DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345423	B. WING		C 02/03/2017
NAME OF P	ROVIDER OR SUPPLIER	·	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
	REHABILITATION AND N				
WILSON	CERABILITATION AND N	URSING CENTER	· · ·	WILSON, NC 27893	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	2567. Management	agement review of the CMS determined the verbiage at F ved to F 241 and is now			
F 241 SS=D	483.10(a)(1) DIGNIT INDIVIDUALITY	Y AND RESPECT OF	F 241		3/3/17
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of This REQUIREMENT by: Based on observatio resident and staff inte maintain dignity by fa ask permission to end 35 residents reviewed a resident's feelings of 7 of 7 failing to knock resident's rooms (R Findings included: 1. Record review reve admitted to the facility diagnoses which inclu Osteoarthritis.	the resident. is not met as evidenced ns, record review, and erviews, the facility failed to iling to knock on doors or ther resident's rooms for 1 of d for dignity which resulted in of undignified treatment and before entering 7 of 7 tesident #49) ealed Resident #49 was		Preparation and/or execution of this p of correction does not constitute admission or agreement by the provide with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulati Resident # 49, and rooms 201,202,203,205,206,208, and 209 ha been ensured dignity by staff knocking and obtaining permission before enter room. Resident rooms have been observed ensure staff knock and obtain permiss before entering room. The administrator and Director of Nurs	er e ons. ve ing to ion
	moderately cognitivel	y impaired and required ssist with all Activities of		have provided education to direct care staff in regards to knocking and obtain permission prior to entering resident rooms.	
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE

Electronically Signed

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.

02/27/2017

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/03/2017 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345423	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON F	REHABILITATION AND N	URSING CENTER			705 SOUTH TARBORO STREET /ILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	observed in her room reclining chair. Resid towards her chest and The door to her room Assistant (NA) #6 ent walked in the bathrood #6 did not knock or a did not speak to Resi remained in the same chair. On 1/31/2017 a Resident #49"s room tray. NA #6 did not kr enter and proceeded from the bedside to th #49 raised her head a and did not hear the l set up the lunch tray she would return late PM, NA #6 entered R retrieved the lunch tray she needed assistant the room. NA #6 did r to enter the room. Observations were m AM and 10:40 AM of observed entering Re knocking or asking pe An interview was con 2/1/2017 at 11:16 AM staff were in and out a #49 stated they just of to. Resident #49 state everybody knocked b stated when she is na knocked, it gave her a bearings" before they	5 AM, Resident #49 was a, seated by the window in a ent #49 head was lowered d appeared to be sleeping. was open. Nursing tered Resident #49"s room, om and exited the room. NA sk permission to enter and dent #49. Resident #49 e position in her reclining at 12:10 PM, NA #6 entered and delivered the lunch nock or ask permission to to move the over bed table he reclining chair. Resident and stated she was napping NA enter the room. NA #6 and informed Resident #49 r to pick up the tray. At 12:47 tesident #49's room, ay, asked Resident #49 if ce with anything and exited not knock or ask permission ade on 2/1/2017 at 10:05 Resident #49's room without ermission to enter. ducted with Resident #49 on I. Resident #49 stated the of her room all day. Resident ame in when they wanted ed it would sure be nice if out they didn't. Resident #49 apping in her chair and they	F	241	The Administrator and/or designee will conduct Quality Improvement Monitor of resident rooms to ensure staff knoc and announce before entering resider rooms. Quality Improvement Monitorir will be conducted by checking 5 days week for 4 weeks, then 6 rooms three days per week for 4 weeks, then 6 roo weekly for 12 weeks, and/or until substantial compliance is reached. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. T Quality Assurance Performance Improvement Committee will evaluate effectiveness of the monitoring/observation tool for maintaining substantial compliance, a make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Exect Director, Director of Clinical Services, Medical Director, Pharmacy Consultar Social Services Director, Activities Director, Maintenance Director, Dietar Director, and Minimum Data Assessm Nurse.	ing k th per oms ms the the the nd tif	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		ECONSTRUCTION	(X3) DATE	
			A. BUILD	NG _			C
		345423	B. WING			02/	03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND N			1	1705 SOUTH TARBORO STREET		
MEGON				V	WILSON, NC 27893		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
			1				
F 241	Continued From page	2		241			
1 271				241			
		d be in her room. Resident to startle her but she was					
	used to it now.	to startie her but she was					
	An interview was con	ducted with NA #6 on					
	2/1/2017 at 1:20 PM.	NA #6 reported she was					
		knock and announce prior					
	to entering residents'	rooms. NA #6 stated it was					
		nd she did not think about it					
		e rooms. NA #6 stated she					
	-	t to knock and did not know					
	-	abit of just walking in the					
	rooms.						
	An interview was con	ducted with the Director of					
		/2017 at 2:25 PM. The DON					
	. . ,	n was for every employee to					
	-	themselves when entering					
	resident's rooms. The	DON stated the facility was					
		ents and all employees were					
		esident's privacy at all times.					
		on of the 200 hall was					
		017 from 12:10 PM to 1:45					
	-	vation Nursing Assistant d entering rooms 201, 202,					
		nd 209. NA #6 was observed					
		ithout knocking or revealing					
	her name, title or purp						
		0 PM NA #6 was observed					
		02, 203 and 205 without					
		her name, title or purpose					
	for entrance.						
	An intonvious was and	ducted with NA #6 co					
	An interview was con						
		NA #6 reported she was knock and announce prior					
		rooms. NA #6 stated it was					
	-	nd she did not think about it					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345423	B. WING				C /03/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON F	REHABILITATION AND N	URSING CENTER			705 SOUTH TARBORO STREET VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 244 SS=D	knew it was important why she was in the har rooms. An interview was com Nursing (DON) on 2/1 stated the expectation knock and announce resident's rooms. The home to all the reside expected to respect re 483.10(f)(5)(iv)(A)(B) GRIEVANCE/RECOM (f)(5) The resident ha participate in resident (iv) The facility must of resident or family groot the grievances and re groups concerning iss in the facility. (A) The facility must be response and rational (B) This should not be facility must implement request of the resider This REQUIREMENT by: Based on record revi	e rooms. NA #6 stated she t to knock and did not know abit of just walking in the ducted with the Director of 1/2017 at 2:25 PM. The DON n was for every employee to themselves when entering e DON stated the facility was ents and all employees were esident's privacy at all times. LISTEN/ACT ON GROUP IMENDATION s a right to organize and groups in the facility. consider the views of a up and act promptly upon ecommendations of such sues of resident care and life be able to demonstrate their le for such response. e construed to mean that the nt as recommended every at or family group. f is not met as evidenced ew and staff and resident		241	Preparation and/or execution of this pl	an	3/3/17
	that were reported in meetings for four con Findings included:				of correction does not constitute admission or agreement by the provide with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by		

