DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	_			OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345180	B. WING _			11/	/06/2013
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEVI	PINES RETIREMENT CO	мм		10	000 WESLEY PINES RD		
WESLEII				L	UMBERTON, NC 28358		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 279 SS=D	COMPREHENSIVE		F 2	279			12/3/13
	to develop, review an comprehensive plan of	d revise the resident's of care.					
	plan for each resident objectives and timetal medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive					
	to be furnished to atta highest practicable pr psychosocial well-beii §483.25; and any ser be required under §48 due to the resident's e	-					
	by: Based on record revi facility failed to develo plan to address a resi developing pressure reviewed for pressure failed to develop a ca receiving an anti-depr #12). The findings include: Ex. #1 Resident #71 of	ulcers for 1 of 1 residents ulcers (resident #71) and			F279 Prior to survey, facility staff had discovered that Resident #71 s initial care plan did not address his being at har risk for developing pressure ulcers. At that point in time, a MDS and care plan was written and implemented that included approaches designed to heal pressure ulcers that had developed and address the Resident had high risk for developing pressure ulcers. Resident was being given appropriate care at the time of survey. During survey, Resident #12 was found	nigh the d #71 e	
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

12/02/2013

					OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345180	B. WING		11/06/20	13
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
WESLEY	PINES RETIREMENT CO	ММ		1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMP THE APPROPRIATE D	(X5) PLETIC ATE
F 279	Continued From page	e 1	F 27	9		
	Status Post Hip Fract and Anemia.	ture, Alzheimer's Dementia	. 21	have an anti-depressant p no diagnosis and no care approaches to monitor the	planned e effects of the	
	(MDS) Assessment d resident as cognitivel	lated 8/26/13 identified the y impaired, having no sk for pressure ulcers,		anti-depressant medication learning this, a facility nur attending physician and w diagnosis for the prescrib	se contacted the vas given a ed	
		sistance with bed mobility chair pressure relieving		anti-depressant. Addition MDS nurse added an app Resident⊡s care plan to a of anti-depressant medica	broach to the address the use	
	-	lan of care dated 8/19/13 ecked or written in the area at risk area.		implemented a behavior r in the Resident⊡s chart. The MDS nurses reviewe of all Residents that had b	nonitoring form d the care plans	
	on 11/6/13 at 8:30AM	vith the Director of Nursing I she stated that the initial e addressed the resident's		admitted and had not yet assessed by the care plan The nurse management to	been fully n nurses.	
		ulcers and interventions t into place related to this		reviewed each Residents medical records to ensure medication has a proper of medication for a proper of	e that every diagnosis. Any	
	facility on 7/19/13 with	ase, Degenerative Joint		medications found to not appropriate diagnosis res the attending physician to discontinue the medicatio proper diagnosis. The ad coordinator has been inst	ulted in a call to either n or give a missions	
	documented the resid anti-depressant medi	ian's order dated 7/19/13 dent was ordered Zoloft, an cation to be given daily.		upon a diagnosis for each from the physician writing orders. In the event that physician does not give a	n medication the admitting the admitting diagnosis for	
	a care plan in place fo anti-depressant use.			each medication, the nurs team will contact the Resi attending physician to obt or an order to discontinue	ident⊡s ain a diagnosis the medication.	
	-	vith the Director of Nursing I she stated that the resident re planned for her		The MDS nurses have replans of every resident re anti-depressant medication use is care planned and t	ceiving on to ensure the	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/20' FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345180	B. WING		11/06/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	
WESIEV	PINES RETIREMENT CO	NANA		1000 WESLEY PINES RD	
WESLET	PINES RETIREMENT CO			LUMBERTON, NC 28358	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE FICIENCY)
F 279	Continued From page	e 2	F2	 behavior is being mor determine the efficacy In-service education v all nurses on the follo 1. If a nurse calls a report of any Residen nurse is responsible f diagnosis for any med orders. 2. The importance of addressing all risk fact 3. The importance of assessing each Reside a medication pass an observed needs/risk f been written on the cas suspected issues hav the nurse manageme can assume that som recognized a potential is responsible for com team. The administrator will sent to all attending p them of the facility ha citation for a medicati proper diagnosis. The inform the attending p federal regulations re- medication is order that a hospital doctor attending physician w medication and did no diagnosis, it is the new responsibility to asses either give a diagnosis medication. 	y of the medication . will be provided for wing issues: physician to give a tto s condition, the or obtaining a proper dication the doctor of the initial care plan etors. of properly dent while performing d comparing factors with what has are plan. Any re to be reported to nt team. No one eone else has al issue; each nurse municating with the draft a letter to be hysicians informing ving received a on not having a e letter will also obysicians that quire that each d have an a given at the time ered. In the event or a previous rote an order for a ot include a w attending doctors□ ss the Resident and

