STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	**403 CRESTVIEW AVENUE WILSON, NC 27893**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 11/4/2019 through 11/08/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # X4FP11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 11/8/2019. Event ID # X4FP11.	F 000		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to refer a resident for a Preadmission Screening and Resident Review (PASRR) Level II screening for one of two residents reviewed for PASRR (Resident #34). Findings included: A review of the medical record revealed Resident #34 was admitted 7/26/2016 with diagnoses including anxiety, psychosis, and affective disorder. Resident #34's Annual Minimum Data Set (MDS) dated 6/16/2019 was reviewed. The MDS noted Resident #34 was cognitively intact, had physical	F 646	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Wilson Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any	11/12/19

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

Electronically Signed | 11/26/2019

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F 646	Continued From page 1 and verbal behaviors which were noted to be worse than the previous assessment, and rejection of care had occurred daily. The MDS also noted Resident #34 had a mental illness diagnosis but no PASRR level II screening was done. In an interview on 11/8/2019 at 8:37 AM, the Social Worker stated she had applied for a level II screening for the resident this morning. On 11/8/2019 at 11:25 AM, the MDS coordinator was interviewed. She explained that when she did assessments, she would check the face sheet (includes demographic information and diagnoses) and verify if the resident had mental illness or retardation diagnoses. She further explained if these diagnoses were present, she would notify the Social Worker who would apply for a PASRR Level II screening. The MDS coordinator stated, "I guess I missed that one."	F 646	deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 11/8/2019 the Preadmission Screening and Resident Review (PASRR) Level II application was submitted by the Social Worker (SW) for Resident # 34. A 100% review of all current residents' diagnosis was initiated on 11/8/2019 by the Minimum Data Set (MDS) Coordinator, (MDS) Nurse, Quality Assurance (QA) nurse, Assistant Director of Nursing (ADON), Staff Facilitator (SF), Registered Nurse (RN) supervisor, Resource Nurse utilizing a midnight census report to determine the need for submission/re-submission of PASRR information. The Social Worker was notified of issues identified during audit to include submission /re-submission of PASRR information as indicated. Audit was completed on 11/12/2019. A 100% of all current residents, to include resident #34 with mental illness progress notes were reviewed on 11/8/19 utilizing a midnight census report to ensure any changes or increase in behaviors were addressed to include submission/ resubmission of PASSR information by the MDS coordinator, MDS nurse, ADON, QA nurse, SF, Treatment nurses, RN	

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F 646	Continued From page 2	F 646	supervisor, and resource nurse. Audit was completed on 11/12/19. On 11/8/2019 the Social worker, Accounts Receivable (AR) Bookkeeper, backup AR Bookkeeper, Admissions Director, Director of Nursing (DON), MDS coordinator, MDS nurse, ADON, QA nurse, SF, Treatment nurses, RN supervisor, and resource nurse were in-serviced by the Administrator on requirements for PASSR submission/ resubmission upon receipt of qualifying diagnosis during resident stay. 10 % of all new residents admission diagnosis and new qualifying diagnosis to include resident #34 will be reviewed by the MDS coordinator, MDS nurse, ADON, QA nurse, SF, Treatment nurses, RN supervisor, and resource nurse to ensure new PASRR Level II qualifying diagnosis are identified for submission/re-submission to PASRR utilizing a PASRR Audit tool 5 X a week X 8 weeks and then monthly X 1 month. Any identified areas of concerns will be completed by the Social work or designee during the audit to include submission/re-submission of information to PASRR. The Director of Nursing (DON) or Administrator will review and initial the PASRR Audit Tool weekly for 8 weeks and monthly for 1 month to ensure that all areas of concern have been addressed. 10% of all current residents with mental illness, to include resident #34 progress notes will be reviewed to ensure any changes or increase in behaviors are	

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F 646	Continued From page 3	F 646	addressed to include submission/resubmission of PASRR information by the MDS coordinator, MDS nurse, ADON, QA nurse, SF, Treatment nurses, RN supervisor, and resource nurse utilizing a PASRR audit tool 5x a week x 8 weeks and then monthly x 1 month. Any identified areas of concern will be forwarded to SW or designee during the audit for submission/ re-submission of information to PASRR. The DON or Administrator will review and initial the PASRR Audit Tool weekly for 8 weeks and monthly for 1 month to ensure that all areas of concern have been addressed. The DON or Administrator will forward the results of the PASRR Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the PASRR Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	