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	345423	A. BUILDING _____ B. WING _____	03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON REHABILITATION AND NURSING CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

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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 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	F 550		4/20/18

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

Electronically Signed | 04/16/2018

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F 550	Continued From page 1 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 interviews, the facility failed to provide care to maintain dignity by not responding to call lights for residents that required assistance with toileting which resulted in the residents soiling themselves (Residents #56 and #57) for 2 of 18 residents and failed to provide care in a dignified manner by standing beside the bed to feed residents for 2 of 18 residents (Residents #20 and #30). Findings included: 1-Record review revealed Resident #56 was admitted to the facility on 10/27/2014 with diagnoses which included Chronic Kidney Disease and Hypertension. Review of the quarterly Minimum Data Set (MDS) dated 2/9/2018 indicated Resident #56 was cognitively intact and required the assistance of 1 staff member for all activities of daily living (ADLs). The MDS further indicated the resident was occasionally incontinent of bowel and bladder. Review of Resident #56's Care Plan revised on 2/9/2108 revealed a focus of a self care deficit related to deconditioning, weakness, impaired mobility and overall status. The interventions included staff to answer call bell promptly and extensive assistance with toileting. An observation and interview was conducted with Resident #56 on 3/20/2018 at 10:21 AM. Resident #56 was in bed, well kept and alert	F 550	An explanation of call bell response time was explained to residents affected by this alleged deficiency on 4/16/18 by nursing supervisor. All staff to be in-serviced on proper answering of call bells to be answered in 15 minutes and to sit with residents that need assistance during feeding times. The Director of Nursing will be responsible for this education from 4/15/2018 to 4/19/2018 The Administrator and/or designee will conduct quality Improvement Monitoring of resident to ensure staff who are assisting residents with eating are sitting with residents while feeding. Quality improvement monitoring will be conducted by checking five residents five days per week for 4 weeks and then five residents three days per week for eight weeks, and/or until substantial compliance is reached. The Administrator and/or designee will conduct quality Improvement Monitoring of resident rooms to ensure timely call light response (within 15 minutes) from staff. Quality improvement monitoring will be conducted by checking five rooms five days per week for 4 weeks and then five rooms three days per week for eight weeks, and/or until substantial compliance is reached. The results of these weekly audits will be	

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F 550	Continued From page 2 and oriented. There was an empty urinal on the bed rail. Resident #56 stated he was unable to get up and toilet himself. The resident indicated he waited a long time for the staff to answer his call bell. He stated sometimes it would be 45 minutes and he would have soiled himself when the staff finally arrived. The resident said he tried to keep the urinal on his bed rail so he could reach it but sometimes the staff would empty it and leave it in the bathroom. The resident stated he felt lousy when he soiled himself. The resident indicated he felt the staff did the best they could and he felt sorry for them because he knew there was not enough help. The resident stated the staff would apologize when they were unable to get to him in time to avoid an accident. An interview was conducted with Nursing Assistant (NA) #10 on 3/21/2018 at 4:37 PM. NA #10 indicated she worked with resident #56 and he was on her regular assignment. NA #10 stated there were days when there was not enough staff and the care did not get completed timely. The NA indicated she recalled times when Resident #56 would have an incontinent episode because she was unable to get to him in time after he called for assistance. NA #10 stated she would apologize to the resident. A telephone interview was conducted with Nursing Assistant (NA)#12 on 3/21/2018 at 6:18 PM. NA #12 stated she worked mostly days (7:00 AM-3:00 PM) and was familiar with Resident #56 and his care needs. NA #12 indicated there were days when she was unable to get to Resident #56 in time to toilet him when he called for assistance. NA #12 indicated the staff tried to work together but the care needs on the hall were heavy and it took a long time to get things done. NA #12	F 550	reported to the Quality Assurance Performance improvement Committee monthly by the Director of Nursing for 3 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and to make changes to the corrective action to maintain substantial compliance. The Administrator will be responsible for this plan of correction. Facility will be in substantial compliance as of April 20th, 2018.	

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indicated if there were only one or 2 on the hall during the day shift, the care could not be completed timely and some care could not be completed at all.

A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated she was aware there were residents who did not get the care they needed timely which caused some continent residents to have incontinent episodes. The DON indicated the lack of available staff was the primary reason lights were not answered timely. The DON further indicated the residents needed to be cared for and ensured dignity was maintained. The DON stated the expectation was call lights would be answered timely to ensure dignity be maintained for all the residents.

2-Record review revealed Resident #57 was admitted to the facility on 5/9/2017 with diagnoses which included Congestive Heart Failure and abnormalities of gait and mobility.

Review of the quarterly Minimum Data Set (MDS) dated 2/12/2018 revealed Resident #57 was cognitively intact and required extensive assistance of 1 person with all activities of daily living (ADLs). The MDS indicated the resident was frequently incontinent of bladder.

Review of the Care Plan with revision date of 2/12/2018 revealed a focus of a self care deficit with interventions which included to assist with toileting frequently and as needed and to answer call bell promptly.

An observation and interview was conducted with Resident #57 on 3/20/2018 at 10:54 AM. The

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resident was observed sitting in her room in a wheel chair. The resident was well kempt and alert and oriented. The resident indicated she had to wait a very long time some days for her call bell to be answered. The resident stated she understood the nursing assistants had other people to take care of and were very busy. The resident stated there have been times when she called for assistance to go to the bathroom and staff would not respond and she would soil herself. The resident stated it was a terrible feeling when she knew she had to go to the bathroom and no one came. The resident stated it made her feel terrible to wet herself.

