STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	**1404 N LAFAYETTE STREET SHELBY, NC 28150**

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		11/23/16

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

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 services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal

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

Electronically Signed | 11/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interviews the facility failed to post the contact information for filing a complaint with the State Complaint Intake Unit and the contact information for the Ombudsman. (Resident #52). The findings included: Resident #52 was admitted to the facility on 05/18/15 with diagnoses which included multiple sclerosis, anemia and thyroid disease. A review of the most recent quarterly Minimum Data Set revealed Resident #52 was cognitively intact for daily decision making. During an interview on 10/25/16 at 9:50 AM with Resident #52 she reported she was the President of the Resident Council. She explained concerns and issues were discussed in the monthly Resident Council Meetings. She stated she did not know anything about the State licensure and certification agency complaint intake unit and had not seen the name or number of the complaint intake unit posted in the facility. Resident #52 further explained she was unsure if other residents knew where to obtain that information. Observations on 10/24/16 at 10:15 AM upon entrance to the facility revealed the front lobby was under renovation and the middle section of the 100 resident hallway was blocked off due to renovation. There were no posted signs to indicate the State licensure and certification complaint intake unit phone number or the	F 156	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. POC Compliance Date: 11/23/16 F 156 Activity Director met with Resident #52 to review contact information for the State Complaint Intake Unit and Ombudsman. On 11/14/16, signs which contained the contact information for the State Complaint Intake Unit and Ombudsman, were placed in the lobby and main corridor. Maintenance Supervisor will be provided education by the Facility Safety Officer, regarding the regulation to ensure the State Complaint Intake Unit and Ombudsman contact information must be posted at all times. A special Resident Council meeting was held on 11/15/16 to review the State Complaint Intake Unit and Ombudsman contact information and locations of the posting. Activity Director or designee, will conduct 5 observations weekly, to ensure compliance. Any identified issues will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 156	Continued From page 3 Ombudsman's phone number. Observation on 10/26/16 at 11:34 AM revealed there were no signs posted to indicate the State licensure and certification complaint intake unit's phone number or the Ombudsman's phone numbers in the front entrance or waiting room or on the 100 hall leading up to the construction area. Observation on 10/27/16 at 10:11 AM revealed there were no signs posted to indicate the State licensure and certification complaint intake unit's or the Ombudsman's phone number in the front entrance or waiting room or on the 100 hall leading up to the construction area. An interview and tour on 10/2716 at 3:20 PM with the Administrator revealed the sign for the Ombudsman's phone number and the number for the State licensure and certification agency had been moved into the Admissions office due to renovation. He confirmed the Admissions Office was not open 24 hours a day and the phone numbers were not visible unless someone was in the office. He stated it was his expectation the phone numbers for the State licensure and certification agency and the Ombudsman phone numbers should be posted in a prominent place in the building and the sign would need to be moved so that it was visible and accessible.	F 156	corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.	F 167		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 167	Continued From page 4 The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post information regarding the location of the results of the most recent survey by the State agency and provide them in a location accessible to residents. The findings included: Resident #52 was admitted to the facility on 05/18/15 with diagnoses which included multiple sclerosis, anemia and thyroid disease. A review of the most recent quarterly Minimum Data Set revealed Resident #52 was cognitively intact for daily decision making. During an interview on 10/25/16 at 9:50 AM with Resident #52 she reported she was the President of the Resident Council. She explained concerns and issues were discussed in the monthly Resident Council Meetings. She stated she did not know anything about a sign that indicated where survey results were kept and was not sure if the State survey results from previous surveys was available. Resident #52 further explained she was unsure if other residents knew where to obtain that information. Observations on 10/24/16 at 10:15 AM upon entrance to the facility revealed the front lobby	F 167	F 167 On 10/28/16, the sign describing the location of the Survey Results was posted in the lobby. In addition, the Survey Results were relocated to the lobby area, accessible to residents. Activity Director met with Resident #52 to review the sign describing the location of the Survey Results and that the Survey Results were relocated to the lobby in an area accessible to residents. Receptionist was provided education by the Administrator regarding the regulation to ensure the location of the Survey Results was posted and that the Survey Results were accessible to residents. A special Resident Council meeting was held on 11/15/16 to review the locations of the posting and Survey Results. Director of Social Services or designee, will conduct 5 observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 167	Continued From page 5	F 167		

was under renovation and there was no posted sign to indicate where survey results were located.

