STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	**523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301**

(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 The facility was found in compiance with the requirement CFR 483.73 Emergency Preparedness Event ID # NTLU11.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		7/10/19

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

Electronically Signed | 07/08/2019

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to cover catheter bags for 1 of 1 resident (Resident #236) reviewed for catheter care. Review of Resident #236's medical record revealed he was admitted to the facility on 06/08/19 with diagnoses of a Secondary Malignant Neoplasm of Prostate, Neoplasm of bladder; HTN, Insulin Dependent DM and Post-Op Bilateral Nephrostomy Tubes. Review of his Minimum Data Set (MDS) assessment data was not available at the time of the Recertification Survey. Review of Resident #236's most recent MDS dated 06/15/19 coded the resident as severely cognitively impaired. Resident #239 required extensive assistance of 2 staff with bed mobility, transfer, dressing, personal hygiene and toilet use and limited assistance of 1 staff with eating. He was assessed as needing total assistance with bathing. On 06/18/19 at 11:44 AM Resident #236 was observed in bed with bilateral nephrostomy tubes with each tube connected to a catheter bag. There were no privacy covers to either of the drainage bags. Resident #236 was alert and	F 550	Corrective action for resident(s) affected. Privacy cover was placed over Resident #236 drainage bags. Corrective action for resident(s) with the potential to be affected. All residents with drainage bags were audited by DNS to ensure that they had privacy covers. What measures/systems will be put into place to ensure the deficient practice does not occur again? Multiple types of privacy covers were ordered to ensure availability. In-Servicing completed with nursing staff to ensure that privacy covers are placed over drainage bags upon admission. Privacy cover in place added to Catheter Clarification Orders. How will performance be monitored and how often? Treatment nurse will complete assessments on residents with drainage bags and document placement privacy covers have been placed. Catheter Clarification Orders will be reviewed in the clinical meeting 5 x per	

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F 550	Continued From page 2 oriented, able to recall some of his medical history and had a clear understanding of the purpose of his nephrostomy tubes. On 6/19/19 at 09:40 AM, Resident #236 was preparing for a Doctor's appointment. The Nephrostomy collection bags were noted and there were no privacy covers on either of Resident #236's drainage bags. On 06/19/19 at 0950 AM, the Medication Tech (MT) #1 stated that the resident was preparing to leave the facility for an appointment. The resident had come to the facility from the hospital with catheter bags as they were. She further stated that normally Med Tech's or the Nurses will replace these bags when there is no cover and she was waiting for staff to bring them so she could change them out. 6/20/19 at 08:50 AM Resident #236 was observed in his bed with no privacy bags noted to his left and right nephrostomy tube drainage bag. The resident stated they were still trying to locate something to go over the bags, but he was not sure what it was called. On 06/21/19 at 10:24 AM, the Director of Nursing (DON) stated that Resident #236 had catheter bags attached that came from the hospital. The facility did not have privacy catheter bags available and they had to be obtained from a sister facility. Resident #236's catheter bags have now been covered as of the evening of 6/20/19. All catheter bags should have a cover for the privacy and dignity of the resident.	F 550	week for 2 weeks. DNS or designee will review Catheter Clarification Orders 5x per week for 2 weeks, then weekly x 4 weeks, monthly x 3 months, and as needed thereafter to ensure compliance. DNS or designee will bring results of compliance to the monthly QA committee meeting x 3 months and as needed. All discussion will be maintain in the meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any changes to the plan will require re-inservicing by the DNS/designee and monitoring to begin again weekly until compliance is met.	
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6)	F 559		7/10/19

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F 559	Continued From page 3 §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify a resident of a room change for 1 of 1 resident reviewed for room change (Resident #49). The findings included: Resident #49 was admitted to the facility on 04/18/19 with diagnoses that included: Aortic Valve Stenosis, Congestive Heart Failure, Hypertension, Atrial Fibrillation and Aftercare following Right Knee surgery. Resident #49's most recent Minimum Data Set (MDS) assessment dated 04/25/19 coded her as cognitively intact. Resident #49 required extensive assistance of 2 staff with bed mobility, transfer, dressing, personal hygiene and toilet use. She was assessed as needing total assistance with bathing. Review of facility records indicate Resident #49	F 559	Corrective action for resident(s) affected. Met with resident #49 and apologized for written notification not having been completed prior to room change. Resident #49 was notified of room availability near bathroom and she requested to change rooms. Written notification completed to all parties involved and room change was completed. Corrective action for resident(s) with the potential to be affected. Room Changes since 2/1/19 were reviewed to ensure that written notifications were completed for all parties involved. What measures/systems will be put into place to ensure the deficient practice does not occur again? In-Servicing provided to ensure prior to changing a room or roommate	

