, there was an error in coding and she missed it. An interview was conducted with the Administrator on 09/20/23 at 2:00 PM. The Administrator stated the MDS should have been coded accurately to reflect the resident's care. The Administrator further added he felt that the mistake was human error and not a breakdown in	F 641	assessment was modified on 9/20/2023 by the Director of Care Management to reflect Section A2100 was coded Discharged Community. Resident # 145 MDS assessment was modified on 9/20/2023 by the Director of Care Management to reflect that dialysis was coded properly on the MDS assessment. Resident #91 MDS assessment was modified on 9/20/2023 by the Director of Care Management to reflect behaviors of wandering were coded properly on the MDS assessment. Resident #33 MDS assessment was modified on 9/20/2023 by the Director of Care Management to reflect resident's accurate weight. Director of Care Management and MDS Coordinator will review current residents with assessments over the last 30 days for accuracy of coding Section E0900, Section K0200 and Section O0100 J. Director of Care Management and MDS Coordinator will also review discharged residents with assessment over the last 30 days for accuracy of coding A2100. Assessment will errors identified will be corrected as appropriate by the Director of Care Management and MDS Coordinator. Audit will be completed by 9/26/2023. Director of Care Management to conduct in-service education to Facility Administrator, Social Worker, Dietary Manager and MDS Coordinator in relation to MDS accuracy for Section E0900, Section A2100, Section K0200 and Section O0100 J on 10/4/2023 utilizing the RAI manual as the source document for	

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F 641	Continued From page 2 MDS. 2. Resident #91 was admitted to the facility on 08/31/23. Diagnoses included, in part, dementia with agitation, restlessness and agitation, and altered mental status. A nursing progress note written on 09/02/2023 by Nurse #1 revealed Resident #91 was having increased agitation, wandering into rooms, attempting to stand/walk, and unable to redirect. The physician was notified, and an order was obtained for 0.25 milligrams of alprazolam (an antianxiety medication) as needed every 12 hours for one week. The MDS 5-day admission assessment dated 09/06/23 revealed Resident #91 was severely cognitively impaired. The MDS was not coded to reflect Resident #91 had any wandering behaviors. A review of Resident #91's care plan dated 09/06/23 revealed the resident was an elopement risk due to impaired cognitive status secondary to dementia as evidenced by wandering aimlessly and potential for attempt to leave facility. Interventions included, in part, initiating safety checks as indicated, observe for exit seeking behaviors and provide diversion activities. An interview with Nurse #1 on 09/19/23 at 11:35 AM revealed when Resident #91 was first admitted he was very confused and had exit seeking behaviors and required a wander guard (a wearable bracelet which alerts staff if the resident wanders close to a monitored door) which was placed on him on 09/08/23.	F 641	training. The Director of Care Management is responsible for auditing the accuracy of Section A2100 on 2 Discharge Assessments weekly for 4 weeks and then monthly for 2 months. The Director of Care Management is also responsible for auditing the accuracy of Section K0200, Section O0100 J and Section E0900 on 5 assessments weekly for 4 weeks and then monthly for 2 months. Results of the monitoring will be taken to QAPI monthly and discussed by the QAPI committee, until deemed unnecessary to discuss any further by the QAPI committee.	

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F 641	Continued From page 3	F 641		

An interview with MDS Nurse #1 on 09/20/23 at 12:30 PM revealed when she completed the MDS assessments she reviewed the electronic medical record (EMR) to include the nursing progress notes, and physician orders, to determine how to accurately code behaviors. She stated she should have coded Resident #91 for wandering based on the nursing note written by Nurse #1. She stated she just missed it and it was an error.

An interview was conducted with the Administrator on 09/20/23 at 2:00 PM. The Administrator stated the MDS should have been coded accurately to reflect the resident's care. The Administrator further added he felt that the mistake was human error and not a breakdown in MDS.

3. Resident #33 was admitted to the facility 08/01/2023 with a diagnosis of cerebral infarction (stroke).

Resident #33's electronic medical record (EMR) revealed he weighed 192.0 pounds on 08/01/2023.

The admission Minimum Data Set (MDS) assessment dated 08/07/2023 listed Resident #33's weight as 058 pounds.

An interview was completed with MDS Nurse #1 on 09/20/2023 at 10:42 AM. MDS #1 stated that 058 pounds was not an accurate weight for Resident #33. She further stated that the Dietary Manager was responsible for filling in the weight on the MDS assessment. MDS #1 indicated that she was responsible for making sure the MDS assessment was coded accurately.