Observation on 10/26/16 at 11:34 AM revealed there was no sign posted to indicate where survey results were located. Further observations revealed there was a plastic file hanger attached to the wall with a black notebook with a label which indicated survey results but the notebook was inside the plastic file hanger approximately 5 feet off the floor and was not accessible to a resident seated in a wheelchair.

Observation on 10/27/16 at 10:11 AM revealed there was no sign posted to indicate where survey results were located. There was a plastic file hanger attached to the wall with a black notebook with a label which indicated survey results but the notebook was inside the plastic file hanger approximately 5 feet off the floor and was not accessible to a resident seated in a wheelchair.

During an interview and tour on 10/27/16 at 3:20 PM with the Administrator, he stated the sign which indicated where the survey results were posted was supposed to be located on an end table in the living room at the entrance of the facility but during the tour of the living room he verified there was no sign.

During a follow up interview on 10/27/16 at 4:15 PM with the Administrator, he confirmed survey results were located in a hot file on the wall at the front door and if a resident wanted to review them then they would have to ask someone to get them out of the hot file for them. He explained the survey results had been moved recently due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 167	Continued From page 6 renovation. He acknowledged the survey results should be readily accessible to residents and in their present location they were not accessible to residents. He stated it was his expectation for the survey results to be moved to a location so they were readily accessible to residents and a sign should be posted with the location of the survey results.	F 167		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and family interviews, the facility failed to develop and provide activity programs which met residents' interests for 2 of 3 residents sampled for review of activities (Residents #14 and #191). The findings included: 1. Resident #14 was admitted to the facility on 09/14/13. Her diagnoses included advanced dementia, obsessive compulsive disorder, macular degeneration, anxiety and legal blindness. The annual Minimum Data Set dated 05/03/16 coded her as having short term memory problems, long term memory problems and having severely impaired decision making skills.	F 248	F 248 Activity Director met with Resident #14 and resident's family to reassess activity preferences and updated the resident's care plan on 11/1/16. Resident #191 was discharged to an assisted living facility on 11/3/16, prior to receiving 2567. Activity Director assessed current resident's activity programming to ensure activities were provided based on interests and preferences. Activities staff was provided education by the Activities Director, regarding the regulation to ensure residents received activities based on interests and preferences. Supervisor of Support Services or	11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 7 She was coded with having no behaviors, and the family participated in the activity preference section. Per family, Resident #14 was noted to feel the activities of listening to music, being in groups of people, doing favorite activities, and going outside were very important to her. She was coded as requiring extensive assistance to total assistance for most activities of daily living and was nonambulatory. Review of the activity notes dated 05/04/16 revealed Resident #14 continued to be out of her room daily and attended the second dining. She enjoyed socializing with others in the hallway, visits with family and pet therapy, coffee and reminiscing about past travels. Activity interests were noted as radio, television, religious, beauty shop, pets, family visits, talking, outdoors, music, and parties. The note continued stating that the activity program was explained, a calendar was given and explained and in room resources were offered. The Activities care plan for Resident #14 was developed on 05/17/06 and last reviewed on 08/13/16 with a note to continue as planned. The care plan identified the problem of impaired vision and hearing related to macular degeneration and cognitive decline related to dementia. The goal was for Resident #14 to attend activity of choice twice weekly and maintain optimal level of activity pursuits and preferences by the next review. Approaches included to provide a monthly activity calendar, offer assistance to activities of choice, provide CD play and CD audio books for listening pleasure, provide opportunities for one on one visits weekly, provide pet therapy visits weekly and she loves coffee and pound cake, enjoys music from the 50's and 60's as she and husband	F 248	designee, will conduct weekly 10% audits of residents to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 8	F 248		

went dancing every weekend when they were younger.

Review of the Activity participation records revealed in September 2016 Resident #14 participated as follows:
09/01/16 one on one social;
09/02/16 one on one sensory;
09/08/16 visitor;
09/12/16 family visit and pet therapy;
09/14/16 visitor;
09/19/16 one on one social;
09/24/16 scripture;
09/26/16 group music;
09/28/16 one on one social and religious group; and
09/30/16 one on one sensory.
There was no indication as to what the one on one activities included or any resident response.