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F 559	Continued From page 4 was transferred from Room 508 to Room 202B. Review of the facility's "Room Change/Roommate Assignment" Policy revised December 2008 states "Prior to changing a room or roommate assignment all parties involved in the change/assignment will be given a written advanced notice of such change, and will include the reason(s) for such change". Review of a facility note dated 06/21/19 from the Admissions Coordinator stated "On 06/14/19, I advised the housekeeping supervisor to in-service his staff of the room change process: room changes only occur once the email notice has been sent." 06/18/19 05:26 PM Resident #49 stated during an interview that she was aware that she was changing rooms due to her therapy being complete but did not know when or where she was going. She asked several of the staff and no one was able to tell her any information about her transfer. Resident #49 stated that it caused a lot of confusion for her as well as her family because they would not know where to find her. She stated that she had requested to be close to the bathroom, so she could wheel herself to the bathroom unassisted by staff. Resident #49 stated that she was transferred from the 500 hall to the 200 hall on 06/13/19. On 06/21/19 at 02:15 PM during an interview with the Admissions Coordinator, she stated Resident #49's room change was discussed in stand-up meeting on 06/13/19 and she was made aware that the resident requested to be moved to a room with her bed close by the bathroom. On the evening of 06/13/19, the housekeeping	F 559	assignment all parties involved in the change/assignment will be given a written advanced notice of such change, and will include the reason (s) for such change. Completion of notification letters to be added to Room Change Announcement form, which is internal communication tool notifying of room change. Notification Letter Completed added to Morning IDT Meeting Form. In-Servicing provided to housekeeping to ensure that they are not completing room changes until “Room Change Announcement” has been received. How will performance be monitored and how often? ED or designee will review all room changes for notification of all parties 5x per week for 2 weeks, then weekly x 4 weeks, monthly x 3 months, and as needed thereafter to ensure compliance. ED or designee will bring results of compliance to the monthly QA committee meeting x 3 months and as needed. All discussion will be maintain in the meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any changes to the plan will require re-inservicing by the ED/designee and monitoring to begin again weekly until compliance is met.	

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F 559	Continued From page 5	F 559		

staff moved the resident without the proper notice. On the morning of 06/14/19, when she was made aware of this, she immediately knew the procedure had not been followed because the resident's assigned bed was not close to the bathroom as Resident #49 had requested.

On 06/21/19 at 03:18 PM The Housekeeping assistant supervisor stated normally receive an email about bed changes. Once the room is cleaned, a tent card is placed on the bed notifying nursing staff to make the bed. After the room is ready, housekeeping staff gathers resident's belongings and transports the resident to new location and nursing staff transports the resident. The Housekeeping assistant supervisor stated she was not on duty during the transfer but was aware that a transfer was pending from the stand-up meeting on 06/13/19.

An interview was conducted with the Social Worker (SW) on 06/21/19 at 3:30 PM. The SW stated that Resident #49's room change was discussed in the 6/13/19 morning meeting, however, it was not finalized from Admissions. She further stated that Resident #49 was moved after she left for the day on 06/13/19 and when she returned on 06/14/19, she was made aware of the transfer. No notice had been sent out, so she was unsure what occurred during the transfer. Normally after all paperwork is completed, the Department heads receive the room change notice via email and the Nursing staff are notified via a written notice that it is okay to move the resident. She further stated that she did not notify the resident of the room change.

