STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/07/25 through 04/10/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CPSM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/07/25 through 04/10/25. Event ID# CPSM11. The following intakes were investigated NC00224296, NC00226148, and NC00226289. 1 of the 10 complaint allegations resulted in deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		4/26/25

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

Electronically Signed | 04/23/2025

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F 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and Responsible Party (RP) and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Form 10055- Skilled Nursing Facility (SNF) Advanced Beneficiary Notification (ABN) and Form 10123-Notice of Medicare Non-Coverage (NOMNC) when the facility initiated discharge from Medicare Part A Services	F 582	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/24/2025, the Business Office Manager completed and provided a Notice of Medicare Non-Coverage	

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F 582	Continued From page 2 when benefit days were not exhausted. This was for 1 of 3 residents (Resident #31) reviewed for beneficiary notice protection. Findings included: Resident #31 was admitted to the facility on 11/20/24 under Medicare Part A covered skilled services. Resident #31's Medicare Part A covered skilled services ended on 1/22/25. He remained in the facility. A review of Resident #31's medical record revealed no evidence Resident #31 was provided with a CMS SNF-ABN and a CMS NOMNC form. On 4/8/25 at 1:49 PM an interview with the Business Office Manager (BOM) indicated Resident #31's Medicare Part A covered skilled services began on 11/20/24. She stated when these covered services ended on 1/22/25, Resident #31 had used 64 of his 100 covered days. She reported Resident #31 had remained in the facility. On 4/8/25 at 1:22 PM a telephone interview with Resident #31's Responsible Party (RP) indicated she was somewhat familiar with CMS SNF-ABN and CMS NOMNC forms. She stated she did not receive a CMS SNF-ABN and a CMS NOMNC for Resident #31 when his Medicare part A services ended on 1/22/25. On 4/8/25 at 1:26 PM an interview with the Social Worker (SW) indicated she would have been responsible for providing Resident #31 with a CMS SNF-ABN and a CMS NOMNC form when	F 582	(NOMNC) and Advance Beneficiary Notice (ABN) to resident #31 and/or resident representative. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/8/2025, Director of Nursing (DON) initiated an audit of all Medicare “A” discharges for the past 30 days. This audit was to ensure a NOMNC and ABN was completed appropriately and provided to the resident and/or resident representative for any resident being discharged from Medicare part A services when benefit days were not exhausted. All areas of concern were addressed by the DON to include issuing appropriate notification of non-coverage is being provided to the resident/resident representative. The audit will be completed by 4/26/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/8/2025, an in-service was initiated by the Administrator with the Business Office Manager and Social Worker regarding Notifications of Medical Non-Coverage (NOMNC) and Beneficiary notices with emphasis on providing appropriate notification related to non-coverage of Medicare “A” and Medicare “B” residents. In-service will be completed by 4/26/2025. All newly hired	

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F 582	Continued From page 3 he was discharged from his Medicare Part A covered services on 1/22/25. She reported she had been new to her position in January 2025, and although she had received training on her position duties, she did not recall issuing the forms to Resident #31. She stated at some point the Director of Nursing (DON) had come to her and asked her if she was issuing the CMS SNF-ABN and CMS NOMNC forms, she had not been, and so she began issuing them at that time. In an interview on 4/8/25 at 1:34 PM the DON stated at some point someone came to her and let her know they didn't think the CMS SNF-ABNs and CMS NOMNCs were being issued. She reported she could not recall who notified her, or exactly when this was. She went on to say she had gone to the SW and let her know she was supposed to be issuing these for Medicare Part A residents. On 4/10/25 at 8:48 AM an interview with the Administrator indicated the SW had been relatively new to her position in January 2025, and as a result of this, had not issued the CMS SNF-ABN and CMS NOMNC forms to Resident #31 like she should have.	F 582	Administrator, Business Office Managers and/or Social Workers will be in-service during orientation regarding Notifications of Medical Non-Coverage (NOMNC) and ABN. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 10% audit of all Medicare “A” discharges will be reviewed by the Director of Nursing (DON) weekly x 4 weeks then monthly x 1 month utilizing the NOMNC and Beneficiary Notice Audit Tool to ensure the appropriate notification of medical non-coverage was provided to the resident/resident representative. The DON will address all areas of concern identified during the audit to include issuing NOMNC/ABN when indicated and re-training of staff. The Administrator will forward the NOMNC and Beneficiary Notice Audit Tool findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine the need for further and /or frequency of monitoring. Corrective Action Plan Completion Date: 4/26/2025	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		4/26/25