Event ID: JRGV11

Facility ID: 923511

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/03/2017 M APPROVEE D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345423	B. WING			C / 03/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	EHABILITATION AND N			17	705 SOUTH TARBORO STREET		
WILSON				W	/ILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	Continued From page	<u>م</u>	E.	244			
		I Meeting minutes from		277	provision of Federal and State regula	tions.	
	reviewed.	-			All resident council minutes for past 1	2	
		I minutes dated 10/20/2016			months have been reviewed for conc	erns	
		ts voiced concerns of water			and resolution.		
	not within reach.	ed consistently and call bells			The Administrator provided education	to	
		I minutes dated November			department managers in regards to	10	
	17, 2016 indicated the	e residents reported the			resident council meeting process and		
	concerns from the pre-	evious month's meeting			procedures, and corrective action to b	be	
		nd voiced continued issues			taken in response to any concerns.		
	-	ot being filled consistently			—		
	and call lights not with	hin reach. I minutes dated December			The Administrator will review resident		
	22, 2016 indicated th				council minutes monthly and monitor concerns weekly for 12 weeks then		
		water pitchers not being			monthly thereafter.		
	The Resident Counci	I minutes dated January 19,					
	2017 indicated the re	•			The results of these audits will be		
		ater pitchers being filled.			reported to the Quality Assurance		
	-	I the residents stated a			Performance Improvement Committe	е	
	reach.	the call lights are not in			monthly by the Director of Clinical Services for six months and/or until		
					substantial compliance is obtained. 1	-he	
	An interview was con	ducted on 2/1/2017 at 12:45			Quality Assurance Performance	-	
	PM with the Resident	Council president (Resident			Improvement Committee will evaluate	e the	
	,	tated the facility staff did not			effectiveness of the		
		and concerns the Resident			monitoring/observation tool for		
		ause the issues of the call			maintaining substantial compliance, a		
	• •	ach and the water pitchers			make changes to the corrective action	III	
		ngoing for several months. ed the Activities Director told			necessary to obtain substantial compliance. The Quality Assurance		
	the Resident Council				Improvement Committee members		
	concerns/grievances				consist of, but not limited to, the Exec	utive	
	-	h, but the issues were not			Director, Director of Clinical Services,		
	improved.				Medical Director, Pharmacy Consulta	nt,	
					Social Services Director, Activities		
		ducted with the Activity			Director, Maintenance Director, Dieta		
	Director (AD) on 2/1/2	2017 at 1:15 PM. The AD			Director, and Minimum Data Assessm	ient	

Facility ID: 923511

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	-	D HUMAN SERVICES MEDICAID SERVICES				I	NTED: 03/03/2017 FORM APPROVED B NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	PLE CONSTRUCTIC		(X3)) DATE SURVEY COMPLETED
		345423	B. WING _				C 02/03/2017
NAME OF PI	ROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
WILSON F	REHABILITATION AND N	JRSING CENTER		1705 SOUTH TA	RBORO STREET 27893		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)		(X5) COMPLETION DATE				
F 244	stated that concerns/g Resident Council mer appropriate Departmer meeting or the next d knew there were issue and the availability of unresolved for the las continued to notify the heads every month. An interview was com Nursing (DON) on 2/1 stated the AD emailed meeting concerns/grie meeting or the next m she was aware of the water pitchers and the she reviewed the con in-serviced staff. The documentation of in-s issues as there was m grievance resolution p stated that listed a time to be resolved. The D	grievances from the nbers are forwarded to the ent Head on the day of the ay. The AD reported she es with the water pitchers call lights which were t several months and she e appropriate department ducted with the Director of /2017 at 2:17 PM. The DON d her the Resident Council evances on the day of the norning. The DON stated ongoing concerns with the e call lights. The DON stated cerns monthly and DON reported there was no ervicing for the continued to implementation of a procedure. The DON further ctual process the facility when grievances needed ON stated the expectation uncil grievances would be	F 2	14 Nurse.			
F 246 SS=D	OF NEEDS/PREFER (e)(3) The right to res the facility with reason resident needs and pu	NABLE ACCOMMODATION ENCES ide and receive services in nable accommodation of references except when to r the health or safety of the	F 2	46			3/3/17