An interview with the Director of Nursing (DON) was conducted on 06/21/19 at 10:24 am. She

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F 559	Continued From page 6 stated that there was a breakdown in communication regarding the transfer of Resident #49 within the housekeeping department. The housekeeping supervisor has been advised to in-service his staff of the room change process so that room changes only occur once the email notice has been sent.	F 559		
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, a tool used for resident assessment) for 1 of 37 resident assessments reviewed (Resident #84). The findings included: Resident # 84 was admitted to the facility on 3/26/2019 with diagnosis that included diabetes and anxiety. Review of the discharge Minimum Data Set (MDS) dated 4/26/2019 indicated Resident # 84 was discharged to acute hospital. Review of the nurse notes dated 4/26/2019 and the medical record indicated Resident # 84 was discharged home . During the interview on 6/20/2019 at 1:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate.	F 641	Corrective action for resident(s) affected. Resident #84 MDS assessment was corrected and transmitted with the correct discharge location. Corrective action for resident(s) with the potential to be affected. Audit was completed on assessments transmitted since 2/1/19 to ensure they reflected accurate discharge location with no inaccuracies identified. What measures/systems will be put into place to ensure the deficient practice does not occur again? Staff in-servicing completed on ensuring compliance with MDS Accuracy per RAI manual. How will performance be monitored and how often? MDS Coordination/Certification and Accuracy Audit developed. Audits will be	7/10/19

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F 641	Continued From page 7 The MDS nurse explained it was coded in error as Resident # 84 was discharged home not in acute hospital. During an interview on 6/20/2019 at 2:30pm with the DON (Director of Nursing), she indicated that discharge to the community should have been coded on Resident # 84's MDS dated 4/26/2019. During Further interview with DON, she stated that it is her expectation that the MDS should be coded accurately.	F 641	completed by IDT on random assessments and care plans 5 x per week for 2 weeks, then weekly x 4 weeks, monthly x 3 months, and as needed thereafter to ensure compliance. MDS Coordinator or designee will bring results of compliance to the monthly QA committee meeting x 3 months and as needed. All discussion will be maintain in the meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any changes to the plan will require re-inservicing by the ED/designee and monitoring to begin again weekly until compliance is met. The Executive Director is responsible for the implementation of this plan.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		7/10/19

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F 656	Continued From page 8 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a Care plan for psychotropic drug use for 1 of 5 residents reviewed for psychotropic medication (Resident # 68). The findings included: Resident # 68 was admitted to the facility on 10/25/ 2018 and had a diagnosis of chronic diastolic, dementia, anxiety and depressive disorder.	F 656	Corrective action for resident(s) affected. Resident #68 Care Area Assessment (CAAs) was completed and Care Plan was updated regarding psychotropic drug usage. Corrective action for resident(s) with the potential to be affected. CAAs & Care Plans were reviewed by 6/28/19 on all current residents to ensure that they reflected psychotropic drug usage and any inaccuracies identified were corrected by the MDS Coordinator	

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F 656	Continued From page 9 The significant Minimum Data Set (MDS) Assessment dated 5/27/2019 revealed the resident was severely cognitively impaired, required extensive assistance with activities of daily living (ADLs). The MDS revealed the resident was taking antianxiety and antidepressant medication 7 days. The Care Area Assessment (CAA) summary sheet revealed Psychotropic drug use was not completed and problem area was not checked to be addressed in the resident's care plan. Review of the resident ' s Comprehensive Care Plan dated 11/06/2018 and reviewed on 2/16/2019 contained no information or interventions regarding the Psychotropic drug use. Review of Medication Administration for Resident # 84 revealed the resident was taking the following medications: Trazodone, Zoloft, Ativan and Depakote. An interview was conducted with MDS Nurse #1 on 6/19/2019 at 1:15 PM. The MDS Nurse was observed to review the Care Plan for Resident # 68. The MDS Nurse stated she did not complete a Care Plan for Psychotropic drug use for the resident and stated, "I missed it." The Administrator stated in an interview on 6/19/19 at 12:52 PM she expected Psychotropic drug use to be care planned per results of the Care Area Assessment.	F 656	What measures/systems will be put into place to ensure the deficient practice does not occur again? Staff in-servicing completed on ensuring that Care Area Assessments are completed for all areas that are triggered on the MDS, ensure that individualized care plan is developed for all areas triggered by MDS Care Area Assessment, and use RAI manual as a reference. How will performance be monitored and how often? MDS Coordination/Certification and Accuracy Audit developed. Audits will be completed by IDT on random assessments and care plans 5 x per week for 2 weeks, then weekly x 4 weeks, then monthly x 3 months, and as needed thereafter to ensure compliance. MDS Coordinator or designee will bring results of compliance to the monthly QA committee meeting x 3 months and as needed. All discussion will be maintain in the meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any changes to the plan will require re-inservicing by the ED/designee and monitoring to begin again weekly until compliance is met.	