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F 641	Continued From page 4 resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Responsible Party interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of discharge (Resident #99) and dialysis (Resident #46) for 2 of 20 residents reviewed for MDS accuracy. The findings included: 1. Resident #99 was admitted to the facility on 2/11/25. A review of Resident #99's electronic health record revealed a discharge MDS assessment was completed on 3/3/25 and indicated the resident was discharged to the hospital. A nurse's note written by Nurse #2 dated 3/3/25 indicated Resident #99 was discharged with his medications, discharge paperwork and all his belongings. The note stated he was picked up by a transportation company. The note did not state Resident #99's discharge location. In an interview with Nurse #2 on 4/9/25 at 9:21 AM she stated Resident #99 was discharged home on 3/3/25. A telephone interview with Resident #99's Responsible Party (RP #1) was conducted on 4/9/25 at 8:18 AM. RP #1 stated Resident #99 was discharged home from the facility on 3/3/25. In an interview with MDS Nurse #1 on 4/9/25 at 9:42 AM she stated Resident #99's discharge MDS should have been coded as discharged	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/09/25, the Minimum Data Set (MDS) Coordinator completed a modification of Discharge Return Not Anticipated Assessment for Resident #99 dated 3/3/25 to reflect accurate coding for discharge to home. On 4/09/25, the MDS Coordinator completed a modification of the admission assessment for Resident # 46 dated 3/13/25 to reflect accurate coding of dialysis services. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 04/09/23, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of MDS discharge assessments for “section A” from 3/3/25 to 4/9/25. This audit is to ensure all MDS’s assessments completed are coded accurately for discharge location. The MDS Coordinator will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 4/26/25. On 4/09/25, the MDS Coordinator under	

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F 641	Continued From page 5 home, not the hospital. She further stated the resident was supposed to be discharged on 3/4/25, but was picked up on 3/3/25. Due to him leaving a day earlier than expected, the discharge MDS was coded as an unplanned discharge which usually meant a resident went to the hospital and was miscoded as such. In an interview with the Administrator on 4/9/25 at 9:53 AM she stated the MDS completed on 3/3/25 should have captured that Resident #99 was discharged home, not the hospital. 2. Resident #46 was admitted to the facility on 3/12/25 with diagnoses that included end stage renal disease. A review of a Physician order dated 3/12/25 revealed an order for Resident #46 to receive dialysis Monday, Wednesday, and Friday at an offsite dialysis clinic. The admission Minimum Data Set (MDS) assessment dated 3/13/25 was not coded for dialysis. In an interview with the MDS Coordinator on 4/9/25 at 11:39 am she stated she was aware Resident #46 received dialysis. The interview further revealed that the MDS Coordinator routinely reviewed hospital discharge summaries and coded the MDS based on the reviews. The MDS Coordinator stated Resident #46 should have been coded for dialysis on the 3/13/25 MDS and the failure to do so had been an oversight. In an interview with the Administrator on 4/9/25 at 3:06 pm he stated the MDS completed on 3/13/25 should have captured that Resident #46 received	F 641	the oversight of the MDS Consultant initiated an audit of the most recent MDS assessment for “section “O” for all current dialysis residents to include resident #46 to ensure all MDS’s assessments completed are coded accurately for dialysis services. The MDS Coordinator will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 4/26/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 04/23/2025, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include discharge location and/or resident receiving dialysis services. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 10% audit of newly completed MDS assessments section “A” and “O” will be reviewed by the MDS consultant and/or	

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F 641	Continued From page 6 dialysis.	F 641	Director of Nursing weekly x 4 weeks then monthly x 1 month utilizing the MDS Accuracy Audit Tool to ensure accurate coding of the MDS assessment to include discharge location and residents receiving dialysis services. All identified areas of concern will be addressed by the MDS consultant and/or DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The Quality Assurance Nurse (QA) nurse will forward the results of MDS Accuracy Audit Tool to the QA Committee monthly x 2 months for review 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. Corrective Action Plan Completion Date: 4/26/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/26/25

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F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 8 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement their infection control practices and procedures when the facility Staff Development Coordinator (SDC) failed to don a gown before entering the room of a resident on Contact Precautions. The facility also failed to implement their policy for Enhanced Barrier Precautions (EBP) when Nurse #1 failed to wear a gown before entering a resident's room to provide medications via a gastrostomy tube (tube inserted directly into the stomach through a small hole in the abdomen to administer hydration, nutrition and medication). The deficient practice occurred for 2 of 20 staff (SDC and Nurse #1) observed for infection control practices. Findings included: 1. Review of the facility policy titled "Contact	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/8/2025, the Assistant Director of Nursing (ADON) completed in-service with the Staff Development Coordinator (SDC) on proper donning and doffing Personal Protective Equipment (PPE) for Contact Isolation. On 04/10/25, the ADON completed an in-service with Nurse #1 on proper donning and doffing personal protective equipment (PPE) for Enhanced Barrier Precautions (EBP) when administering meds via feeding tube. Address how the facility will identify other	