Event ID: GQXK11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	0: 12/17/20 [/] 1 APPROVE 0: 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345180	B. WING		11/0	06/2013
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	VINES RETIREMENT CO	MM		1000 WESLEY PINES RD		
				LUMBERTON, NC 28358		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 279 F 314 SS=D	PREVENT/HEAL PR Based on the compre- resident, the facility n who enters the facility	NT/SVCS TO ESSURE SORES chensive assessment of a hust ensure that a resident y without pressure sores	F 279	Henceforth, all new admission of be reviewed in the next ITM (interdisciplinary team meeting) held every weekday morning. T will ensure that each medication diagnosis and that all risk factor being addressed in the initial ca Any deficiencies will be address immediately. These reviews will routine part of our ITM agenda. Any nurse found to accept an o medication without a diagnosis re-educated/re-trained to the im and necessity of each medication a proper diagnosis. In the even nurse making this same mistake than once, the facility s progres disciplinary policy will be implen could result in termination. Audit sheets will be completed f new admission chart review for weeks, then once per quarter th These audit sheets will become the facility s QAPI records.	meeting The team in has a rs are are plan. Sed I become a rder for a will be oportance on having at of any e more ssive nented and for every three three hereafter. a part of	12/3/13
	individual's clinical co they were unavoidab pressure sores receiv	ssure sores unless the ondition demonstrates that le; and a resident having ves necessary treatment and nealing, prevent infection and om developing.				

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		MEDICAID SERVICES				. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE S COMPL	
		345180	B. WING		11/06/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	PINES RETIREMENT CC	ОММ		1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 314	Continued From pag	e 4	F 314	1		
	This REQUIREMEN ⁻ by:	Γ is not met as evidenced				
	Based on record rev facility failed to initiat development of prese resident at high risk f ulcers (Resident #71 The findings include: Resident #71 was ac admitted on 8/19/13 Status Post Hip Frac and Anemia. Review of the initial of identified Resident # hip, having an indwe risk, at risk for dehyd tract infection, having toileting, bed mobility motion and having a for documentation of none of the preventa checked.	Imitted to the facility on with diagnoses including ture, Alzheimer's Dementia care plan dated 8/19/13 71 as having a fractured right lling urinary catheter, as a fall ration, at risk for a urinary g a decline in walking, v, transferring and range of surgical incision. The area pressure ulcer was blank; tive interventions were		F314 Prior to survey, facility sta discovered that Resident #71 □s ini care plan did not address his being risk for developing pressure ulcers. that point in time, a MDS and care was written and implemented that included approaches designed to h pressure ulcers that had developed address the Resident □ s high risk for developing pressure ulcers. Reside was being given appropriate care a time of survey. A root cause analysis revealed that whose care was being directed by initial care plan completed at the tim admission could possibly be affected we determined that the root cause problem was an inadequate initial of plan. Therefore a nurse audited the medical record of every Resident w been recently admitted and was sti served by the initial care plan. Nor these Residents were found to have factors that were not being address	tial at high At plan eal the l and or ent #71 t the cothers an ne of ed as of the care e who had II being ne of e risk sed	
	8/19/13 documented and long term memo impaired cognitively i an indwelling urinary required total assista transferring, ambulat #71 scored a 15 on t assessment tool for s at high risk, mobility He had a surgical inc	ion and toileting. Resident		 with proper care planned approach On 11/19/13 and 11/20/13 all nurse attended an in-service training/retra regarding: " Training on completion of the in nursing assessment and initial care " Where the initial care plan and nursing assessment forms will be for along with a sample initial care plar nursing assessment " How to view any Resident □s completed care plan via the computation 	s aining nitial plan initial pund, n and	