A telephone interview was conducted with Nursing Assistant (NA)#12 on 3/21/2018 at 6:18 PM. NA #12 stated she worked mostly days (7:00 AM-3:00 PM) and was familiar with Resident #57 and her care needs. NA #12 indicated there were days when she was unable to get to Resident #57 in time to toilet her when she called for assistance. NA #12 indicated the staff tried to work together but the care needs on the hall were heavy and it took a long time to get things done.

An interview was conducted on 3/22/2018 at 2:41 PM with Nursing Assistant (NA) #11. NA #11 confirmed she worked with Resident #57 often. NA #11 stated the resident was incontinent at times but there were times when the resident knew she needed to go. The NA stated there had been times the resident called to go to the bathroom and she was unable to get to the resident because there was not enough staff on the hall. NA #11 stated Resident #57 would apologize when she had an incontinent episode due to the wait time. NA #11 indicated she felt bad for the resident when she would apologize

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F 550	Continued From page 5 because it was not the resident's fault. A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated she was aware there were residents who did not get the care they needed timely which caused some continent residents to have incontinent episodes. The DON indicated the lack of available staff was the primary reason lights were not answered timely. The DON further indicated the residents needed to be cared for and ensured dignity was maintained. The DON stated the expectation was call lights would be answered timely to ensure dignity be maintained for all the residents. 3. A review of the medical record revealed Resident #22 was admitted 9/9/2014 with diagnoses of dementia, Alzheimer's disease, depression, and right shoulder, elbow and wrist stiffness. The Annual Minimum Data Set dated 6/22/2017 noted Resident #22 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADL), with the physical assistance of one or two persons. The Care Area Assessment noted an area of cognitive loss/ dementia and communication and these areas went to care planning.	F 550		

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The care plan dated 7/7/2016 indicated Resident #22 had an ADL care deficit and an intervention of staff would provide extensive assistance with eating both meals and snacks.
On 3/19/2018 at 12:40 PM, Nursing Assistant (NA) #1 was observed to be standing by the bed of Resident #22, feeding the Resident lunch. Without prompting, NA #1 stated she was supposed to be sitting to assist Resident #22 to eat. NA #1 stated she was taught to sit during feeding at another facility.
On 3/22/2018 at 10:10 AM, the Nursing Supervisor stated she thought anyone who was feeding should stand to feed residents. The Nursing Supervisor was shown the regulation and said she understood.
On 3/22/2018 at 11:00 AM, the facility Administrator was made aware of the regulation and stated he would start an in-service. The Administrator stated he expected staff to follow the regulations.

4. A review of the medical record revealed Resident #30 was admitted 5/9/2014 with diagnoses of COPD, Congestive Heart Failure, anxiety, dementia, dependence on oxygen supplement and Peripheral Vascular Disease.
The quarterly Minimum Data Set (MDS) noted Resident #30 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the assistance of one to two persons.
On 3/22/2018 at 8:20 AM NA #2 was observed to be sanding and feeding Resident #30. The Nursing Supervisor was noted to enter Resident #30's room and try and wake her and encourage her to eat. The Nursing supervisor was standing while in the room. The facility Administrator also went into Resident #30's room and attempted to

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F 550	Continued From page 7 feed her while standing. On 3/22/2018 at 10:00 AM NA #2 stated she was taught to sit while assisting residents to eat. On 3/22/2018 at 10:10 AM, the Nursing Supervisor stated she thought anyone who was feeding should stand to feed residents. The Nursing Supervisor was shown the regulation and said she understood.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		4/20/18

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F 561	Continued From page 8 facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor residents' choices by not providing showers as scheduled for 3 of 18 residents (Resident #8, Resident #56 and Resident #57). Findings included: 1-Record review revealed Resident #8 was admitted to the facility on 11/27/2017 with diagnoses which included left sided hemiplegia (paralysis) following a stroke and Congestive Heart Failure. Review of the Admission Minimum Data Set (MDS) dated 11/29/2107 revealed Resident #8 was cognitively intact and required the extensive assistance of 1 person for all his activities of daily living (ADLs). The MDS also revealed it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #8's care plan dated 11/27/2107 included a focus of a self-care deficit with interventions which included to provide assistance of 1 person with showers twice a week. Review of the facility grievances reveled a grievance form submitted by Resident #8 dated 3/8/2018 which indicated the resident reported he did not get showers twice a week. The grievance form included a resolution which listed the resident's showers were added to the MD orders to ensure they were given as scheduled.	F 561	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #8, #56 and #57 were given showers per the residents choice of time per shower schedule by nursing staff. The Nurse supervisors will conduct quality Improvement Monitoring of resident showers to ensure residents who are supposed to get showers will be offered showers. Quality improvement monitoring will be conducted by a nurse supervisor verifying showers on five residents five times each week for four weeks and then five residents three days per week for eight 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 Nursing for 3 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and to make changes to the corrective action to obtain substantial compliance. The	