Review of the Activity participation records revealed in October 2016 Resident #14 participated as follows:
10/6/16 one on one social;
10/09/16 one on one social;
10/12/16 one on one social;
10/14/16 one on one cognitive;
10/15/16 religious group;
10/19/16 visitor; and
10/22/16 one on one social and visitor.
There was no indication as to what the one on one activities included or any resident response.

Resident #14 was observed during the survey with no CD player in the room and not involved in any activities as follows:
10/24/16 at 4:49 PM sitting across from nursing station in hall, eyes closed;
10/25/16 at 9:05 AM sitting across form nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 9	F 248		

station in hall;
10/25/16 at 11:42 AM in bed asleep;
10/25/16 at 2:51 PM in bed asleep;
10/26/16 at 8:29 AM in dining room eating until returned to hallway at 8:48 AM;
10/26/16 at 9:03 AM, 9:12 AM and at 9:21 AM sitting in broda chair in room no tv or music playing;
10/26/16 at 9:42 AM sitting in room no tv or music while an exercise group was observed in the dining room and the dining room tv was playing golden oldies music;
10/26/16 at 10:10 AM sitting in room no tv or music;
10/26/16 at 10:45 AM in bed;
10/26/16 at 1:29 PM in dining room being cleaned up after lunch, then brought and sat outside room in hall clapping her hands;
10/26/16 at 2:41 PM in room in chair no tv or music;
10/26/16 at 2:52 PM staff attempted to put to bed, the resident refused and left in room by bed with no tv or music when observed on 10/26/16 at 3:19 PM, at 6:07 PM, just rocking back and forth;
10/26/16 at 6:17 PM served tray in dining room;
10/27/16 at 8:41 AM in dining room being fed;
10/27/16 at 9:29 AM and 9:51 AM in hall in broda chair asleep while in dining room there is exercise and makeup.
10/27/16 at 10:31 AM, 11:22 AM, and 11:56 AM in hall asleep;
10/27 at 2:02 PM sitting in hall while group activity in progress; and
10/27/16 at 2:55 PM in bed no music or tv.

On 10/27/16 at 4:14 PM the Activity Director (AD) was interviewed. The AD stated Resident #14 loved rock and roll music, reminiscing about travels weekly pet visits and church. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 10	F 248		

that Resident #14 was usually at her best in the mornings. AD described cognitive one on one involved memory stimulation and social one on one involved current events and discussed what was going on, what she liked to do and sometimes singing. AD stated pet therapy came every Monday (also noted on the calendars for every Monday) but she could not explain why Resident #14 did not receive pet therapy except for once in two months. She also stated that she loved a specific music activity that came monthly but she only attended it one of two months with no reason provided. AD stated a CD player was not kept in her room but the tv should be on easy listening channels. AD stated the goals to the activity care plan was not being met for Resident #14.

Interview on 10/27/2016 at 7:49 PM with the Director of Nursing revealed she expected for the activities to be provided according to the care plan.

2. Resident #191 was admitted to the facility on 09/06/16 with diagnoses which included multiple fractures, heart disease, chronic kidney disease, arthritis, difficulty walking, pain and depression.

A review of the most recent admission Minimum Data Set (MDS) dated 9/13/16 indicated Resident #191 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #191 was totally dependent on staff for transfers and bed mobility and he had indicated his activity preferences were very important to him including having books, magazines and newspaper to read, listening to music, being around animals and pets, keeping up with news, going outside in good weather and participating in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 11	F 248		

religious practices.

A review of the initial activity assessment dated 09/15/16 indicated Resident #191's activities were to listen to the radio to old country music, gardening of plants and flowers, family visits, pets (especially cats), read newspapers and talking and conversing with others. The assessment indicated the activity programs were explained, an activity calendar was given and explained and goals were set for 1 activity per week.

A review of a care plan for activities dated 09/26/16 revealed Resident #191 considered doing his favorite things important and a goal indicated Resident #191 would tolerate participating in at least 1 activity of preference daily through next review. The approaches were listed to inform Resident #191 of programmed activities available, ensure communication with other disciplines to be involved to avoid conflicts with therapy, treatments and tasks, enjoys old country music, dining out, being outdoors and has many cats, assist with obtaining morning newspaper when available, assist with going out to patio as able and has poor hearing and uses hearing aid. The care plan further indicated to make sure his hearing aid was in with sufficient batteries and place near front of room or activity leader to promote adequate hearing.

A review of an Activity Calendar dated September 2016 revealed Resident #191 received a one on one social activity on 09/14/16 and one on one activity in his room on 09/23/16.