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
		345180	B. WING		1	1/06/2013
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
WESLEY F	PINES RETIREMENT CO	ММ		1000 WESLEY PINES RD LUMBERTON, NC 28358		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
F 314	Continued From page	e 5	F 31	4		
	assessment portion of Resident #71 as imm Review of the most re (MDS) Assessment of resident as cognitivel pressure ulcers, at ris ulcer, needing extens mobility, having range one side of his lower bed or chair pressure Review of the Care A dated 8/26/13 trigger Ulcers related to decr Review of the Nursing 8/29/13 read in part, appears to be SDTI (si injury). " Area on the centimeters x 6 centin 4 centimeters x 2.5 cc not opened but dark r to touch. The feet we feet clear of the mattr Review of a revised C in part, " Problem - S Area to heels will hea Pressure relieving de reposition often, mon needed and treatment	of the assessment identified obile in bed. ecent Minimum Data Set lated 8/26/13 identified the y impaired, having no sk for developing pressure sive assistance with bed e of motion impairment to extremities and having no e relieving devices. rea Assessment Summary ed in the area of Pressure reased bed mobility. g Progress Note dated " areas to bilateral heels suspected deep tissue e right heel was 5 meters and the left heel was entimeters. The area was maroon in color and boggy re placed on elevators with ress. Care Plan dated 8/29/13 read 6DTI bilateral heels; Goals - al x 30 days; Approaches - vice while in bed, encourage itor and report changes as		terminal at the nurses deal "Original care plans are Residents charts and all mexpected to read the care plasign them for all Residents in "All nurses are expected constantly assessing each F they encounter them, search need or risk factor that is no addressed, and communicat findings to the nursing team. has the responsibility to imp approaches needed and eith care plan themselves or go of MDS nurse and ask her to a care plan. All care plan ame be communicated to all nurs the 24 hour report book and on the Residents MARs to on-coming nurse of a chang The nursing administrative s the initial nursing assessment the initial care plan forms. T assessment forms were four some unnecessary question deleted. The assessment for initial care plan forms were four some unnecessary duestion deleted. The assessment rearranged to flow with the of thereby decreasing the poss confusion for the nurse comforms. All initial care plans will be re- next ITM meeting held every	found in the urses are ans and then in their care to be Resident as hing for any t being ting any . Each nurse lement any her amend the directly to the mend the endments will hing staff via via notes left alert the e. .taff reviewed in forms and the hd to have s, which were orms and cound to not ent form was care plan form, sibility of pleting the	
	elevating the feet to r	educe pressure, foam boots Skin Prep bilaterally to heels		morning. Any initial care pla deficient will be corrected im The nurse that had complete	in found to be imediately. ed the care	
	Review of Significant	Change MDS dated 9/2/13		plan will receive additional tr nurse responsible for 3 defic		

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIP	LE CONSTRUCTION	(X3) DATE). 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	ì, '	<u> </u>		LETED
		345180	B. WING		11/	06/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
WESLEY	PINES RETIREMENT CO	омм		1000 WESLEY PINES RD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Continued From pag	e 6	F 31	4		
		t as having 3 unstageable		plans will be deemed inc		
		receiving ulcer care and		no longer be allowed to o	complete care	
	naving a pressure re	lieving device to the bed.		plans. Audit sheets will be com	oleted for everv	
		ational therapy Assistant		new admission chart revi	iew for three	
	weekly progress note			weeks, then once per we		
bilate		ed that Resident #71 had ic tissue on his heels and a		months, and once per qu These audit sheets will b		
	thera-boot had been			the facility⊡s QAPI recor	•	
	Physician 's orders dated 9/4/12 included a flow mattress to the bed and placed on the 9/4/13.					
	Physician 's orders of	dated 9/5/13 included Zinc				
	220milligrams for 3 n	nonths by mouth everyday,				
		e times a day with meals and ams by mouth twice daily for				
	identified the residen	d Care Plan dated 9/18/13 t at risk for skin breakdown assist needed with bed				
	suspected deep tissu	of bowel, and having 3 ie injuries (one on each heel great toe) and redness to				
	groin area. Interventi good nutrition, treatm	ons included to encourage nent as ordered, apply ts as ordered, specialty air				
	mattress as ordered, and as needed, prom	skin assessment weekly npt incontinent care every 2-3				
		oam boots to bilateral heels ed and elevating feet as				
	Resident #71 's Albu	results of 8/19/13 identified Imin level at 2.4 (low), (low) and his Hematocrit				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2013 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345180	B. WING				11/	06/2013
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE		
WESLEY F	PINES RETIREMENT CO	ММ			1000 WESLEY PINES RD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 314	Continued From page was 26.0 (low).	27	F	314				
	11/6/13 revealed he w mattress to his bed. H	esident on 11/4/13 through vas using a specialty air flow le wore foam boots and had chair foot rest when out of						
	on 11/5/13 at 4:00PM	-						
	Nursing on 11/6/13 at initial care plan should resident ' s immobility	and Alzheimer ' s Dementia risk of developing pressure						
F 328	11/6/13 at 2:30PM sh the left heel ulcer had was improving measu centimeters. The righ measuring 0.8 centim further stated that the toe were still black in odor and there was n areas. She stated the mattress and wears for the resident was adm position he was place in the bed.	with the Treatment Nurse on e stated that on 10/16/13 I resolved. The right heel uring 2.5 centimeters x 3 nt great toe was improving teters x 0.5 centimeters. She right heel and right great color, had no drainage or o pain associated with the resident is on a specialty bam boots. She stated when itted he stayed in whatever ed because he was immobile		328				12/3/13
SS=D	NEEDS							1210/10