Facility ID: 923511

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345423	B. WING		C 02/03/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
	EHABILITATION AND N	URSING CENTER		705 SOUTH TARBORO STREET VILSON, NC 27893	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 246	by: Based on observatio and resident interview a call light within reac reviewed for call light Findings included: Record review reveal admitted to the facility diagnoses which inclu Chronic Kidney Disea Review of the Quarte 1/5/2017 indicated Re cognitively impaired a total assistance of 1 p Daily Living. Review of Resident # recent revision dated problem of self-care of extensive to total assis Daily Living. One of th keep the call bell with The Care Plan revise problem of incontinen related to impaired m interventions listed wa reach and visual field	dents. is not met as evidenced ns, record review and staff vs, the facility failed to place th for 1 of 35 residents placement. (Resident #1) ed Resident #1 was y on 9/11/2012 with uded Chronic Pain and ase. rly Minimum Data Set dated esident #1 was moderately and required extensive to berson for all Activities of the interventions listed was to in reach and visual field. d on 1/9/2017 also listed a the of bowel and bladder oblity. One of the as to keep the call bell within	F 246		to thin ill ring are king 5, 4 iance e The
	1/30/2017 at 3:40 PM oriented. Resident # wheelchair which was feet from the right sid	I. Resident #1 was alert and		effectiveness of the monitoring/observation tool for maintaining substantial compliance, a make changes to the corrective action necessary to obtain substantial	ind

Facility ID: 923511

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/03/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345423	B. WING				C / 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON	REHABILITATION AND N	URSING CENTER			705 SOUTH TARBORO STREET VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	 wall. Resident #1's ca hanging in the space wall. During the intervishe was up in her whe #1 further reported the call light was out of histories bed when she was unable to re- bed when she was in call light. Resident #1 for someone or wait for someone or wait for som	all bell was observed between the bed and the view Resident #1 reported eelchair every day. Resident here were many times the er reach and positioned the wall. Resident #1 stated ach all the way across the her wheelchair to get the 1 stated she would either yell for staff to come into the issistance. sident #1 on 1/31/2017 at isident #1 sitting in her room the call light was located reen the mattress and the sident #1 on 2/1/2017 at isident #1 sitting in her room the call light was located reen the mattress and the sident #1 on 2/2/2017 at isident #1 sitting in her room the call light was located reen the mattress and the sident #1 on 2/2/2017 at isident #1 sitting in her room the call light was located reen the mattress and the sident #1 sitting in her room the call light was located reen the mattress and the sident #1 sitting in her room the call light was located reen the mattress and the sident #1 sitting in her room the call light was located reen the mattress and the sident #1 sitting in her room the call light was located reen the mattress and the	F	246	compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Exec Director, Director of Clinical Services Medical Director, Pharmacy Consulta Social Services Director, Activities Director, Maintenance Director, Dieta Director, and Minimum Data Assess Nurse.	, int, ry	

Facility ID: 923511

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-				PRINTED: 03/03/20 FORM APPROV OMB NO. 0938-03	
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
	345423	B. WING		C 02/03/2017	
ROVIDER OR SUPPLIER				DE	
REHABILITATION AND N	URSING CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC DATE DATE	
remember to place the though she was awar of calling for assistan An interview was con Nursing (DON) on 2/2 DON stated the expe be within reach so the assistance. 483.20(b)(1) COMPR ASSESSMENTS (b) Comprehensive A (1) Resident Assess must make a compre resident's needs, stre preferences, using th instrument (RAI) spec assessment must inc (i) Identification and (ii) Customary routir (iii) Cognitive patterr (iv) Communication. (v) Vision. (v) Vision. (vi) Mood and behav (viii) Physical fun problems. (ix) Continence. (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions. (xiii) Activity purs (xiv) Medications (xv) Special treatmer	the call light in reach even re Resident #1 was capable ce. ducted with the Director of 2/2017 at 10:30 AM. The ctation was for call lights to residents could call for REHENSIVE assessments ment Instrument. A facility hensive assessment of a engths, goals, life history and re resident assessment cified by CMS. The dude at least the following: d demographic information ne. ns. vior patterns. ell-being. actioning and structural sis and health conditions. cional status. suit.	F 246		3/3/17	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER REHABILITATION AND N SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page remember to place th though she was awar of calling for assistant An interview was com Nursing (DON) on 2/2 DON stated the expe be within reach so the assistance. 483.20(b)(1) COMPF ASSESSMENTS (b) Comprehensive A (1) Resident Assessimust make a comprefice and the experiment of	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345423 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 remember to place the call light in reach even though she was aware Resident #1 was capable of calling for assistance. An interview was conducted with the Director of Nursing (DON) on 2/2/2017 at 10:30 AM. The DON stated the expectation was for call lights to be within reach so the residents could call for assistance. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Congnitive patterns. (iv) Communication. (v) Vision. (vi) Mod and behavior patterns. (iv) Continence. (x) Disease diagnosis and health conditions. (xii) Physical functioning and structural problems.	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIEN/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CA A BUILDING 345423 B. WING ROVIDER OR SUPPLIER STR TROUDER OF SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 8 remember to place the call light in reach even though she was aware Resident #1 was capable of calling for assistance. F 246 An interview was conducted with the Director of Nursing (DON) on 2/2/2017 at 10:30 AM. The DON stated the expectation was for call lights to be within reach so the residents could call for assistance. F 272 ASSESSMENTS (b) Comprehensive Assessments F 272 (b) Comprehensive Assessments The assessment must include at least the following: F 272 (i) Resident Assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Orditions. (iv) Physical functioning and structural problems. (ix) Continence. (ix) Dental and nutritional status. (xii) Skin Conditions. (xii) Skin Conditions. (xii) Skin Con	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	