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F 561	Continued From page 9 Record review revealed an entry on 3/9/2018 by the facility Social Worker (SW). The note indicated it was a late entry note from 3/8/2018. The note indicated an interdisciplinary team meeting was conducted and Resident #8 reported he was not getting showers twice a week. The note further reported the resident requested his showers be completed as scheduled. A review of the Facility Shower Policy revised on 10/2017 with the next revision date listed as 10/2020 revealed residents were to be offered showers two times a week and placed on a schedule for the Certified Nursing Assistants (CNAs). A review of the Bath/Shower Schedule located at the Nurses Station revealed Resident #8 shower days were Wednesday and Saturdays on the 3:00 PM to 11:00 PM shift. An observation and interview was conducted with Resident #8 on 3/20/2018 at 2:47 PM. Resident #8 was sitting in a wheelchair in his room watching television. The resident was alert and oriented. The resident reported he took a shower every day at home prior to coming to the facility. The resident stated he did not get showers as scheduled. The resident stated he was not offered showers most of the time and when he requested a shower he was told there was not enough staff to take him to the shower. An interview was conducted with Nursing Assistant (NA) #10 on 3/21/2018 at 4:37 PM. NA #10 confirmed she worked with Resident #8 often as he was on her regular assignment. NA #10 reported the resident shower assignments sheets are located at the nursing station. NA #10	F 561	Director of Nursing will be responsible for this plan of correction. Facility will be in substantial compliance as of April 20th, 2018.	

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revealed there were evenings when showers were not completed. NA #10 indicated when they are short staffed there just is not enough time to get the showers completed.

A telephone interview was conducted with Nursing Assistant (NA) #12 on 3/21/2018 at 6:18 PM. NA #12 reported she worked most of the time on the 7:00 AM to 3:00 PM shift and did work some 3:00 PM to 11:00 PM shifts. NA #11 reported stated there were shifts she was unable to complete the showers listed on the assignment sheet due to the number of residents she was responsible for. NA #11 indicated there was not time to get the showers completed on most of the shifts she worked.

A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON indicated she was aware of Resident #8 not getting his scheduled showers. The DON stated she had spoken with the nursing assistants and the nurses regarding the resident's request to ensure showers were completed. The DON stated she also gave the resident her personal cell phone number and instructed him to call her if he did not get a shower by 9:00 PM on his scheduled shower days. The DON said the resident told her he didn't call her because he didn't want to bother her at home. The DON stated the expectation was for showers to be completed twice a week.

An interview was conducted with Nursing Assistant (NA)#11 on 03/22/18 4:26 PM. NA #11 reported Resident #8 was on her regularly assigned hall. NA #11 indicated there were times she was unable to complete the assigned showers because the care on the hall is heavy

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and there is not enough staff or time to get the showers completed.

An interview was conducted with the Administrator on 3/23/2018 at 3:22 PM. The Administrator stated the facility policy was for showers to be completed twice a week and the expectation was showers would be completed per the facility policy.

2-Record review revealed Resident #56 was admitted to the facility on 10/27/2014 with diagnoses which included Chronic Kidney Disease and Hypertension.

Review of the quarterly Minimum Data Set (MDS) dated 2/9/2018 indicated Resident #56 was cognitively intact and required the assistance of 1 staff member for all activities of daily living (ADLs). The MDS further indicated the resident was occasionally incontinent of bowel and bladder.

Review of Resident #56's Care Plan revised on 2/9/2108 revealed a focus of a self-care deficit related to deconditioning, weakness, impaired mobility and overall status. The interventions included the resident was to have showers twice a week.

Review of the facility grievances revealed a grievance dated 2/15/2018 which indicated Resident #56 complained he did not receive scheduled showers twice a week. The grievance resolution was documented by the Director of Nursing (DON) on 2/23/2018 and indicated the DON listed the showers on the Medication Administration Record to ensure showers were

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completed. The MAR was reviewed and there were no documented showers given.
A review of the Facility Shower Policy revised on 10/2017 with the next revision date listed as 10/2020 revealed residents were to be offered showers two times a week and placed on a schedule for the Certified Nursing Assistants (CNAs).

A review of the Bath/Shower Schedule located at the Nurses Station revealed Resident #8 shower days were Monday and Thursdays on the 3:00 PM to 11:00 PM shift.

An observation and interview was conducted with Resident #56 on 3/20/2018 at 10:21 AM. Resident #56 was in bed, well kempt and alert and oriented. Resident #56 stated he was unable to get up independently. The resident stated he asked and asked for showers and final told someone up front he wanted some of his money back so he could hire someone to give him a shower. The resident stated he talked with the Director of Nursing (DON) and she gave him her personal cell number and instructed him to call if he didn't get a shower on his scheduled days. The resident indicated he never called her at home because she was busy and she needed some time without worry from work. and toilet himself. The resident stated the staff told him there was not enough help on the hall to take him to the shower.

An interview was conducted with Nursing Assistant (NA) #10 on 3/21/2018 at 4:37 PM. NA #10 indicated she worked with resident #56 and he was on her regular assignment. NA #10 stated there were days when there was not enough staff

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and the care did not get completed timely. The NA indicated she recalled times when Resident #56 did not get his scheduled showers. NA #10 stated she would apologize to the resident.