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/20 FORM APPROVE MB NO. 0938-03
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345180	B. WING				11/06/2013
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				10	00 WESLEY PINES RD		
WESLET	PINES RETIREMENT CO	////////		LL	JMBERTON, NC 28358		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 328	 F 328 Continued From page 8 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, and review of facility policy, the facility failed to ensure proper storage of respiratory 		F	328	F328 The nursing staff immed went to the Resident rooms listed corrected the problem of the resp	and and	
		residents (Resident Identifier ng nebulizer and CPAP			equipment not being stored proper face masks were cleaned, dried, placed in plastic bags for storage current date was written on the pl bags. Any Resident using respiratory eq	and The lastic	
	Medications through Nebulizer, dated 201 procedure #29 - "Wh	policy entitles Administering a Small Volume (Handheld) 0, Section Steps in the en equipment is completely bag with resident's name			has the potential to be effected. Therefore the nursing staff did a r room sweep to ensure that all res equipment was being properly sto correcting any deficient practice f A master list of all Residents was ensure that we will be able to che	room to spiratory ored, found.	5
	3/12/13 with diagnose Fibrosis.	vas admitted to the facility on es including Pulmonary			piece of equipment in use. This I became the facility s audit list fo respiratory equipment. All MD or written will be taken to the next da	ist r ders ay⊡s ITI	
	for October 2013 idea receives Albuterol Su	ation Administration Record ntified that Resident #64 Ilfate P/F UD 2.5mg/3ml vial es per day at 8AM, 2PM and			meeting for review. Any Residen receiving an order for respiratory equipment will be added to the m Anyone having an order discontir	aster list	

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	10. 0938-039 FE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COI	MPLETED
		345180	B. WING		1	1/06/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	PINES RETIREMENT CO	ММ		1000 WESLEY PINES RD LUMBERTON, NC 28358		
(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 (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 328	 8PM. (According to L Handbook, 12th editive bronchodilator in airw asthma or Chronic Of Disease.) During an observation nebulizer was observe table uncovered. During an observation nebulizer was observe table uncovered. During an observation showed the nebulizer beside table uncovered. During an interview w on 11/6/13 at 8:55am nebulizers are to be r lock bag after use. Ex #2 Resident #71 w 8/19/13 with diagnostic for the month of Nove that Resident #71 wa treatments via a hand diagnosis of Pneumo Observations were m The nebulizer, includi be sitting on the night 	exi-Comp's Drug Reference on, Albuterol is used as a vay obstruction due to bstructive Pulmonary n on 11/4/13 at 4:10pm the red sitting on the bedside n on 11/5/13 at 8:35am the red sitting on the bedside n on 11/6/13 at 8:45am r was observed sitting on the ed. with the Director of Nursing o she stated that all rinsed and bagged in a zip was admitted to the facility on es including Pneumonia. ation Administration Record ember 2013 documented is receiving respiratory d-held nebulizer for the nia. hade on 11/5/13 at 12:00PM. ing mask, was observed to	F 32	be stricken from the list. The MD will also be checked for an appropriately attending the ITM will be responsi amend the Resident s care plan appropriately. All nursing staff will be in serviced importance and necessity of storir respiratory equipment correctly. All Residents with respiratory equipment correctly. All Residents with respiratory equipment is stored properly. will then be performed weekly for months and thereafter will be perf quarterly as part of the facility of program. Any deficient practice will result in responsible employees being retration. Any employee that fails on three coccasions to store the equipment will be disciplined per the facility progressive disciplinary policy, up including termination.	ained. or more properly s	