Facility ID: 923511

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		345423	B. WING		C 02/03/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	02/00/2011
WILSON F	REHABILITATION AND N	URSING CENTER		705 SOUTH TARBORO STREET VILSON, NC 27893	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 272	Continued From page		F 272		
	on the	al assessment performed			
	of the Minimum Data (xviii) Documentat	triggered by the completion Set (MDS). ion of participation in sessment process must			
	include direct observatior	and communication with as communication with			
	licensed and non-license on all shifts.	d direct care staff members			
	observation and comp as well as communication non-licensed direct cat shifts. This REQUIREMENT	ess must include direct munication with the resident, ation with licensed and are staff members on all is not met as evidenced			
		review, the facility failed to esident's dental status for 1		Resident # 22□S Comprehensive assessment has been completed to include oral status. Current resident□s comprehensive assessments have been audited to	
	#22 was admitted 11/	al record revealed Resident 2/2016 with diagnoses of and altered mental status.		ensure they are complete and include status. Administrator and/or Director of Nursir have provided education to the assessment team on accuracy of the	
	11/15/2016 noted Res impaired for cognition	Data Set (MDS) dated sident #22 was moderately , needed one person's and was noted by staff to ds.		comprehensive assessment to include oral status. Administrator and/or designee will conduct Quality Improvement Monitor of all newly admitted residents to ensu	ing
	observed propelling h	PM, Resident #22 was erself in a wheel chair in the erview at that time Resident		that comprehensive assessment is completed and includes oral status. Quality Improvement will be completed weekly on any comprehensive	d

Event ID: JRGV11

Facility ID: 923511

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 03/03/2017 M APPROVEE D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345423	B. WING			C / 03/2017
	ROVIDER OR SUPPLIER	URSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 SOUTH TARBORO STREET WILSON, NC 27893	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETION DATE
F 272 F 280 SS=D	 #22 stated she did not like to have some. Renot have any teeth. The Admission MDS reviewed for L0200 d no natural teeth or towas not checked. The options was: None of checked. The admission nursin and Oral Status was On 2/1/2017 at 11:25 interviewed and state doing this assessment an error. The MDS not the admission nursing the residents when shassessment. On 2/2/2017 at 10:50 Director of Nursing (E was the MDS would F 483.10(c)(2)(i-ii,iv,v)(PARTICIPATE PLANI 483.10 (c)(2) The right to particip including the right to particip included in the plar equest meetings and constructions of the plan of care, included in the plar equest meetings and constructions of the meetings and constructions of the plan of care. 	ot have dentures but would esident #22 stated she did dated 11/9/2017 was ental status. The section B: oth fragment(s) (edentulous) e last choice of dental status i the above and this was ag assessment was reviewed blank. AM, the MDS nurse was ed she did not remember nt, but she must have made urse indicated she goes by g assessment and looks at he does the pain AM, in an interview, the DON) stated the expectation be accurate. 3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development of his or her person-centered g but not limited to: pate in the planning process, identify individuals or roles to unning process, the right to	F 2	assessments completed for the we twelve weeks, then monthly for the months. The results of these audits will be reported to the Quality Assurance Performance Improvement Comm monthly by the Director of Clinical Services for six months and/or und substantial compliance is obtained Quality Assurance Performance Improvement Committee will evalue effectiveness of the monitoring/observation tool for maintaining substantial compliance make changes to the corrective ac necessary to obtain substantial compliance. The Quality Assurant Improvement Committee members consist of, but not limited to, the E Director, Director of Clinical Service Medical Director, Pharmacy Const Social Services Director, Activities Director, and Minimum Data Asset Nurse.	ree iittee til d. The uate the e, and ction if ce s xecutive ces, ultant, s ietary	3/3/17

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/03/2017 (I APPROVED): 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		345423	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON F	REHABILITATION AND N	JRSING CENTER			1705 SOUTH TARBORO STREET WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	11	F	280			
	expected goals and o amount, frequency, a	bate in establishing the utcomes of care, the type, and duration of care, and any the effectiveness of the					
	(iv) The right to receiv included in the plan o	e the services and/or items f care.					
		e care plan, including the ificant changes to the plan					
		-					
	(i) Facilitate the inclus resident representativ	ion of the resident and/or e.					
	(ii) Include an assess strengths and needs.	ment of the resident's					
	(iii) Incorporate the re cultural preferences ir	sident's personal and n developing goals of care.					
	483.21 (b) Comprehensive C	are Plans					
	(2) A comprehensive	care plan must be-					
	(i) Developed within 7 the comprehensive as	days after completion of ssessment.					
	(ii) Prepared by an int includes but is not lim	erdisciplinary team, that ited to					

Facility ID: 923511

If continuation sheet Page 12 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/03/2017 (I APPROVED): 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345423	B. WING _				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND N			17	705 SOUTH TARBORO STREET		
		DRSING CENTER		W	/ILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	≥ 12	F 2	280			
	(A) The attending phy	/sician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
	the resident and the r An explanation must medical record if the	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the					
		staff or professionals in ined by the resident's needs e resident.					
	team after each asse comprehensive and q assessments.	vised by the interdisciplinary ssment, including both the quarterly review					
	Based on staff interv facility failed to update multiple falls for one of care plans (Resident precautions or actions Resident #22.	iew and record review, the e or revise a care plan after of 22 residents reviewed for #22), which provided no s to prevent further falls for			Resident # 22 s care plan has been reviewed and updated to reflect any needed interventions for falls. Care Plans for those residents having experienced falls have been reviewed a updated as needed for any new interventions for falls. Administrator and/or Director of Nursing	g	
		al record revealed Resident the facility 11/2/2016 with			have provided educational training for t care plan team in relation to care plan	he	