A telephone interview was conducted with Nursing Assistant (NA)#12 on 3/21/2018 at 6:18 PM. NA #12 stated she worked mostly days (7:00 AM-3:00 PM) and some evening shifts (3:00 PM to 11:00 PM). NA #12 indicated she was familiar with Resident #56 and his care needs. NA #12 indicated there were evenings when the staffing on the hall was low and the resident did not receive a shower. NA #12 indicated the staff tried to work together but the care needs on the hall were heavy and it took a long time to get things done.

A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated the expectation was for showers to be completed twice a week.

An interview was conducted with the Administrator on 3/23/2018 at 3:22 PM. The Administrator stated the facility policy was for showers to be completed twice a week and the expectation was showers would be completed per the facility policy.

3-Record review revealed Resident #57 was admitted to the facility on 10/27/2014 with diagnoses which included Chronic Kidney Disease and Hypertension.

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Review of the quarterly Minimum Data Set (MDS) dated 2/9/2018 indicated Resident #57 was cognitively intact and required the assistance of 1 staff member for all activities of daily living (ADLs).
Review of the Care Plan with revision date of 2/12/2018 revealed a focus of a self-care deficit with interventions which included to assist with all activities of daily living.

A review of the Facility Shower Policy revised on 10/2017 with the next revision date listed as 10/2020 revealed residents were to be offered showers two times a week and placed on a schedule for the Certified Nursing Assistants (CNAs).

A review of the Bath/Shower Schedule located at the Nurses Station revealed Resident #8 shower days were Tuesday and Friday on the 7:00 AM to 3:00 PM shift.

An observation and interview was conducted with Resident #57 on 3/20/2018 at 10:54 AM. The resident was observed sitting in her room in a wheel chair. The resident was well kempt and alert and oriented. The resident indicated she used to get showers but didn't anymore. The resident reported she asked in one of her Care Plan meetings (she did not remember when) why she did not get showers and they responded by asking her if she requested showers. The resident stated she told them she never had to ask for them before. The resident indicated the staff didn't ask her and she quit requesting because she was told there was not enough staff to give showers. The resident did not remember the last shower she received.

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An interview was conducted with Nurse #5 on LPN 03/21/18 at 2:52 PM. Nurse #5 indicated the shower schedule is on the assignment sheets and the nursing assistants are responsible for the showers. Nurse #5 reported sometimes the residents refused showers and she would document the refusal. Nurse #5 did not recall Resident #57 refusing a shower.

A telephone interview was conducted with Nursing Assistant (NA)#12 on 3/21/2018 at 6:18 PM. NA #12 confirmed she worked with Resident #57 on the 7:00 AM to 3:00 PM shift on Tuesday, 3/20/2018. NA #12 indicated she did not offer the resident a shower and stated she must have forgotten. NA #12 indicated there usually isn't enough staff to get the showers completed.

A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated the expectation was for showers to be completed twice a week.

An interview was conducted with Nursing Assistant (NA)#11 on 03/22/18 4:26 PM. NA #11 reported Resident #8 was on her regularly assigned hall. NA #11 indicated there were times she was unable to complete the assigned showers because the care on the hall is heavy and there is not enough staff or time to get the showers completed.

An interview was conducted with the Administrator on 3/23/2018 at 3:22 PM. The Administrator stated the facility policy was for showers to be completed twice a week and the expectation was showers would be completed per the facility policy.

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F 684	Continued From page 16	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews and record review, the facility failed to assess a resident for a wound and failed to schedule a wound clinic appointment for nine days for one of three residents reviewed for wound care (Resident #9). Findings included: A review of the medical record revealed Resident #9 was admitted 3/30/2015 with diagnoses of Osteoarthritis, visual loss in both eyes and anemia. The Quarterly Minimum Data Set (MDS) dated 3/2/2018, noted Resident #9 to be cognitively intact and needed extensive assistance for all Activities of Daily Living with the physical help of one person. The care plan dated 9/12/2017 noted a focus of risk for impaired skin integrity related to weakness and deconditioning. Interventions included: Notify MD of skin integrity issues as indicated. Observe skin integrity daily with care. Treatment as ordered.	F 684	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #9 is going to the wound clinic weekly and has since seen a partial healing of the wound. A full skin assessment of all patients in the facility will be completed by April 20th, 2018 by the nursing staff. Quality improvement skin assessments will be conducted by a nurse supervisor on five residents five times each week for four weeks and then five residents three days per week for eight weeks and/or until substantial compliance is reached. Any wound concerns will be referred to wound physician for further follow-up. Results of all the skin assessments will be submitted to the Quality Assurance	4/20/18

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F 684	Continued From page 17 A review of orders revealed an order dated 12/13/2016 for weekly skin checks on Tuesdays 7 - 3 shift, once daily every Tuesday, complete assessment. A review of the Treatment Administration Record (TAR) revealed an assessment was documented on 2/6/2018 and 2/13/2018, but no assessment was documented on 2/20/2018. A review of the progress notes dated 2/26/2018, revealed Resident #9 complained of pain to touch on the left side of the great toe on the right foot. Resident #9 rated the pain on a scale of zero to ten (zero being no pain and ten being the most painful) as a 4. Resident #9 refused pain medication. Nurse #1 noted purulent drainage from the toe. Nurse #1 applied antibiotic ointment and a dry dressing. Nurse #1 notified the physician and Resident #9 was started on an antibiotic twice daily for ten days. There was no order to send Resident #9 to the wound clinic. The progress notes were reviewed from 2/26/2018 until 3/7/2018, when it was noted Resident #9 had an appointment at the wound clinic that morning and further documents Resident #9 was sent to the hospital to be admitted for cellulitis. Resident #9 was readmitted to the facility on 3/11/2018. A review of the History and Physical (H & P) from the hospital admission on 3/7/2018 noted Resident #9 had a wound for the past 2 - 3 weeks and was on an antibiotic. The H & P indicated Resident #9 initially developed a blister which	F 684	Performance Improvement Committee by the Director of Nursing every month for 3 months or until substantial compliance has been obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and to make changes to the corrective action to obtain substantial compliance. The Director of Nursing will be responsible for this plan of correction. Facility will be in substantial compliance as of April 20th, 2018.	