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F 641	Continued From page 4	F 641		

An interview was conducted with the Administrator on 09/20/2023 at 2:00 PM. The Administrator stated that Resident #33's weight of 058 pounds was just a human error. He further stated he didn't think there was a breakdown in the MDS process, just a human mistake.

4. Resident #94 was admitted to the facility on 9/18/23.

A progress note dated 08/16/23 stated Resident #94 was scheduled to discharge home on 08/17/23.

A progress note dated 08/17/23 stated the Resident discharged from the facility at 12:30 PM. The note indicated discharge papers were signed by the Resident and no problems or concerns were voiced by the Resident.

A Discharge Return Not Anticipated Minimum Data Set (MDS) assessment dated 08/17/23 revealed the Resident was cognitively intact and was coded as being discharged to an acute hospital.

An interview was completed on 09/20/23 at 11:42 AM with MDS Nurse #2. The Nurse reviewed Resident #94's Discharge MDS and confirmed the discharge status was coded incorrectly and should have been coded as a discharge to the community.

An interview was completed on 09/20/23 at 12:25 PM with the Administrator. He indicated the MDS assessment should accurately reflect the discharge status of a resident. The Administrator stated the incorrect documentation was due to human error and not a breakdown in the MDS

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F 641	Continued From page 5 process.	F 641		
F 812 SS=E	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. (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 observation and staff interviews the facility failed to a) ensure that prepared foods were labeled and dated when stored in the walk-in refrigerator and, b) failed to date leftover foods stored for use. These practices had the potential to affect food served to residents in the facility. Findings included: During the initial tour of the kitchen on 09/17/23 at 12:30 PM the following was observed in the presence of the Kitchen Manager:	F 812	Please accept this Plan of Correction as Wilson Healthcare and Rehabilitation Center's credible allegation of compliance for the alleged deficiency cited. Submission and implementation of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by Federal and State laws, which requires an acceptable Plan of Correction as a condition of continued certification.	10/3/23

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F 812	Continued From page 6 a. The walk-in refrigerator was observed with the following: a 4-quart plastic container of macaroni salad covered with clear plastic wrap with no date, a metal container covered with clear plastic wrap labeled "Pureed Pork for Dinner" with no date, and a metal container covered with clear plastic wrap and labeled "Pureed Food for Dinner" with no date or food specification. b. The reach-in refrigerator was observed with the following: a partially used thickened lemon-flavored water with no open date, a container of apple sauce partially used with no open date, a container of vanilla yogurt partially used with no open dated, and 3 small Styrofoam bowls filled with a cream-colored food and covered with clear plastic wrap with no open date or food specification. In an interview with the Dietary Manager-in-Training (MIT) on 09/17/23 at 12:30 PM during the inspection of the food storage, he stated he had made rounds that morning and checked foods for dates. He explained that he thought the food in the reach in fridge that had been opened did not need to be labeled with a date. He noted it was his second day of employment at the facility. In an interview with the Kitchen Manager on 09/17/23 at 12:30 PM she stated all the kitchen staff had been educated and knew that any food in storage that had been opened or prepared had to be identified, labeled, and dated. In an interview with the Administrator on 09/20/23 at 12:15 PM he stated the Dietary MIT told him he had not had a chance to check food storage for	F 812	No residents in the facility had any ill effects relating to this issue. The items that were found opened and not dated were not served to any of our residents in the facility. The items that were identified as being opened and not dated were immediately discarded by dietary staff. On 9/17/2023, all refrigerators, freezers and dry storage rooms in the kitchen were inspected by the Dietary Manager and any items that were opened and did not have dates on them were immediately discarded. Dietary Manager will educate all current dietary staff on the topic of when an item is opened and stored it must be labeled and dated immediately by 9/26/2023. A monitoring tool will be utilized and initiated by the Dietary Manager to audit all foods in the freezer, refrigerator, and dry storage room in the kitchen to ensure that all opened items are properly dated and labeled per policy. This audit will be conducted daily by the Dietary Manager or Dietary Manager in Training x 4 weeks and then monthly x 2 weeks. Audit records and results will be reported to the Administrator. The results of the monitoring will be discussed monthly at our Quality Assurance Performance Improvement (QAPI) meeting for 3 months with any recommendations and continue education. The Dietary Manager will be	

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F 812	Continued From page 7 labeling on the morning of 9/17/23 and he felt that was the reason open food items in the refrigerators were not dated.	F 812	responsible for overall compliance. The QAPI committee will determine if additional monitoring is required past the initial three months, which will be reflected in the QAPI minutes.	