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	345372	A. BUILDING ______ B. WING ______	C 03/06/2024

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/03/24 through 03/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ITSI11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 03/03/24 through 03/06/24. Event ID # ITSI11. The following intakes were investigated NC00211166. 1 of 1 allegation did not result in a defiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		3/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/13/2024

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.

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F 657	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise the care plan to reflect the discontinuation of hospice care. This was for 1 of 2 residents (Resident #30) reviewed for hospice and end of life care. Findings included: Resident #30 was admitted to the facility on 9/30/20 with a diagnosis of dementia. A review of the significant change Minimum Data Set (MDS) assessment for Resident #30 dated 12/15/23 revealed he was not receiving hospice care. A review of Resident #30's care plan dated last revised on 12/28/23 revealed in part a focus area initiated on 9/5/23 and last revised on 12/27/23 for hospice care. The goal was for Resident #30 to be free from pain through the next review. An intervention was spiritual care consult. On 3/4/24 at 2:40 PM an interview with Nurse #1 indicated she was the resource nurse. She stated Resident #30 had been receiving hospice care, but this had been discontinued on 12/8/23. On 3/4/24 at 3:04 PM an interview with MDS Nurse #1 indicated she completed Resident #30's significant change MDS dated 12/15/23 because his hospice care was discontinued. She went on	F 657	On 3/4/2024, Resident #30 care plan for hospice was corrected by the MDS Coordinator. On 3/11/2024, Director of Nursing completed an audit to ensure that only residents who are under hospice services are care planned for hospice. The Director of Nursing will address any concerns identified during audit, to include removing the hospice services from the care plan. Audit will be completed by 3/12/2024. On 3/4/2024, the DON completed in service with MDS nurses, on accuracy of care plans after completion of MDS assessments to include hospice services. All newly hired MDS Coordinators and/or MDS nurses will be in-serviced by the Director of Nursing during orientation regarding review of care plans for accuracy. 10% of Care Plans reviewed weekly for accuracy to include hospice services by the Director of Nursing, or QI nurse utilizing the Care Plan Audit Tool weekly x4 weeks and then monthly x1 month X 1 month. This audit is to ensure accuracy of care plans reviewed. The MDS coordinator, and/or Director of Nursing will	

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F 657	Continued From page 2 to say Resident #30's last care plan review was done on 12/28/23. MDS Nurse #1 stated she would have been responsible for ensuring the hospice care focus area was removed from Resident #30's care plan at that time. She went on to say she had missed this. She further indicated she had a check list that she used for updating care plans which included hospice status. MDS Nurse #1 stated this had been an oversight on her part. On 3/6/24 at 9:19 AM an interview with the Director of Nursing indicated Resident #30's care plan should be an accurate reflection of the care he was receiving. She went on to say when Resident #30 had a care plan review and revision on 12/28/24, hospice care should have been removed from his care plan if he was no longer receiving it. On 3/6/24 at 9:26 AM an interview with the Administrator indicated Resident #30's hospice care focus area should have been removed from his care plan if he was no longer receiving it. He stated that's what the checklist was for.	F 657	address all areas of concern identified during the audit to include updating care plan and/or retraining the MDS coordinator or MDS nurses when indicated. The administrator will review and initial the care plan audit tool weekly x4 weeks then monthly x1 month to ensure any areas of concerns were addressed. The Quality Improvement (QI) nurse will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x2 months. The Executive QAPI Committee will meet monthly x2 months and review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		3/7/24

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F 812	Continued From page 3 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to dry dishes individually by nesting (stacking dishes/utensils of the same size without an air gap) 4 deep dish pans and 2 large metal mixing bowls, while still wet, on the drying rack for 1 of 3 kitchen observations. Findings included: During observation on 3/3/24 at 10:24 AM 4 deep dish pans and 2 large metal mixing bowls were observed nested on the drying rack. Upon requesting Dietary Cook #1 to remove the top dish, water was visible on the surfaces of the dishes nested together. During an interview on 3/3/24 at 10:24 AM Dietary Cook #1 stated the 4 deep dish pans, and 2 large metal mixing bowls were left over from last night to dry on the drying rack. She did not know why they had been nested in each other. Upon observing the stack of deep-dish pans and large metal mixing bowls, and separating them, she stated the dishes were still wet from last night because they were nested. She further stated staff should not nest dishes that were drying because moisture could be trapped and could cause contamination.	F 812	On 03/03/2024, Dietary Cook #1 separated 4 deep dish pans and 2 metal mixing bowls for proper drying. On 3/4/2024, in-service was initiated by Dietary Manager on proper drying technique and the consequences of not separating wet dishes for air drying. In-service will be complete 3/7/2024. All newly hired Dietary Aides and Cooks will be in-serviced by the Dietary Manager during orientation regarding proper drying technique. On 3/4/2024 the Dietary Manager initiated an audit of stacked dishes to ensure proper nesting procedures are in place utilizing the Dish Nesting Audit Tool. The Dietary Manager will address all concerns identified during the audit to include nesting wet dishes and re-education of staff. The administrator will review the Dish Nesting Audit Tool weekly x4 weeks and then monthly x1 month to ensure all concerns addressed. The administrator will present the findings of the Dish Nesting Audit Tool to the	