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broke open 3 weeks ago. The documentation further stated redness and swelling had increased involving the entire foot and extending up the calf. The H & P also indicated the physician at the wound clinic sent Resident #9 to the hospital as a direct admit for intravenous (IV) antibiotics for right lower extremity cellulitis (inflammation in the tissues of the leg.)

A review of orders revealed no order for Resident #9 to be sent to the wound clinic, however, there was a progress note dated 3/12/2018 which indicated an appointment was made for Resident #9 at the wound care center for 3/14/2018 at 9:15 AM and transportation was arranged and Resident #9 and her family member were aware.

On 3/20/2018 at 3:13 PM, in an interview, Resident #9 stated her right great toe was red and swollen, and her family member told her that it needed to be looked at. Resident #9 stated a nurse saw it and put some medicine on it and later went to see a doctor at the wound clinic and he said I needed to go straight over to the hospital. Resident #9 stated she did go to the hospital and was admitted and stayed five days and got IV antibiotics.

Resident #9 stated the facility physician never looked at her toe, but did come into the beauty shop at the facility one day after she returned from the hospital, did not look at her toe, but wanted to know what happened about her toe and about spending five days in the hospital.

Resident #9 stated she had an appointment at the wound clinic on 3/21/2018 and hoped to get good news.

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F 684	Continued From page 19 A review of the notes from the 3/21/2018 wound clinic appointment revealed an open wound measuring 2.5 cm x 4.2 cm x 0.1 cm and noted to be decreasing in area. Resident #9 was observed for wound treatment on 3/23/2018 at 9:50 AM. The treatment was noted to be cleanse with normal saline, calcium alginate dressing applied and wrapped with dry gauze. Resident #9 tolerated well and had no complaints of pain. On 3/23/2018 at 2:20 PM in an interview, the Nursing Supervisor stated she did not know why Resident #9 was not sent to the wound clinic earlier. The Supervisor looked through the orders and stated there was no order to send Resident #9 to the wound clinic. The Supervisor stated her expectation was the staff would obtain an order for a resident to go to the wound clinic and would not wait nine days.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide supervision to prevent accidents, investigate each accident to determine causative factors, and implement interventions to prevent further	F 689	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or	4/20/18

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F 689	Continued From page 20 accidents for 1of 1 residents (Resident # 40) reviewed for accidents which resulted in numerous and continued falls. Findings included: Record review revealed Resident #40 was admitted to the facility on with diagnoses which included abnormalities of gait and mobility, muscle weakness and Dementia. A review of the documentation of a fall in service for nursing staff dated 11/22/2017 was completed. The in-service documentation included appropriate interventions for falls and how to complete the documentation for falls. A sign in sheet dated 11/22/2017 revealed signature indicated the information was received and the persons who signed would be held accountable for carrying out the duties and responsibilities of the falls in service information. There were 11 nurse signatures on the sign in sheet. Review of the annual Minimum Data Set (MDS) dated 1/17/2018 indicated Resident #40 was severely cognitively impaired and required extensive assistance of 1 person for all activities of daily living. The MDS indicated the resident was not stable and required staff assistance with surface to surface transfers and moving from a seated to standing position. The MDS indicated the resident had no impairments of her upper or lower extremities and used a wheelchair for mobility. Review of the Care Area Assessment (CAA) dated 1/17/2018 revealed Resident #40 was at risk for falls related to poor safety awareness, impulsiveness and the inability to retain	F 689	executed because it is required by provision of Federal and State regulations. Resident #40□s environment has been checked by the nurse supervisor for any identified potential accident hazards by nursing supervisor on April 13, 2018. Resident #40's care plan has been reviewed for further potential interventions for Resident #40 including toileting pattern review and therapy has assessed resident for potential new interventions. The physician has also completed a medication review for Resident #40 to help prevent future falls. All resident rooms will have been audited by the nursing supervisor to check for and ensure that resident areas are clear of any potential accident hazards by April 20, 2018. The Director of Nursing will provide education by April 20, 2018, to nursing staff in regards to checking resident rooms before and after care to ensure the environment is free and clear of any potential accident hazards and that Nurses will complete investigation sheet and put in a new intervention for each fall. Staffing patterns to be looked at around falls. Quality improvement monitoring will be conducted by a nurse supervisor five days per week for five resident rooms for four weeks, then five days per week for five resident rooms for eight weeks and/or until substantial compliance is obtained. All fall investigations and interventions will be reviewed during morning meeting to ensure that there is a new intervention in	