A review of an Activity Calendar dated October 2016 revealed Resident #191 had a one on one social on 10/03/16 and attended absentee voting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 12 on 10/24/16.	F 248		

During an interview on 10/25/16 at 12:34 PM with a family member she stated she and another family member visited Resident #191 daily. She explained Resident #191 received therapy services but she was unaware he had been invited to attend activities and had not seen him doing activities.

During an observation on 10/26/16 at 9:46 AM a group activity was in progress in the main dining room with exercises and oldies music. Resident #191 was observed in bed in his room.

During an observation on 10/26/16 at 11:26 AM Resident #191 was in bed with his eyes closed and there were no newspapers visible in the room.

During an observation on 10/26/16 at 2:49 PM Resident #191 was in bed in his room with his eyes closed while a group activity was in progress in the main dining room with residents and activity staff.

During an interview on 10/27/16 at 4:28 PM with the Activity Director she explained Resident #191 was in therapy and was in rehabilitation a lot of the time when they had group activities. She further explained when a resident was admitted to the facility she or her assistants explained the activity calendar and if they had activity interests they were expected to work with therapy staff to schedule the activity around the resident's treatments. She stated Resident #191 did not like to come out of his room and some residents subscribed to newspapers and they could get extra newspapers to offer to residents. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 248	Continued From page 13 confirmed there was no documentation that Resident #191 had refused activities that had been offered to him on the September or October Activity calendars. She verified there were only 2 activities provided in the month of September to Resident #191 since only 2 events were documented and there were only 2 activities provided to Resident #191 in the month of October since only 2 events were documented. She explained activity staff were expected to indicate what activity the resident received and highlight the activity on the activity calendar sheet. She further explained she had talked to activity assistants about a week ago because they had not documented when a resident had refused activities and they needed a way to track when activities were offered but the resident was unavailable or had refused. During an interview on 10/27/16 at 7:49 PM the Director of Nursing stated it was her expectation for activities to be provided according to the care plan. She further stated she expected for activities to be done and if they were not done it should be documented.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair 13 resident doors with broken and splintered laminate and wood on 4 of	F 253	F 253 Resident rooms #111,#112, #200, #201, #203, #302, #312, #316,#324, #326,	11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 14 4 resident hallways (Resident rooms #111, #112, #200, #201, #203, #302, #312, #316, #324, #326, #327, #407 and #409; failed to repair damaged wood and laminate on the edges of smoke prevention doors on 1 of 4 resident hallways (100 Hall adjacent to the lobby area); and failed to clean a soiled broda chair for 1 resident (Resident #14) on 1 of 4 resident hallways (300 Hall). The findings included: 1. Resident doors with broken and splintered laminate and wood were observed as follows: a. Observations of Room #111 on 10/25/16 at 11:25 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/26/16 at 3:02 PM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/27/16 at 1:30 PM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #112 on 10/25/16 at 11:26 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/26/16 at 3:03 PM revealed the door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/27/16 at 1:31 PM revealed the door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door.	F 253	#327, #407 and #409, will have wood and laminate repaired. Damaged wood and laminate on the edges of smoke prevention doors (100 Hall adjacent to the lobby area) will have wood and laminate repaired. Resident #14's broda chair was cleaned on 10/27/16. Facility wide observations conducted to ensure wood and laminate on doors was in good repair and broda chairs were clean. Housekeeping and maintenance staff will be provided education by the Facility Safety Officer, regarding the regulation to ensure wood and laminate on doors in good repair and broda chairs clean. Admissions Coordinator or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 15	F 253		

c. Observations of Room #200 on 10/25/16 at 11:27 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:04 PM revealed the door of resident room #200 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:32 PM revealed the door of resident room #200 had broken and splintered laminate on the edges of the bottom half of the door.

d. Observations of Room #201 on 10/25/16 at 11:28 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:05 PM revealed the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:33 PM revealed the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door.

e. Observations of Room #203 on 10/25/16 at 11:29 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:06 PM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:34 PM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 16	F 253		

f. Observations of Room #302 on 10/25/16 at 11:30 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:07 PM revealed the door of resident room #302 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:35 PM revealed the door of resident room #302 had broken and splintered laminate on the edges of the bottom half of the door.