Event ID: JRGV11

Facility ID: 923511

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/03/2 FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345423	B. WING		02/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
				1705 SOUTH TARBORO STREET	
		UKSING CENTER		WILSON, NC 27893	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET HE APPROPRIATE DATE
F 280	Continued From page	13	F 2	80	
1 200			F 2		llintonyontiona
	diagnoses that include mobility and altered m	ed abnormal galt and nental status. The 14 day		updates as they relate to fa The Administrator and/or D	
		IDS) dated 11/15/2016		Nursing will conduct Quality	
		22 was moderately impaired		Monitoring for falls to ensur	
	for cognition and need	ded extensive assistance for		is updated as necessary for	
		e. The MDS noted Resident		interventions for falls. Quali	
		ring transitions and walking.		Improvement Monitoring wi	
		sment (CAA) indicated a		5 days per week for resider	
		this area went to care plan.		quality improvement meetir during falls meeting for 12 v	
	Review of the care pla	an dated 11/16/2016		then weekly during falls me	
		22 needed safety measures		thereafter.	
		f accidents and injury. The		The results of these audits	s will be
	-	luded checking the resident		reported to the Quality Assu	
		with toileting routinely,		Performance Improvement	
		Il promptly, and giving		monthly by the Director of C	
	medications as ordered	ts, observing for changes in		Services for six months and substantial compliance is o	
		nsferring carefully with		Quality Assurance Performation	
	assistance.	iolomity that		Improvement Committee w	
				effectiveness of the	
		vestigations for Resident		monitoring/observation tool	for
		vere 9 investigated falls from		maintaining substantial con	-
		/28/2017. There were no		make changes to the correct	
	after each fall.	nterventions in the care plan		necessary to obtain substation compliance. The Quality A	
	aller each iall.			Improvement Committee m	
	On 2/2/2017 at 10:43	AM, in an interview, the		consist of, but not limited to	
	MDS nurse stated she			Director, Director of Clinica	
	interventions in the ca	are plan when she received		Medical Director, Pharmacy	
	them from the Directo	or of Nursing (DON).		Social Services Director, A	
	In an interview an 0/0	12017 at 10,55 ANA the DON		Director, Maintenance Director	, ,
		/2017 at 10:55 AM, the DON n was the care plan would		Director, and Minimum Data Nurse.	a Assessment
		s occurred. The DON stated			
		erventions for the resident's			
	care plan.				
F 323		(3) FREE OF ACCIDENT	F 3	23	3/3/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/03/2017 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345423	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND N			1	705 SOUTH TARBORO STREET		
		DRSING CENTER		V	VILSON, NC 27893		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=E	Continued From page HAZARDS/SUPERVI		F	323			
	(d) Accidents. The facility must ensu	ire that -					
	(1) The resident envir from accident hazards	onment remains as free s as is possible; and					
		eives adequate supervision es to prevent accidents.					
	appropriate alternativ bed rail. If a bed or si must ensure correct in	ails, including but not limited					
	(1) Assess the resider from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with nt representative and obtain or to installation.					
		ed's dimensions are sident's size and weight. is not met as evidenced					
	Based on observation interviews and record prevent falls and mini for one of two residen (Resident #22), result resident, and the facil	review, the facility failed to mize the potential for falls its reviewed for accidents ting in continued falls for the ity failed to maintain safe			Resident # 22 s environment has bee checked for any identified potential accident hazards. Resident rooms have been checked to ensure areas are clear of any potential accident hazards.		
	checked for water ten	es in two of two rooms nperature (rooms 106 and e as a safety hazard for			The Administrator and/or Director of nursing have provided education to nursing staff in regards to checking resident rooms before and after care to		