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2013 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345180	B. WING _			11/	06/2013
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WESLEY	PINES RETIREMENT CO	мм			000 WESLEY PINES RD .UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 328	The nebulizer was ob nightstand, without a tubing uncovered. During an interview w 8:55am she stated that rinsed and bagged in Ex. 3 Resident # 2 wa 9/28/04 and readmitted including obstructive and Review of Resident # documented a Physica apply continuous posis machine (CPAP) at bo remove every morning During an observation CPAP face mask was bedside table uncove During an observation CPAP face mask was bedside table uncove During an observation CPAP face mask was bedside table uncove During an interview w she stated that the CF covered with a bag to During an interview w	served to be sitting on the mask, with the end of the ith the DON on 11/6/13 at at all nebulizers are to be a zip lock bag after use. as admitted to the facility on ed on 11/1/11 with diagnosis sleep apnea. 2 ' s clinical record ian ' s Order dated 5/2/12 to tive airwave pressure edtime at 17 cm water, g. n on 11/5/13 at 9:36 AM the observed sitting on the red. n on 11/5/13 at 1:50 PM the observed sitting on the red. n on 11/6/13 at 8:42 AM the observed sitting on the red. ith Resident #2 ' s Nurse PAP mask is supposed to be protect the mask. ith the Director of Nursing 1 she stated that the CPAP	F 3	328			

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				CONSTRUCTION	OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345180	B. WING		11/06/2013	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	PINES RETIREMENT CO	ММ		000 WESLEY PINES RD UMBERTON, NC 28358		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	
F 329	Continued From page	e 11	F 329			
F 329 SS=D		483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			12/3/13	
	unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use	· •				
	resident, the facility n who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic al dose reductions, and ons, unless clinically n effort to discontinue these				
	by: Based on record rev interviews, the facility (5) sampled residents medications had a su anti-depressant medi	□ is not met as evidenced iew and staff and physician of failed to ensure (1) of five as reviewed for unnecessary ipporting diagnosis for an cation and failed to ensure ant medication use was #12).		F329 A nurse promptly called the affected Resident s attending physic and was given a diagnosis for the anti-depressant the Resident was tak The care plan nurse promptly amend the Resident s care plan to include behavior monitoring and placed a behavior monitoring form in the	ting.	

Facility ID: 923543

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/20 ⁷ FORM APPROVE MB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	RUCTION (X3) DATE S	
		345180	B. WING				11/06/2013
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	PINES RETIREMENT CO	MM			000 WESLEY PINES RD		
			LUMBERTON, NC 28358				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 12	F	329			
	The findings include:	dmitted to the facility on			Resident⊟s medical record. Any Resident taking anti-depres medication has the potential to affected. Therefore, a list of all	be	
	3/19/13 and re-admit with diagnoses includ Disease, Hypertensid			anti-depressants being used by Residents was obtained from th pharmacy. Each Resident on th audited to ensure that a proper	r facility ne he list was		
	and Degenerative Jo			was in the medical record and a care planning was in place to m	appropriat	e	
	(MDS) Assessment of an active diagnosis of			behavior of the Resident and th of the medication.	e effects		
		ss documented no, never.			All Residents receiving anti-dep drug therapy have an appropria diagnosis in their medical record	ate d, as well	
	Resident #12 did not of an Anti-Depressan	have a care plan for the use t.			as behavior monitoring in place Going forward, we will request f pharmacy a report listing all		
		al Discharge summary dated t a diagnosis of Depression.			anti-depressant medications in the Residents receiving the med This will be our initial master list	dications.	
	Medication Administr	, April, May, and June 2013 ation Record showed no tation that the resident was			review all MD orders during the meeting each weekday morning or delete names to or from the r	g and add	
		pressant medication Zoloft.			as MD orders are received. In t that a GDR has been ordered, t	that will be	9
		d from the hospital on mentation of an order for			noted as well. At least one of th nurses will be in attendance at a meeting and will therefore be as need to amend a Resident s ca	each ITM ware of th	e
	and signed by the fac an order for Zoloft 25	ian ' s orders dated 7/19/13 cility physician documented milligrams to be given each t did not have a diagnosis to			according to the MD orders give MDS nurse will amend the care implement a behavior monitorin the Resident□s chart.	plan and	
	support the indication	n for the use of Zoloft.			When the monthly pharmacy re received they will be compared	to the	
	Review of the Medication Administration Record dated July 2013 documented that Zoloft 25milligrams each evening was started on				master list by nursing administration ensure that the pharmacy has a and/or deleted Residents per th	added	