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F 689	Continued From page 21 information due to decreased cognition. The CAA indicated the area of falls would be care planned. Review of the Care Plan which was revised on 1/17/2018 with the Care Area Assessment for Resident #40 included a focus of falls related to poor balance, poor communication/comprehension, poor safety awareness and a history of falls. The goal was the resident would resume usual activities without further incident through the target date of 4/26/2018. There were numerous interventions documented in the care plan with the most current interventions listed as: bed in low position, fall mat at bedside, bed alarm, non-slip mat to wheelchair cushion, anti-roll back brakes on wheelchair and resident to be toileted every 2 hours. Review of Resident #40's medical record revealed facility Fall Risk Assessments. The Fall Risk Assessments listed a score of 16 or higher as a high risk for falls. Resident #40's falls risk score was 30 on 1/17/2018, 21 on 3/11/2018 and 21 on 3/18/2018. The following fall investigations from 1/1/2018 through 3/18/2018 for Resident #40 were reviewed with circumstances and interventions listed: 1/1/18 at 6:14 PM-Resident was found on the floor beside her bed. No new fall interventions documented. 1/2/2018 at 3:29 AM- Resident was found sitting on the floor beside her bed, bed alarm was sounding. The resident was transported to the Emergency Room for evaluation for a hematoma to the left side of her head and returned to the	F 689	place for each fall. QAPI Committee to meet weekly x8 and then as needed to review results of the interventions initiated for effectiveness and will make system changes as needed based on weekly monitoring. Results of all the fall investigations will be submitted to the Quality Assurance Performance Improvement Committee by the Director of Nursing every month for 3 months or until substantial compliance has been obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and to make changes to the corrective action plan as necessary. The Director of Nursing will be responsible for this plan of correction. Completion of this plan of correction will be in place on April 20th, 2018.	

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facility with no new orders. No new fall interventions documented.
1/4/2018 at 7:10 AM-Resident was found sitting on the floor outside of her room door. No new fall interventions documented.
1/6/2018 at 12:49 PM-Resident was found sitting on the mat beside her bed. No new fall interventions documented.
1/7/2018 at 10:12 PM-Resident was found at the entrance of the dining room sitting on the floor. An order for a urinalysis was obtained and an antibiotic was stated for a urinary tract infection on 1/8/2018.
1/9/2018 at 3:53 PM-Resident was found in her room on the floor. No new fall interventions documented.
2/6/2018 at 10:19 AM-Resident was observed to be scooting on the floor in the hallway in front of her wheelchair. Physical Therapy evaluation for strengthening was ordered. The resident was not a candidate for therapy due to her inability to retain instructions.
2/9/2018 at 5:15 AM-Resident was found on the floor in her room. No new fall interventions documented.
2/25/2018 at 11:30 PM- Resident was found on the floor in another resident's room. No new fall interventions documented.
3/2/2018 at 10:32 AM-Resident was found on the floor in her bathroom. No new fall interventions documented.
3/3/2018 at 8:19 AM- Resident was found sitting on the floor in her room. The intervention documented was the resident was to be supervised during breakfast.
3/4/2018 at 9:00 AM-Resident was found on the floor in her bathroom. The intervention documented was the resident was to be toileted in bathroom after each meal.

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F 689	Continued From page 23 3/10/2018 at 2:12 PM-Resident found on the floor in her room. No new fall interventions documented. 3/11/2018 at 12:30 AM-Resident was found on the floor beside her bed. No new fall interventions documented. 3/11/2018 at 10:31 PM-Resident was found sitting on the floor on another hall. No new fall interventions documented. 3/12/2018 at 11:16 AM-Resident was found in the hallway on the floor. The intervention documented was to ensure the resident was properly positioned in the wheelchair. 3/16/2018 at 1:40 AM-Resident fell from her wheelchair while she was in her bathroom. No new fall interventions documented. 3/18/2018 at 4:01 AM-Resident was found on the floor in the hallway. No new fall interventions documented. An observation of Resident #40 was conducted on 3/19/2018 at 12:18 PM. The resident was in her wheelchair in the facility dining room eating lunch. There was a staff member in the dining room assisting the residents with set up for the meal. The resident was observed eating after tray set up. A continual observation of Resident #40 was conducted on 3/21/2018 from 3:30 PM to 4:30 PM. The resident was observed in her wheelchair in the hallway beside the nurse's station. The resident was observed sleeping in her wheelchair during the entire observation time. The resident was leaned forward with her hands in her lap and her head was rested on her knees. The resident's back was not touching the back of the chair. Multiple staff members passed by her during the observation and no attempts were made to	F 689		

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reposition the resident.

An interview was conducted with Nursing Assistant (NA) #10 on 3/21/2018 at 4:37 PM. NA #10 indicated she cared for Resident #40. NA #10 stated she was aware of the resident's continued falls. NA # 10 indicated she tried to watch the resident but sometimes there are not enough nursing assistants to get all the care done or to provide the supervision the resident needs.

A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated she was very familiar with Resident #40 and her continued falls. The DON reported the nursing staff were in serviced on falls and interventions. The DON stated the staff were not consistently implementing new interventions for each of the resident's falls. The DON stated there was a daily clinical meeting and the falls were discussed during the meeting with interventions reviewed. The DON indicated the staff were not consistently making sure the interventions were followed when they were put in place. The DON stated the facility did not have enough staff to provide the supervision Resident #40 required. The DON reported the expectation was the facility would provide adequate supervision for Resident #40 and the other residents in the facility.