Facility ID: 923511

If continuation sheet Page 15 of 22

PREFIX TX0 CALCEL CHARGENT ALL TOTAL SECTION SHOLLD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) COMPLE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 15 F 323 Findings included: 1. A review of the medical record revealed Resident #22 was admitted to the facility 11/1/2/2016 with diagnoses that included abnormal gait and mobility, altered mental status and over active bladder. The 30 day Minimum Data Set tollet use. The MDS noted Resident #22 was moderately impaired for cognition and needed extensive assistance for transfers and tollet use. The MDS noted Resident #22 was unsteady during transitions and walking and was only able to stabilize with huma massistance. The Care Area Assessment (CAA) indicated a concern for fails and this area went to care plan. F durinistrator and/or Director of A weeks, then 5 days per week for 3 ix resident rooms for four weeks, then four resident rooms soft of aur oweeks, then four resident rooms soft of aur weeks, then four resident rooms soft of aur oweeks, then only able to stabilize with huma massistance. The care Area Assessment (CAA) indicated a concern for fails and this area went to care plan. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minimize the risk of accidents as ordered, monitoring for medication as a ordered, monitoring for medication sais ordered, monitoring for medication as actered, monitoring for medication as actered, monitoring for medication as actered, monitoring for medicated at 6:55 PM, Resident #22 tripped over roommate's oxygen tubing, was in the floor with back against the bed and walker was turned over. Resident #22 hand an brasion on her back. Monitors included; Resident #24 tripped over roommates oxygen tubing, was in the floor with back against the bed and awa			ND HUMAN SERVICES				FOR	D: 03/03/20 M APPROVE <u>D. 0938-03</u>
345423 B. WHG Colloges Colloges <th< th=""><th></th><th></th><th></th><th>· ,</th><th></th><th colspan="2">COMPLETED</th></th<>				· ,		COMPLETED		
WILSON REHABILITATION AND NURSING CENTER TOS SOUTH TARBONO STREET VILIO PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ODRECTION RECOLLERCY OR ISC DENTIFYING INFORMATION) In In REPRODUCTS SLAN OF CORRECTION (EACH ODRECTION RECOLLERCY) CORRECTION (EACH ODRECTION (EACH ODRECTION RECOLLERCY) CORRECTION (EACH ODRECTION (EACH ODRECTION (EACH ODRECTION (EACH ODRECTION RECOLLERCY) CORRECTION (EACH ODRECTION (EACH ODRECTION (EA			345423	B. WING				
WILSON, NC 27833 CMUSP, IC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REACED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) Omega (EACH DEFICIENCY) F 323 Continued From page 15 F 323 F ndings included: 1. A review of the medical record revealed Resident #22 was admitted to the facility 11/2/2016 with diagnoses that included abnormal gait and mobility, altered mental status and over active biadder. The 30 day Minimum Data Set tollet use. The MDS noted Resident #22 was unsteady during transitions and walking and was only able to stabilize with human assistance. The Care Area Assessment (CAA) indicated a concern for falls and this area went to care plan. F 323 Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minimize the risk of accidents and injury. The plan interventions included checking the resident frequently and assist with toleiting routinely, answeng the call bell promptly, and giving medications as ordered, monitoring for medication side effects, observing for changes in mental status and transferring carefully with assistance. F admitistrator nad/or until substantial compliance is obtained. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minitize the risk of accidents and injury. The plan interventions included checking the resident medication side effects, observing for changes in mental status and transferring carefully with assistance. Actual the dead walker was turned over. Resident #22 hered and walker was turned over. Resident #22 hered and wasker to call for assistance. Alert and orented. Poor memory. Poor safety awareness. F admitinitrator and/or maintenance department will conduct Qual	NAME OF PR	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG IEACH CORRENT MACTION YOR USE DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR USE DENTIFYING INFORMATION) PREFX TAG IEACH CORRENT ACTION SHOULD BE CROSS-REFERENCE OF THE APPRORMATION) COMMENT BAT F 323 Continued From page 15 F 323 Image: State of the medical record revealed Resident #22 was admitted to the facility 11/2/2016 with clauge approxement gait and mobility, altered mental status and over active bladed: The 30 day Minimum Data Set tollet use. The MDS noted Resident #22 was unsteady during transitions and waiking and was to file use. The MDS noted Resident #22 was unsteady during transitions and waiking and was unsteady during transitions and waiking and was unsteady during transitions and waiking and was to minimize the risk of accidents are quelta. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minimize the risk of accidents are order, monitoring for medication said effects, observing for changes in mental status and transferring carefully with assistance. F Administrator had been educated by engineering direct on the acceptable transition and been educated by engineering director on the acceptable water temp for resident raeas. The Administrator nad been educated by engineering director on mazar	WILSON F	EHABILITATION AND N	URSING CENTER					
Findings included: 1. A review of the medical record revealed Resident #22 was admitted to the facility 11/2/2016 with diagnoses that included abnormal gait and mobility, altered mental status and over active bladder. The 30 day Minimum Data Set (MDS) dated 11/29/2016 indicated Resident #22 was moderately impaired for cognition and needed extensive assistance for transfers and toilet use. The MDS noted Resident #22 was unsteady during transitions and walking and was only able to stabilize with human assistance. The Care Area Assessment (CAA) indicated a concern for falls and this area went to care plan. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minize the risk of accidents and injury. The plan interventions included checking the resident frequently and assist with toileting routinely, answering the call bell promptly, and giving medication side effects, observing for changes in mental status and transferring carefully with assistance. A Quality Care Control Report completed by the Director of Nursing (DON) and dated 11/11/2016, indicated at 6:55 PM, Resident #22 tryped over roommate's oxygen tubing, was in the floor with back against the bed and walker was turned over. Resident ezo Alet and oriented. Poor memory. Poor safety awareness.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETIO DATE
Findings included:of any potential accident hazards.1. A review of the medical record revealedThe Administrator and/or Director ofResident #22 was admitted to the facilityNursing will conduct Quality Improvement11/2/2016 with diagnoses that included abnormalmedication andactive bladder. The 30 day Minimum Data SetMonitoring for room hazards to ensure the(MDS) dated 11/29/2016 indicated Resident #22massistance. Thewas moderately impaired for cognition and6 days per week for 8 resident rooms forneeded extensive assistance for transfers and4 weeks, then 5 days per week for 8 resident rooms fortoilet use. The MDS noted Resident #22 wasresident rooms for four weeks, then fourunsteady during transitions and walking and wasresident rooms for four weeks, then fouronly able to stabilize with human assistance. TheCare Area Assessment (CAA) indicated aConcern for falls and this area went to care plan.weekly for three months and/or untilReview of the care plan dated 11/16/2016substantial compliance is obtained.indicated Resident #22 needed safety measuresThe Administrator and/or maintenancedepartment sitaus and transferring carefully withassistance.A Quality Care Control Report completed by the Director of Nursing (DON) and dated 11/11/2016, indicated at 61:55 OM, Resident #22 thipped over rooms for four weeks, then foor with back against the bed and walker was turned over.A Quality Care Control Report completed by the Director of Nursing (DON) and dated 0 vert. Resident #22 thipped over rooms for fure weeks, then foor with back against the bed and walker was t	F 323	Continued From page	e 15	F 3	323			
A Quality Care Control Report dated 12/9/2016 and completed by the DON, indicated at 12:20 Performance Improvement Committee monthly by the Director of Clinical		Findings included: 1. A review of the me Resident #22 was ad 11/2/2016 with diagn gait and mobility, alte active bladder. The 3 (MDS) dated 11/29/2 was moderately impa needed extensive as toilet use. The MDS r unsteady during trans only able to stabilize Care Area Assessme concern for falls and Review of the care pl indicated Resident #2 to minimize the risk of plan interventions inco frequently and assist answering the call be medications as order medication side effect mental status and tra assistance. A Quality Care Contro Director of Nursing (Di indicated at 6:55 PM, roommate's oxygen to back against the bed Resident #22 had an Monitors included: Re assistance. Alert and Poor safety awarenes A Quality Care Contro	dical record revealed mitted to the facility oses that included abnormal ared mental status and over 0 day Minimum Data Set 016 indicated Resident #22 aired for cognition and sistance for transfers and noted Resident #22 was sitions and walking and was with human assistance. The nt (CAA) indicated a this area went to care plan. an dated 11/16/2016 22 needed safety measures of accidents and injury. The cluded checking the resident with toileting routinely, ell promptly, and giving ed, monitoring for ts, observing for changes in nsferring carefully with of Report completed by the DON) and dated 11/11/2016, Resident #22 tripped over ubing, was in the floor with and walker was turned over. abrasion on her back. esident asked to call for oriented. Poor memory. ss.			of any potential accident hazards. The Administrator and/or Director of Nursing will conduct Quality Improver Monitoring for room hazards to ensur- resident room environment is free and clear of any potential hazards. Quality Improvement Monitoring will be condu- 5 days per week for 8 resident rooms 4 weeks, then 5 days per week for si- resident rooms for four weeks, then weekly for three months and/or until substantial compliance is obtained. Rooms 107 and 106 water temperature were lowered to the acceptable range 100- 116 fahrenheit. Resident rooms water temperatures to been checked to ensure they are with acceptable range for safe usage. The Administrator had been educated engineering director on the acceptable water temp for resident areas. The Administrator and/or maintenance department will conduct Quality Improvement Monitoring for room haz to ensure the resident room environm- is free and clear of any potential haza Quality Improvement Monitoring will to conducted 5 days per week for 8 res rooms for 4 weeks, then 5 days per w for six resident rooms for four weeks, the weekly for three months and/or until substantial compliance is obtained. The results of these audits will be reported to the Quality Assurance Performance Improvement Committe	ment e the d d ucted s for x pur res of nave of nave of the d by e zards nent ards. pe ident yeek then ien	