Event ID: GQXK11

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		ND HUMAN SERVICES MEDICAID SERVICES				RINTED: 12/17/2013 FORM APPROVED MB NO. 0938-0391
STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345180	B. WING			11/06/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
WESLEY	PINES RETIREMENT CO	57.54		1000 WESLEY PINES RD		
WESEET				LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 329	month of behavior ma The behaviors listed Changes and Insomr evenings were listed Review of the Pharm 2013 through Octobe notes in reference to recommendations for Zoloft. During an interview v Nursing on 11/5/13 a is not a listed diagnos medication. During an interview v 11/5/13 at 4:15pm he every medication on Administration Recor beside it. He further physician accepts the the physician is respo every medication has During an interview v on 11/6/13 at 8:30am expected that each n appropriate diagnosis be done on resident During an interview v at 2:20pm he stated i diagnosis for each m	al record documented one onitoring for August 2013. were Restlessness, Mood hia. All days, nights and as 0 or unchanged. acy Progress Notes for July er 2013 did not reflect any the Zoloft or r a diagnosis for the use of with the Assistant Director of t 2:04pm he stated that there sis for the use of the with the Administrator on e stated that he wished that the Medication d would have a diagnosis stated that when the e resident as his patient, then onsible for making sure a diagnosis. with the Director of Nursing n she stated that it is nedication in use have an a and that monitoring would 's requiring the use of	F 3	29 orders. The audit will order for a GDR has recorded by the phar The DON or her desi- weekly chart audit of chart that has had an added or discontinue GDR within the past of determine that the an appropriate diagnosis appropriate care plan monitoring has been discontinued as appro- weekly audits will be times 3 months. A m be implemented as a the facility S QAPI pr The NHA and DON re pharmacy recommen MDs response has be ensure that recommen reductions and duplic been addressed appr attending physicians. A root cause analysis any discrepancies for determine where the Appropriate action wi the discrepancy and a breakdown in the sys	been properly macy. gnee will perform a each Resident □s a anti-depressant d, or an order for a week. The audit wil nti-depressant has a s in the chart and that ning and behavior put in place or eithe opriate. These performed weekly nonthly audit will then n on-going part of rogram. eview each month □ ndations after the een recorded to endations for dose cate therapy have ropriately by the s will be performed of breakdown occurred address the	l n at r n s

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	-	ND HUMAN SERVICES			PRINTED: 12/17/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345180	B. WING		11/06/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESLEY I	PINES RETIREMENT CO	мм		1000 WESLEY PINES RD LUMBERTON, NC 28358	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 329	Continued From page	e 14	F 32	29	
F 428 SS=D	medical record. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON		F 42	28	12/3/13
		each resident must be e a month by a licensed			
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.				
	by: Based on record rev Consulting Pharmacia interview, the facility irregularity in the med identified and reported	st interview and Physician failed to ensure that an		F428 During survey, Resid found to have an anti-depress prescribed with no diagnosis a planned approaches to monito of the anti-depressant medical learning this, a facility nurse of attending physician and was g	ant and no care or the effects tion. Upon ontacted the
	The findings include:			diagnosis for the prescribed anti-depressant. The nurse management team	has
	Resident # 12 was ac Resident was admitter re-admitted on 3/27/1 diagnoses including (Hypertension, Anemi Degenerative Joint D	ed on 3/19/13 and I3 and 7/19/13 with Coronary Artery Disease, a, Osteoarthritis and		reviewed each Residents □ M/ medical records to ensure that medication has a proper diagn medications found to not have appropriate diagnosis resulted the attending physician to eith discontinue the medication or	t every nosis. Any e an I in a call to er
	(MDS) Assessment d	rterly Minimum Data Set lated 9/17/13 did not reflect f Depression under section I.		proper diagnosis. The admiss coordinator has been instructe upon a diagnosis for each mee	sions ed to insist