g. Observations of Room #312 on 10/25/16 at 11:31 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:08 PM revealed the door of resident room #312 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:36 PM revealed the door of resident room #312 had broken and splintered laminate on the edges of the bottom half of the door.

h. Observations of Room #316 on 10/25/16 at 11:32 AM revealed the door of the resident's room had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:09 PM revealed the door of resident room #316 had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:37 PM revealed the door of resident room #316 had broken and splintered laminate and wood on the edges of the bottom half of the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 17	F 253		

i. Observations of Room #324 on 10/25/16 at 11:33 AM revealed the door of the resident's room had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:10 PM revealed the door of resident room #324 had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:38 PM revealed the door of resident room #324 had broken and splintered laminate and wood on the edges of the bottom half of the door.

j. Observations of Room #326 on 10/25/16 at 11:34 AM revealed the door of the resident's room had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:11 PM revealed the door of resident room #326 had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:39 PM revealed the door of resident room #326 had broken and splintered laminate and wood on the edges of the bottom half of the door.

k. Observations of Room #327 on 10/25/16 at 11:35 AM revealed the door of the resident's room had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/26/16 at 3:12 PM revealed the door of resident room #327 had broken and splintered laminate and wood on the edges of the bottom half of the door.
Observations on 10/27/16 at 1:40 PM revealed the door of resident room #327 had broken and splintered laminate and wood on the edges of the bottom half of the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 18 l. Observations of Room #407 on 10/25/16 at 11:36 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/26/16 at 3:13 PM revealed the door of resident room #407 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/27/16 at 1:41 PM revealed the door of resident room #407 had broken and splintered laminate on the edges of the bottom half of the door. m. Observations of Room #409 on 10/25/16 at 11:37 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/26/16 at 3:14 PM revealed the door of resident room #409 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/27/16 at 1:42 PM revealed the door of resident room #409 had broken and splintered laminate on the edges of the bottom half of the door. 2. Observations of smoke prevention doors on the 100 hall adjacent to the lobby area on 10/25/16 at 11:38 AM revealed the double doors had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/26/16 at 3:15 PM revealed the set of double smoke prevention doors on the 100 hall adjacent to the lobby area had broken and splintered laminate on the edges of the bottom half of the door. Observations on 10/27/16 at 1:43 PM revealed the set of double smoke prevention doors on the	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 19	F 253		

100 hall adjacent to the lobby area had broken and splintered laminate on the edges of the bottom half of the door.

During an interview and tour on 10/27/16 at 3:08 PM the Maintenance Supervisor he explained the facility used a work order system. He further explained staff could enter work orders in the computer system but staff could also write a note or tell him or his Maintenance Assistant any concerns or repairs that were needed. Then maintenance staff entered the repair in the work order system for tracking purposes. He stated they checked work orders daily and it was his expectation for everything to be reported that needed to be repaired. He confirmed the facility was under renovation but the project would be a year to a year and a half before the renovations were completed and they had started with renovating a few rooms at a time on the 100 hall. He also confirmed there were no other projects underway at this time other than routine maintenance. The Administrator joined the tour and acknowledged all of the resident doors in the building had damage and confirmed some of the doors had broken out sections in the laminate and wood which could cause rough edges.

During a follow up interview on 10/27/16 at 3:20 PM with the Administrator he stated it was his expectation for the splinters and rough edges on the doors to be repaired so that there would be no harm or risk to residents from rough edges or splinters on doors.