Facility ID: 923511

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/03/2017 AMAPPROVED O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345423	B. WING			02/03/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
WILSON F	REHABILITATION AND N	URSING CENTER			05 SOUTH TARBORO STREET ILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 323	PM, Resident #22 wa Therapy. Resident sta included: Resident wi poor safety awareness agitated if re-directed for assistance. Divers activities resident doe interested in magazin interventions were ad A Quality Care Contro DON and dated 12/11 Resident #22 was see down the hallway by injuries noted and RC as resident continued being assisted. Per ro of her bed. Ongoing r confused-gets agitate at times. Re-educated call bell, not getting u interventions were ad A Quality Care Contro and completed by the AM, Resident #22 fou was observed by staf out of wheelchair with floor at that time. No i included: Poor safety continually self-prope when she wants to. N initiated at that time. A Quality Care Contro DON and dated 1/2/2 staff entered room, R buttocks with brief arc	s found on floor by Physical ates she didn't fall. Monitors th dementia. She has very as and becomes easily . Educated resident to call sional activities and group as not stay long. Not res. No injury noted. No ded at that time. of Report, completed by the 1/2016, indicated at 7:30 AM, en crawling out of room, nurse who notified unit. No DM (range of motion) active to move around floor while commate, Resident slid out monitors: Resident slid out monitors: Resident slid out monitors: Resident is ed easily. Unable to re-direct d in safety, calling for assist, p by herself. No new Ided at that time. DI Report dated 12/29/2016 e DON, indicated at 11:00 und on floor on 100 hall. She f member to pull herself up n hand rails. She slid to the injuries noted. The monitors awareness. Demented, Is and will try stand and walk to new interventions were	F 3	23	Services for six months and/or until substantial compliance is obtained. Th Quality Assurance Performance Improvement Committee will evaluate effectiveness of the monitoring/observation tool for maintaining substantial compliance, at make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Exect Director, Director of Clinical Services, Medical Director, Pharmacy Consultar Social Services Director, Activities Director, Maintenance Director, Dietar Director, and Minimum Data Assessm Nurse.	the nd if utive nt, y	