Facility ID: 923543

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLE NAME OF PROVIDER OR SUPPLIER 345180 B. WING 11/06 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/06 WESLEY PINES RETIREMENT COMM SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 12/17/20 [/] RM APPROVE VO. 0938-039
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE 2JP CODE WESLEY PINES RETIREMENT COMM STREET ADDRESS. CITY, STATE 2JP CODE (VA) ID PRESERTING MARKING CONSTRUCTION PROVIDER OR SUPPLIER (VA) ID PRESERTING MARKING CONSTRUCTION FORMATION) PROVIDER OR SUPPLIER (VA) ID PRESERTING MARKING CONSTRUCTION FORMAT	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		CONSTRUCTION (X3) DA	
1000 WESLEY PINES RE LUBERTON, NC 23835 CMUDERS FLAN OF CORRECTION (EACH OPERCIENCY MAY STREMENT OF DEFICIENCES (EACH OPERCIENCY MAY IS DEPORTERY ING INFORMATION) PROVIDERS FLAN OF CORRECTION (EACH OPERCIPACY MAY IS DEPORTERY RECEIPTION OR LSC DEPTRY ING INFORMATION) PROVIDERS FLAN OF CORRECTION (EACH OPERCIPACY ALLO OF CORRECTION (EACH OPERCIPACY (EACH OPERCIN			345180	B. WING		1	1/06/2013
WESLEY PINES RETIREMENT COMM LUMBERTON, NC 2338 (M) ID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH ECREMENT WIST REPRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION) PROVIDENTIFYING INFORMATION) F 428 Continued From page 15 F 428 Continued From page 15 F 428 Review of the Hospital Discharge summary dated 7/19/13 did not reflect a diagnosis of Depression. F 428 F 428 Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication Administration Records for March 2013 through June 2013 showed no order for or documentation that the resident was receiving the anti-depressant medication Zoloft. The resident returned from the hospital on 7/19/13. The hospital discharge orders were reviewed. There was no documentation of a order for Zoloft. The resident returned from the hospital on 7/19/13 documented that Zoloft an order for Zoloft. MAR had a diagnosis lated, view a diagnosis printed by the facility physician documented an order for Zoloft. Review of the Physician's orders dated 7/19/13 and signed by the facility physician documented an order for Zoloft. Apart of the monthly MARs review, the nursing team will ensure that henceforth, each medication. As a a part of the monthly MARs review, the nursing team will ensure that henceforth, each medication for a diagnosis for the use of Zoloft. During an interview with the Assistant Director of Nursing on 11/5/13 at 2.04 pm hs stated that the resorted to the QA committee by the consultant pharmacist.	NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
Displaying the provided stated and the physician's orders for March 2013 F 428 Continued From page 15 F 428 Review of the Hospital Discharge summary dated 7/19/13 did not reflect a diagnosis of Depression. Administration Records for March 2013 through June 2013 and review of the Medication and freework on order for or documentation that the resident was receiving the anti-depressant medication Zoloft. F 428 F 428 Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication Administration Records for March 2013 through June 2013 and review of the Medication and free the spital discharge orders were reviewed. There was no documentation of an order for Zoloft. F 428 F 428 Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication and that the resident was receiving the anti-depressant medication Zoloft. F 428 Review of the Physician's orders dated 7/19/13. The hospital discharge orders were reviewed. There was no documentation of an order for Zoloft. F 428 F 428 Review of the Physician's orders dated 7/19/13 and signed by the facility physician documented that 2/19/13 and signed by the facility physician documented that Zoloft 2/213. F 428 F 428 Review of the Pharmacy Progress Notes for July 2013 through October 2013 did not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the use of Zoloft. F aview of the Pharmacy Progress Notes for July 2013 through October 2013 did not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the u	WESLEVE		5454		1000 WESLEY PINES RD		
PREFIX TAG LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG LEACH DEFICIENCY F 428 Continued From page 15 F 428 Form the physician viting the admitting 0rders. In the event that the event that medication. The rusident returned from the hospital on 0rder for Zoloft. Review of the Physician 's orders dated 7/19/13 and signed by the facility physician documented an order for Zoloft 25milligrams to be given each evening. The resident did not have a diagnosis to support the indication for the use of Zoloft. The consultant Pharmacist will monitor all new orders to assure that a indication with a supporting diagnosis is documented for all medications. A consult will be generated to the attending Physical for any missing information. A quart of the metation physical consultant pharmacist.	WEDLETT				LUMBERTON, NC 28358		
 Review of the Hospital Discharge summary dated 7/19/13 did not reflect a diagnosis of Depression. Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication Administration Records for March 2013 through June 2013 showed no order for or documentation that the resident was receiving the anti-depressant medication Zoloft. The resident returned from the hospital on 7/19/13. The hospital discharge orders were reviewed. There was no documentation or for Zoloft. Review of the Physician 's orders dated 7/19/13 and signed by the facility physician documented an order for Zoloft. Review of the Physician of the use of Zoloft. Review of the Medication Administration Record dated July 2013 documented that Zoloft 25milligrams each evening was started on 7/22/13. Review of the Pharmacy Progress Notes for July 2013 through October 2013 di not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the use of Zoloft. During an interview with the Assistant Director of Nursing on 11/5/13 at 2:04pm he stated that the resident tain indication for the use of Zoloft. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETION DATE
