

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48230</p> <p>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.</p> <p>Findings included:</p> <p>1. Review of the facility policy titled Contact 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 #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.</p> <p>50404</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		