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345423	B. WING				C 03/2017
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WILSON	REHABILITATION AND N	URSING CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Dementia. Gets up wi in wheel chair (w/c). her w/c. No new inter that time. A nurse's note dated #22 observed sitting of Resident unable to st pain or discomfort sta ROM to all extremities Report. A Quality Care Contro completed by the DO nurse from 300 hall ca that Resident #22 fell Nurse on 100 hall ass injuries. Monitors incli dementia and poor sa continue to monitor re checks. Offer rest per aware to monitor her interventions were ini plan at that time. A Quality Care Contro 1/7/2017, indicated at found on floor in hallw injury noted. Resident to take herself to the crawled to the hallway included: Resident de awareness. Wanders unassisted despite fre interventions were ad A Quality Care Contro	hen she wants. Propels self Wanders around building in ventions were initiated at 1/2/2017 noted Resident on floor in front of bed. ate what happened. Denies ited "I'm alright" Positive s. No Quality Care Control DI Report dated 1/4/2017 and N, indicated at 7:00 PM, a ame and notified 100 nurse in the floor in the hall. sessed resident for no uded: Resident has severe afety awareness. Will esident. Frequent safety riods/ go back to bed. Staff while in hallways. No new tiated or added to the care DI Report by the DON, dated t 1:45 PM, Resident #22 vay-unobserved fall. No t roommate stated "She tried bathroom and fell. She y." The ongoing monitors emented, poor safety , propels self in w/c. Gets up equent reminders. No new	F	323			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/03/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
		345423	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON F	REHABILITATION AND N	URSING CENTER			1705 SOUTH TARBORO STREET WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	buttocks with pants lo feces on floor. Reside that she had gotten o someone to help her. Resident is demented safety-calling for assis checked by aide 1 ho resident often. Resident #22 was ob propelling herself in h Throughout the surve observed being assis going into and out of f On 1/31/2017 at 4:30 an interview, that she indicated if she turned Nursing Assistants (N would get up to the ba #22 stated she had to sometimes fell. On 2/1/2017 at 2:00 F #22 wore a brief beca incontinent episode. I got up on her own an In an interview on 2/2 nurse stated she put in the care plan when Director of Nursing (D On 2/2/2017 at 10:55 DON stated she alwa #22, even after multip the investigations not demented and confus	wered to knees, smearing ent #22 stated in the report ut of the chair to get Ongoing monitors included: A. Re-educated to st. Resident was last ur prior. Continue to check oserved on 1/31/2017 allways and in her room. y, Resident #22 was ted into the bathroom and the bathroom alone. PM, Resident #22 stated, in had fallen. Resident #22 d on the call bell and the IAS) did not come, she athroom by herself. Resident use she sometimes had an NA #1 stated Resident #22 d had falls. /2017 at 10:43 AM, the MDS revisions and interventions they were received from the DON). AM, in an interview, the ys re-educated Resident ole falls, and even though	F	323			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
							C
		345423	B. WING			02/	03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON REHABILITATION AND NURSING CENTER							
					WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 202		10					
F 323	10		- F :	323			
		tate the Resident. The DON ns were the NAs would					
		our and the nurses would					
	check on Resident #2						
	In an interview on 2/2	2/2017 at 11:15 AM, NA #1					
	stated she checked n	nost of her residents every					
	-	e no one was on the floor, or					
	residents on occasior	A#1 was observed assisting ח.					
	very busy hall and us	AM, NA #2 stated she had a ually made it around her ninutes. NA #2 was observed					
	-						
	· ·	ew on 2/2/2017 at 2:15 PM,					
		cian was interviewed and fied him when the Resident					
		an stated he would expect					
		o work together to come up					
		s, although, a fall mat was					
		ng and a low bed could be a ongoing struggle and I feel					
		eir best", he stated. The					
	physician maintained	there must be a balance					
	between Resident #2						
	independence, and w	hat she needs to be safe.					
	On 2/3/2017 at 8:50 Å	AM, in an interview, the					
		nager stated Resident #22					
	started Physical Ther	apy (PT) and Occupational					
		3/2016 and was discharged					
		PT and discharged from OT					
		nost goals not being met.					
		ed Resident #22 improved and ambulation, but did not					
	-	e toileting and transfers. The					
	PT Manager stated sl						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/03/2017 RM APPROVED NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MRED.		LE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED	
		345423	B. WING			C 02/03/2017		
	ROVIDER OR SUPPLIER	URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 SOUTH TARBORO STREET WILSON, NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	was a note on the do nursing to screen Re- OT. The PT Manager from the MDS nurse, screening for Resider 2. On 1/31/2017 at 10 of water temperatures bathroom sink of room hot to touch. The Mai directed to room 107 facility Administrator of thermometer and the registered 122 Fahre was then directed to 106, and the hot water 123F. The Administrat have the hot water ta 10:50 AM on 1/31/20 the Maintenance Direct tank temperature of the ho of room 106 at 11:35 were posted in the fa using the hot water. On 2/2/2017 at 9:30 A Maintenance Director for the facility had tra cleaned out. The Mai adjusted the tank tem acceptable level. The water temps were chi hall monthly. The tem	had falls, but all she needed or or a phone call from sident #22 for further PT and received a telephone call who scheduled a quarterly int #22 in March, 2017. D:36 during a routine check s, the hot water in the in 107 was found to be very intenance Director was with a thermometer. The came to the room with a hot water temperature inheit (F). The Administrator the bathroom sink of room er temperature registered itor stated he was going to ink temperature lowered. At 17, the Administrator stated ector had lowered the water 10 degrees. At 11:00 AM the of water was checked to be is sink of room 107. The of water in the bathroom sink AM was 113F. No signs cility to keep residents from	F	323	3			

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		ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES					0. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILD	ING _		с		
		345423	B. WING				03/2017	
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	EHABILITATION AND N			1	1705 SOUTH TARBORO STREET			
				1	WILSON, NC 27893			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES II (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	E	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)			
F 323	Continued From near	- 04						
F 323	Continued From page temperature in room		F	323				
	temperature in room	100 was 115F.						
		PM, in an interview, the						
		his expectation would be the						
	safe level throughout	es would be maintained at a the facility						
	,	the facility.						

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