Review of the Hospital Discharge summary dated orders. 7/19/13 did not reflect a diagnosis of Depression. orders. Review of the Physician's Orders for March 2013 through June 2013 and review of the Medication Administration Records for March 2013 through ant enview of the Medication Zoloft. The resident returned from the hospital on 07/19/13. The hospital discharge orders were reviewed. There was no documentation of an order for Zoloft. The resident featured for the facility physician documented an order for Zoloft. Review of the Physician's orders dated 7/19/13 and signed by the facility physician documented dated July 2013 documented that Zoloft 25milligrams to be given each evening. The resident did not have a diagnosis to support the indication Administration Record dated July 2013 documented that Zoloft 25milligrams each evening was started on 7/22/13. The consultant Pharmacist will monitor all new orders to assure that an indication. A quarterly compliance report will be presented to the QA committee by the consultant pharmacist. Review of the Pharmacy Progress Notes for July 2013 through October 2013 did not reflect any notes in reference to the Zoloft or recommendations for a diagnosis for the use of Zoloft. The consultant pharmacist. During an interview with the Assistant Director of Nursing on 11/6/13 at 2:04pm he stated that tthe resident has indicators for being the medication A quarterly compliance report will be presented to the QA committee by the consultant pharmacist.	F 428	Continued From page	e 15	F 4	28		
During an interview with the Administrator on		7/19/13 did not reflect Review of the Physic through June 2013 at Adminstration Record June 2013 showed n that the resident was anti-depressant medi The resident returned 7/19/13. The hospital reviewed. There was order for Zoloft. Review of the Physic and signed by the fac an order for Zoloft 25 evening. The residen support the indication Review of the Medica dated July 2013 docu 25milligrams each ew 7/22/13. Review of the Pharm 2013 through Octobe notes in reference to recommendations for Zoloft. During an interview w Nursing on 11/5/13 a resident has indicato but no listed diagnost	et a diagnosis of Depression. ian's Orders for March 2013 nd review of the Medication ds for March 2013 through o order for or documentation receiving the ication Zoloft. d from the hospital on d discharge orders were is no documentation of an ian 's orders dated 7/19/13 cility physician documented imilligrams to be given each it did not have a diagnosis to n for the use of Zoloft. ation Administration Record umented that Zoloft rening was started on acy Progress Notes for July er 2013 did not reflect any the Zoloft or a diagnosis for the use of with the Assistant Director of t 2:04pm he stated that the rs for being the medication is.		 orders. In the event that if physician does not give a each medication, the nurst team will contact the Resi attending physician to obtor an order to discontinue. The nurse management to each Resident s current of the exercise stated aborensured that each medicated MAR had a diagnosis alrewritten in. These MARs had a diagnosis alrewritten in. These MARs hat to the pharmacy with the renter all the diagnosis into so the next month MAR had a diagnosis printed by each a part of the monthly MAF nursing team will ensure the each medication has a diaby it. The consultant Pharmacis new orders to assure that with a supporting diagnosi documented for all medication for any missing A quarterly compliance represented to the QA comrese to the pharmace in the physician for any missing A quarterly compliance represented to the QA comrese to the pharmace in the pharmace is the pharmace in the physician for any missing A quarterly compliance represented to the QA comrese to the pharmace is the pharmace in the pharmace is the pharmace is the pharmace in the pharmace is the pharmace is	the admitting diagnosis for se management ident □s sain a diagnosis the medication. eam printed MAR. As a part ove, the team ation on each eady listed, or nave been sent request that they their database Rs will have a medication. As Rs review, the that henceforth, agnosis printed st will monitor all an indication is is ations. A consult ttending information. port will be	

Facility ID: 923543

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2013 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345180	B. WING			11/	06/2013
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	PINES RETIREMENT CO	MM			000 WESLEY PINES RD .UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	 11/5/13 at 4:15pm he every medication on the every medication on the Administration Record He further stated that the resident as his paresponsible for making a diagnosis. During an interview woon 11/6/13 at 8:30am expected that each mappropriate diagnosis During an interview woon 11/6/13 at 9:28am resident #12 had initia medication in May 20 and then re-started. believed she had a diagnosis. During an interview woat 2:20pm he stated right will notice a medication will make a recomme diagnosis. It is importante the started is the started of the star	stated that he would expect he Medication d have a diagnosis beside it. when the physician accepts tient, then the physician is g sure every medication has ith the Director of Nursing she stated that it is edication in use have an	F	428			

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