An observation was made of Resident #40 on 3/22/2108 at 8:04 AM. The resident was observed sitting in her wheelchair beside the bed with the bedside table in front of her. The resident was eating breakfast. There were no staff members in the room with the resident during the meal. Nursing Assistant (NA) # 9 entered the room at 8:40 AM and asked the resident if she

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WILSON REHABILITATION AND NURSING CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

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F 689	Continued From page 25	F 689		

was finished eating. The resident indicated she was finished eating and the NA removed the try from the room.
An observation of Resident #40 was conducted on 3/22/2018 at at 8:50 AM. The resident was observed in her wheelchair in the hall outside of her room. The resident was asleep in the chair, leaned to the left side with her head resting on her arm.

An interview was conducted with Nurse #5 on 3/22/2108 at 9:13 AM. Nurse #5 indicated she was the nurse responsible for Resident #40 and the resident was on her regular facility assignment. Nurse #5 stated she was familiar with the resident's care needs. Nurse #5 reported the resident was a challenge to care for due to her falls risk and the frequency of the resident's falls. Nurse #5 indicated she felt the resident needed constant supervision to ensure her safety is maintained. The nurse stated there was no way the facility staff could provide the needed supervision for the resident due to the staffing levels.

An interview was conducted with NA #9 on 3/22/2108 at 9:40 AM. NA #9 indicated she was the assigned to Resident #40. The NA revealed the resident was on her usual assignment and she was familiar with the resident. NA #9 reported she was aware of the resident's risk for falls. The NA stated she tried to make sure she watched the resident closely and attempted to toilet her every 2 hours. The NA indicated she had other residents to care for and there was no way she could supervise the resident all the time. The NA stated if the resident indicated she did not need to be toileted, she did not attempt to take her to the bathroom. The NA stated she would take the

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F 689	Continued From page 26 resident to the bathroom and sit her on the toilet if she indicated she needed to go. The NA stated she was unaware the resident needed to be supervised for breakfast. An interview was conducted with the Administrator on 3/23/2108 at 03:32 PM. The Administrator reported he was aware of Resident #40 and her continued falls. He stated the expectation was the facility staff would provide adequate supervision for the residents.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		4/20/18

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F 725	Continued From page 27 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, resident and family interviews and observations, the facility failed to provide sufficient nursing staff by not answering call bells for 2 of 18 residents who needed toileting assistance (Resident #56 and Resident #57), failed to honor resident ' s choices by not offering showers on the designated shower days for 3 of 18 residents (Resident #8, Resident #56 and Resident #57) and failed to provide supervision to prevent accidents for 1 of 1 residents (Resident #40) reviewed for accidents. Findings included: 1-This citation is cross referenced to F550- Based on record review, observation and staff interviews, the facility failed to provide care to maintain dignity by not responding to call lights for residents that required assistance with toileting which resulted in the residents soiling themselves (Residents #56 and #57) for 2 of 18 residents. 2. This citation is cross referenced to F561- Based on observations, record review, resident and staff interviews the facility failed to honor residents' choices by not providing showers as scheduled for 3 of 18 residents (Resident #8, Resident #56 and Resident #57). 3. This citation is cross referenced to F689- Based on observation, medical record review and staff interview, the facility failed to provide supervision to prevent accidents, investigate each accident to determine causative factors, and	F 725	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. A staffing protocol was created to address process for staffing and establishing minimum staffing standards for the facility as well as mandatory overtime. This plan was created by the Administrator by April 13, 2018. Staff has been in-serviced, by nursing supervisor on April 13, 2018, that facility staffing guidelines are in effect and on alternative weeks, they may be asked to stay longer so that the building is adequately staffed. This schedule will allow for supervisors to help ensure that the staffing does not fall below acceptable standards per State and Federal Guidelines and will have a protocol for nursing to follow on each shift to help meet staffing guidelines. The results of these audits will be reported to the Quality Assurance Performance improvement Committee monthly by the Director of Nursing for 3 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness	

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F 725	Continued From page 28 implement interventions to prevent further accidents for 1of 1 residents (Resident # 40) reviewed for accidents which resulted in numerous and continued falls. An interview was conducted with Nursing Assistant (NA) #10 on 3/21/2018 at 4:37 PM. NA #10 stated there were days when there was not enough staff and the care did not get completed timely and some care such as showers did not get completed at all. NA #10 indicated the 100 hall was heavy with many total care residents and it was just difficult when there were not at least 2 nursing assistants on the hall for the 3:00 PM to 11:00 PM shift. NA #10 stated sometimes they needed more than 2 to get everything completed. NA #10 stated she recalled times there was only 1 nursing assistant on the hall. A telephone interview was conducted with Nursing Assistant (NA)#12 on 3/21/2018 at 6:18 PM. NA #12 stated she worked mostly days (7:00 AM-3:00 PM) but did also work some evenings (3:00 PM to 11:00 PM). NA #12 indicated the staff tried to work together but the care needs were heavy and it took a long time to get things done. NA #12 indicated if there were only one or 2 on the hall during the day shift, the care could not be completed timely and some care could not be completed at all. A telephone interview was conducted with the Director of Nursing (DON) on 3/21/2018 at 7:40 PM. The DON stated she was aware there were residents who did not get the care they needed. The DON indicated the lack of available staff was the primary reason there were issues with call light response time, showers not given and	F 725	of the monitoring/observation tool for maintaining substantial compliance, and to make changes as necessary. The Administrator will be responsible for this plan of correction. Facility will be in substantial compliance as of April 20th, 2018.	