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F 880	Continued From page 9 Precautions" dated 4/2023 and revised on 6/13/24 stated in part: contact precaution recommendations include wearing a gown when entering room and caring for the resident. Review of the signage on the door to Resident #36's room read in part, "Contact precautions, everyone must: wear a gown when entering the room and remove before leaving". During observation on 4/8/25 at 3:45 PM the Staff Development Coordinator (SDC) entered Resident #36's room wearing gloves and no gown. While in the room she helped the resident get comfortable in bed and took a soiled tissue from her to throw away. The SDC removed her gloves and washed her hands before leaving the room. During an interview with the SDC on 4/8/25 at 3:48 PM she stated she thought it was an Enhanced Barrier Precaution room. After reviewing the contact precautions signage on the door, she stated she should have donned a gown before entering the room. An interview with the Director of Nursing (DON), who was also the Infection Preventionist, was conducted on 4/8/25 at 3:56 PM. The DON stated the SDC should have donned a gown before entering the room of Resident #36. She further stated all staff were educated on infection prevention practices upon hire, yearly and as needed. In an interview with the Administrator on 4/8/25 at 4:10 PM he stated infection prevention practices must be followed at all times and the SDC should have donned a gown before entering Resident	F 880	residents having the potential to be affected by the same deficient practice. On 4/9/25, the Quality Assurance (QA) nurse initiated 20 random staff observations on donning and doffing of personal protective equipment (PPE) for the isolation precautions indicated to include but not limited to EBP and/or contact precautions. The QA nurse will immediately educate staff for all concerns identified during the observations. The observations will be completed by 4/26/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/9/25, the Infection Preventionist (IP) initiated an in-service with all nurses and nursing assistants on PPE with emphasis on donning/doffing appropriate PPE for isolation precautions indicated to include but not limited to precautions for EBP and/or contact precautions. The in-service will be completed by 4/26/25. After 4/26/25, any nurse or nursing assistant who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses and nursing assistants will be educated during orientation by the IP. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 880	Continued From page 10 #36's room. He further stated all residents on contact precautions have an orange sign attached to their door so staff could easily know which precautions were required for which task. 2. Review of the facility policy titled "Enhanced Barrier Precautions" dated 4/2023 and revised on 6/13/2024 stated in part; Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions to reduce the risk of Multidrug Resistant Organisms (MDRO) transmission during high-contact resident care activities. Includes the use of both gowns and gloves. The (EBP) apply to residents with the presence of indwelling medical devices with or without the presence of an MDRO infection or colonization. An example of indwelling medical devices includes feeding tubes. During an observation of medication administration on 4/9/25 at 9:53 AM, Nurse #1 entered resident #50's room which had an EBP sign posted on the exterior of the door, to administer medication via gastrostomy tube (a hollow tube inserted directly through the skin of the abdomen into the stomach to deliver nutrition, hydration and medication). Nurse #1 performed hand hygiene prior to entering the room and donned (put on) a clean pair of gloves but did not don a gown. Nurse #1 administered the medication using a feeding syringe (a large 2-part syringe used to administer oral medications) through a gastrostomy tube. In an interview with Nurse #1 on 4/9/25 at 10:15 AM she stated the hall nurse told her she didn't need to wear a gown; she could not remember the name of the nurse.	F 880	The IP will complete 10 staff observations weekly x 4 weeks then monthly x 1 month utilizing the PPE Audit Tool. This audit is to ensure staff used appropriate donning and doffing of personal protective equipment (PPE) for the isolation precautions indicated to include but not limited to EBP and/or contact precautions. The IP nurse will immediately re-train staff for all concerns identified during the observations. The Director of Nursing (DON) will review and present the results of the PPE Audits to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months to review the PPE Audit Tool for trends and/or issues and to determine the continued need and frequency of monitoring. Corrective Action Plan Completion Date 4/26/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 An interview was conducted with the Quality Improvement Nurse on 4/9/25 at 10:25 AM. During the interview she stated the nurse should have worn a gown into a room with an EBP sign posted when administering medications through a gastrostomy tube. During an interview with the Director of Nursing (DON) on 4/9/25 at 10:40 AM, she stated she would have expected the nurse to wear a gown when administering medication through a gastrostomy tube and an EBP sign was posted on the door. An interview was held with the Administrator on 4/9/25 at 12:34 AM, at which time he stated when an EBP sign was posted, he would expect the nurse to wear a gown when administering medications through a gastrostomy tube.	F 880		