2. Resident #14 was observed sitting n a broda chair with white dried matter on the seat, arm rests and bolster pillows as follows:
On 10/25/16 at 9:05 AM;
On 10/26/16 at 9:03 AM and 10:12 AM;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 253	Continued From page 20 On 10/27/16 at 9:29 AM; and On 10/27/16 at 3:48 PM. Interview and observations with the Administrator and the Housekeeping supervisor on 10/27/16 at 3:48 PM confirmed the broda chair Resident #14 sat in was soiled and needed to be cleaned. The Administrator stated at the first of the year, a company was hired to clean the wheelchairs in the facility. The Administrator stated he was not happy with the work provided and arranged with the housekeeping department (a contract company) to schedule and clean the residents' wheelchairs around June 2016. In September 2016, the Administrator noticed a problem with soiled wheelchairs again and in October met with the Housekeeping Supervisor and scheduled a housekeeper to clean 2 wheelchairs per night 5 days a week. This started 10/12/16 and the schedule showed he cleaned 12 wheelchairs so far, starting with 100 hall. Review of this schedule revealed it would be weeks before Resident #14's broda chair was scheduled for cleaning. The Housekeeping Supervisor stated that they would clean additional chairs as needed if they were brought to her attention.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 21 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for the areas of cognition, vision, psychotropic medications, incontinence, falls, and activities of daily living skills for 4 of 14 sampled residents reviewed for comprehensive assessments (Residents #14, #101, #156 and	F 272	F 272 Resident #14 Care Area Assessment in the area of the areas of Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 22 #2). The finding included: 1. Resident #14 was admitted to the facility on 09/14/13 with diagnoses including advanced dementia, macular degeneration, anxiety, renal insufficiency, depression, legal blindness, obsessive compulsive disorder, and anxiety. The annual Minimum Data Assessment dated 05/03/16 coded Resident #14 with adequate vision, having cataracts, glaucoma or macular degeneration, long and short term memory impairments, severely impaired cognitive skills for decision making, requiring extensive assistance to toilet and always being incontinent of bowel and bladder, receiving antipsychotic, antidepressant and antianxiety medications 7 out of the last 7 days and having had one fall with injury since the last assessment. Review of the Care Area Assessments completed 05/04/16 revealed no individual information explaining why these areas were a problem for the resident, how the problem affected their day to day routines and no analysis of the findings as follows: a. Cognition stated this was a long term care resident with hospice services in place related to confusion as evidenced by dementia. b. Vision stated to see the approaches for vision in the activities of daily living care area assessment. There was no care area assessment for activities of daily living skills as this area did not trigger for an assessment. c. Incontinence stated the resident was incontinent of bowel and bladder with confusion as evidenced by advanced dementia with hospice	F 272	addressed. Resident #101 Care Area Assessment in the area of Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. Resident #156 Care Area Assessment in the area of Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. Resident #2 Care Area Assessment in the area of Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. MDS Coordinators will be provided education by the Director of Clinical Operations, regarding Federal and State regulation to ensure underlying causes, contributing factors, and risk factors were addressed in the Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills Care Area Assessments. MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments following education by the Director of Clinical Operations and forward to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 23 in place. d. Falls stated the resident had a recent fall related to confusion as evidenced by advanced dementia. e. Psychotropic medications stated the resdient received antipsychotic, antianxiety, antidepressant, hypnotic medications as ordered by the physician. On 10/27/16 at 5:47 PM an interview was conducted with MDS coordinator #1 who completed the nursing sections including incontinence, falls and psychotropic medications, of the MDS and CAAs. MDS Coordinator stated that she gathered information for the MDS from the record, the resident, staff and personal observations. In the analysis she included diagnoses and information gathered about that area. Although she was able to describe Resident #14's abilities, strengths and weaknesses, the details were not in the CAA itself. She stated she would write in the CAA what the care plan would include. Interview with the Social Worker on 10/27/2016 at 7:16 PM revealed she had an assistant who also completed the CAAs which included vision and cognition. The Social Worker stated that the CAA should paint a picture of the resident and how the areas of cognition and vision affected them. She stated the CAA did not paint a picture of the resident and training would be necessary. On 10/27/2016 7:35 PM interview with Director of Nursing revealed she expected the CAA to be accurate and reflective of the individual resident's clinical picture. 2. Resident #101 was admitted to the facility on	F 272	underlying causes, contributing factors, and risk factors were addressed in the Cognition, Vision, Psychotropic Medications, Incontinence, Falls, and Activities of Daily Living Skills Care Area Assessments. Director of Nursing or designee, will conduct weekly 10% audits of the Care Area Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 24	F 272		

12/28/15. His diagnoses included anemia, hypertension, diabetes, acute hypoxemic respiratory failure, renal failure and iron deficiency.

The admission Minimum Data Set dated 01/04/16 coded him with having severely impaired cognition, requiring extensive assistance with most activities of daily living skills, and having no behaviors.

Review of the Care Area Assessments (CAA) completed 01/07/16 revealed no individual information explaining why these areas were a problem for the resident, how the problem affected their day to day routines and no analysis of the findings as follows:
a. Cognition had no analysis of findings, just a check list.

On 10/27/2016 at 7:35 PM interview with the Social Worker revealed that the cognition CAA was submitted but not completed. No other explanation was provided.

On 10/27/2016 7:35 PM interview with Director of Nursing revealed she expected the CAA to be accurate and reflective of the individual resident's clinical picture.