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F 725	Continued From page 29	F 725		

residents not supervised when there were issues with falling. The DON stated the Administrator was hiring additional staff but with call outs and the turnover, there was not adequate staff to meet the residents' needs. The DON stated the expectation was to have enough staff to meet the needs of all the residents.

An interview was conducted on 3/22/2018 at 2:41 PM with Nursing Assistant (NA) #11. NA #11 stated there was not enough staff to get all the care completed on most shifts when she worked. NA #11 indicated the facility based the assignments on the number of residents and not the care the residents required.

An interview was conducted with Nurse #5 on 3/22/2108 at 9:13 AM. Nurse #5 indicated the facility was short staffs at times and it was difficult for the staff to get the required care completed. Nurse #5 stated some residents required more care and the staff struggled to get it all done with the facility staffing levels. Nurse #5 indicated at times all the care could not get completed. The nurse stated there was no way the facility staff could provide the needed supervision for all the resident due to the staffing levels.

An interview was conducted with NA #9 on 3/22/2108 at 9:40 AM. NA #9 indicated there were times all the required care could not be completed due to call outs or not enough staff on the halls.

An interview was conducted with the Nursing Supervisor on 3/22/18 2:56 PM. The Nursing Supervisor revealed she was the one responsible for the schedule and the staffing. The Nursing Supervisor stated ideally the staffing levels would

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F 725	Continued From page 30 consist of 8 nursing assistants on the day shift in the Long Term Care section and 2 nursing assistants on the Rehabilitation Unit, 6 to 8 nursing assistants in the Long Term Care section on the evening shift with 2 nursing assistants on the Rehab Unit and 4 nursing assistants in the Long Term Care section for night shift with 2 nursing assistants on the Rehab Unit. The Nursing Supervisor reported the facility census fluctuated but was an average of 65 on the Long Term Care Side. The Nursing Supervisor stated there was an assignment sheet completed daily for the staff and she tried to divide the assignments fairly. She indicated she tried to staff on acuity but when the census changed and residents were moved, the acuity could change. The Nursing Supervisor stated administration was aware there were issues with the staffing numbers and were trying to get more staff hired. The staffing sheets were reviewed from December 2017 through 3/23/2017. The review of the staffing sheets revealed there were less than the ideal staffing numbers almost daily. There were days and evenings which were reviewed to have less than half of the ideal staffing levels. An interview was conducted with the Administrator on 3/23/2108 at 03:32 PM. The Administrator reported he was aware of the need for additional staff in the facility and he was trying to secure more staff. The Administrator stated the expectation for staffing was to provide appropriate staffing to each resident's individual needs.	F 725		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		4/20/18

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F 867	Continued From page 31 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility's Quality Assurance Performance Improvement (QAPI) Committee failed to maintain implemented procedures put into place 3/3/2017. These interventions were in 2 areas originally cited in the recertification survey of 2/3/2017 (F241 and F323) and recited in the recertification survey of 3/23/2018. The deficiencies were in the areas of dignity and supervision to prevent accidents. The continued failure of the facility during two consecutive federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referenced to: 1)F550-Based on record review, observation and staff interviews, the facility failed to provide care to maintain dignity by not responding to call lights for residents that required assistance with toileting which resulted in the residents soiling themselves for 2 of 18 residents and failed to provide care in a dignified manner by standing beside the bed to feed residents for 2 of 18 residents. The facility was cited during the 2/3/2017 recertification survey for failing to knock on	F 867	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. A QAPI Team met on 3/23/18, 3/29/18, 4/5/18, 4/12/18 to discuss deficiencies F550, F561, F684, F689, F725, F867. QAPI committee discussed deficiencies and created Plan of Correction for all alleged deficiencies. QAPI Committee to meet weekly x8 and then as needed to review results of monitoring initiated for alleged deficiencies and will make system changes as needed based on monitoring. Administrator or designee will monitor QAPI committee meetings, completion of recommended audits/monitoring and QAPI recommendations monthly x6 and or substantial compliance has been reached. The Administrator is responsible for this plan of correction. Facility will be in substantial compliance as of April 20th, 2018.	

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F 867	Continued From page 32	F 867		

residents' doors or ask permission to enter resident's rooms.

2)F689- Based on observation, medical record review and staff interview, the facility failed to provide supervision to prevent accidents, investigate each accident to determine causative factors, and implement interventions to prevent further accidents for 1of 1 residents reviewed for accidents which resulted in numerous and continued falls.

The facility was cited during the 2/3/2017 recertification survey for failing to prevent falls and minimize the potential for falls and failing to maintain safe hot water temperatures.

During an interview with the Administrator on 3/23/2018 at 6:44 PM, the Administrator stated the QAPI Committee met monthly and identified, developed and implemented plans of action to correct identified quality deficiencies. The Administrator stated he felt the inconsistencies in staffing were responsible for ineffectiveness of the corrective actions from the previously identified deficiencies.