STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Pines Retirement Comm	1000 Wesley Pines Road Lumberton, NC 28358

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43798 Based on record review and staff interviews, the facility neglected to provide a breakfast tray for a dependent Resident (Resident #212) for 1 of 3 residents reviewed for neglect. Findings included: Resident #212 was admitted to the facility on [DATE]. Her diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) and aphasia (loss of ability to understand or express speech). Resident #212's quarterly Minimum Data Set Assessment (MDS) dated [DATE] coded the Resident as cognitively impaired. She was coded as dependent with personal hygiene, toileting, oral hygiene and eating. Review of Resident #212's care plan revealed a care focus area initiated 3/11/24 that indicated that Resident #212 was at nutritional risk and interventions included staff to assist with feeding Resident at mealtimes. Facility investigation report dated 5/20/24 indicated Resident #212 was not provided with a breakfast tray on 5/15/24. The report indicated the Director of Nursing (DON) became aware of the incident at 11:20 AM when the Dining Assistant notified her that Resident #212's breakfast tray was still in the warmer in the kitchen. The DON went to inquire about the tray with Nursing Assistant #1 (NA #1) who was assigned to care for Resident #212 on 5/15/24 7:00 AM - 3:00 PM shift and NA #1 stated she forgot. During an interview on 11/13/24 at 11:40 AM with the Dining Assistant, she stated nursing assistants were responsible for obtaining trays from the food cart or kitchen for residents that ate meals in their rooms and required feeding assistance. The Dining Assistant stated she found Resident #212's tray in the warmer in the kitchen on 5/15/24 at around 11:20 AM and notified Nurse #1 that the tray was still in the kitchen. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 11:55 AM with Nurse #1, she stated she became aware that Resident #212 did not receive a breakfast tray on 5/15/24 when she was notified by the Dining Assistant at around 11:20 AM that Resident #212's tray was still in the kitchen. When she asked NA #1 about the tray, NA #1 stated she forgot about the tray. Nurse #1 explained that Resident #212 was dependent on staff for feeding and NA #1 should have obtained the tray from the kitchen to feed the Resident. She further stated that if NA #1 was busy she should have informed her that she needed assistance and she would have obtained the tray and fed Resident #212 herself. Attempts to interview NA #1 were unsuccessful. An Interview was conducted with the Director of Nursing (DON) on 11/13/24 at 12:06 PM. The DON stated that breakfast was normally served between 7:30 AM and 9:00 AM. She indicated that NA #1 stated she had forgotten to feed Resident #212 and when asked why she did not ask for assistance, NA #1 stated she was not running behind and that she got sidetracked and forgot about the tray. The DON verbalized Resident #212 ate her meals in her room with feeding assistance and NA #1 should have retrieved the breakfast tray from the kitchen and fed the Resident or asked for assistance from another staff member.