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F 812	Continued From page 4 During an interview on 3/4/24 at 8:50 AM the Dietary Manager stated when dishes were placed on the drying rack and were wet, they were not to be nested due to the risk of bacterial growth. He concluded the 4 deep dish pans, and 2 large metal mixing bowls should not have been nested the night before while on the drying rack which caused them to still be wet on the morning of 3/3/24. During an interview on 3/5/24 at 2:18 PM the Administrator stated dishes were not to be nested while drying due to the risk of bacterial growth.	F 812	Quality Assurance and Performance Improvement (QAPI) committee monthly x2 months. The QAPI committee will meet monthly for 2 months and review with Dish Nesting Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		3/11/24

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F 867	Continued From page 5 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 6	F 867		

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its

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F 867	Continued From page 7 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 8/27/21 and 2/16/23. This was for a recited deficiency in the area of Food and Nutrition Services (F812). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F812: Based on observations and staff interviews the facility failed to dry dishes individually by nesting (stacking dishes/utensils of the same size without an air gap) 4 deep dish pans and 2 large metal mixing bowls, while still wet, on the drying rack for 1 of 3 kitchen observations. During the recertification and complaint survey of 8/27/21 the facility failed to maintain sanitary conditions in the kitchen by: 1. failing to ensure	F 867	On 3/7/2024, the administrator initiated an audit of previous citations and action plans from 8/27/2021 to 3/6/2024 including F 812 Food Procurement/Storage to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by Quality Improvement (QI) Nurse for any concerns identified. The Regional Nurse consultant will address all concerns identified during the audit to include but not limited to education of staff. This audit will be completed by 3/11/2024. On 3/6/2024, the regional nurse consultant initiated an in-service with the Administrator and Director of Nursing (DON), Quality Assurance Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient	

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F 867	Continued From page 8 the dishwasher was rinsing dishes at the correct temperature to sanitize the dishes; 2. by failing to discard expired food and to date opened resealable food items stored in the walk-in refrigerator; 3. by not properly storing and dating open dry food items; and by failing to store food items off the floor. During the recertification and complaint survey of 2/16/23 the facility failed to (1) label foods items with an open and expiration date and discard expired food items stored for use in 1 of 1 walk-in refrigerator for 1 of 2 kitchen observations and (2) label food items with an open and expiration date stored for use in 1 of 1 walk-in freezer. In an interview with the Administrator on 3/6/24 at 9:38 am he indicated he felt the continued issue with Food Safety Requirements was because the previous issues differed from the current issue. He further stated the current issue occurred because an employee did not pay attention and moved to fast to complete a task. He stated the facility in-serviced the staff weekly, monthly, and as needed if issues arose. The Administrator stated the facility would review its process and would focus on the whole kitchen and put corrective action in place.	F 867	practice to include dietary services. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-services will be completed 3/8/2024. All newly hired administrators, DONs and QI nurses will be educated during orientation regarding the QA process. All data collected for identified areas of concerns to include F 812 Food Procurement/Storage will be taken to the Quality Assurance committee for review monthly x3 months by the QI nurse. The Quality Assurance committee will review the data and determine if the plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QI nurse. The regional nurse consultant will ensure that the facility is maintaining an effective QA program by reviewing and initialing the Executive committee quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions to include F 812 Food Procurement/Storage and all current citations and QA plans are followed and maintained quarterly x1. The regional Nurse Consultant will immediately retrain the Administrator, DON and QI nurse for	

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F 867	Continued From page 9	F 867	any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the QI nurse to the Executive Committee Quarterly meeting x1 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	