3. Resident #156 was admitted to the facility on 03/11/16 with diagnoses including adult failure to thrive, glaucoma, dementia, and left lower extremity amputation.

The admission Minimum Data Set dated 03/17/16 coded him with intact cognition, moderately impaired vision, requiring extensive to total assistance with activities of daily living skills and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 25	F 272		

being frequently incontinent of bladder and totally incontinent of bowels.

Review of the Care Area Assessments completed 03/29/16 revealed no individual information explaining why these areas were a problem for the resident, how the problem affected their day to day routines and no analysis of the findings as follows:
a. Vision stated this resident had limited vision due to diagnoses of being legally blind and he can identify objects only.
b. Activities of Daily Living Skills stated the resident required extensive assistance with bed mobility, dressing and eating and total assistance with toilet use, personal hygiene and bathing.
c. Incontinent stated that during the 7 day look back period, the resident was frequently incontinent of bladder and totally incontinent of bowels.

On 10/27/16 at 5:47 PM an interview was conducted with MDS coordinator #2 who completed the nursing sections including activities of daily living skills and incontinence of the MDS and CAAs. MDS Coordinator stated that she gathered information for the MDS from the record, the resident, staff and personal observations. In the analysis she included diagnoses and information gathered about that area. Although she was able to describe Resident #156's abilities, strengths and weaknesses, the details were not in the CAA itself. She stated she would write in the CAA what the care plan would include.

Interview with the Social Worker on 10/27/2016 at 7:16 PM revealed she had an assistant who also completed the CAAs which included vision. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 26	F 272		

Social Worker stated that the CAA should paint a picture of the resident and how the area of vision affected him. She stated the CAA did not paint a picture of the resident and training would be necessary.

On 10/27/2016 7:35 PM interview with Director of Nursing revealed she expected the CAA to be accurate and reflective of the individual resident's clinical picture.

4. Resident #2 was re-admitted to the facility on 08/03/16 with diagnoses which included high blood pressure, joint disease, dementia, agitation, psychosis and depression.

A review of the most recent significant change Minimum Data Set (MDS) dated 08/23/16 indicated Resident #2 had long and short term memory problems and was severely impaired in cognition for daily decision making and the Care Area Assessments (CAAs) indicated Resident #2 triggered for falls and the analysis of findings indicated confusion sustaining falls as evidenced by a diagnosis of dementia.

During an observation on 10/26/16 at 10:17 AM Resident #2 was in bed on a mattress on the floor.

During an observation on 10/27/16 at 9:40 AM Resident #2 was lying on a mattress on the floor and was folding the edges of her blanket.

During an interview with MDS Coordinator #1 she confirmed the analysis of findings for Resident #2's falls was incomplete. She explained one of the things she could do was to define dementia and she needed to have painted a better picture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 272	Continued From page 27 of the resident and how her dementia placed her at fall risk. She stated she wanted to leave out information that was not needed but she should have added more when she did the CAA. During an interview on 10/27/16 at 7:35 PM the Director of Nursing stated she expected the CAA to be accurate and reflective of the individual resident's clinical picture.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 278	Continued From page 28 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed tot accurately code information including the areas of cognition, vision, dental and falls on the Minimum Data Set assessments for 3 of 14 sampled residents (Residents #14, #101 and #156). The findings included: 1. Resident #14 was admitted to the facility on 09/14/13 with diagnoses including advanced dementia, macular degeneration, anxiety, renal insufficiency, depression, legal blindness, obsessive compulsive disorder, and anxiety. Review of dental notes revealed Resident #14 was seen on 08/03/15 and she was found edentulous and not a candidate for dentures due to dementia. She was subsequently seen by the dentist on 11/24/15 and 06/22/16 both times being found edentulous. The annual Minimum Data Assessment (MDS) dated 05/03/16 coded Resident #14 with adequate vision with no glasses and having cataracts, glaucoma or macular degeneration. She was coded as having clear speech, being understood and understanding, and not being able to conduct the Brief Interview for Mental Status (BIMS) due to her being rarely or never understood. She was coded as having no dental issues and was not marked as being edentulous. The quarterly MDS dated 07/26/16 also coded	F 278	F 278 Resident #14 MDS Assessment sections of Cognition, Vision, Dental and Falls, were reviewed and analyzed by the MDS Coordinator to ensure accuracy of the resident's assessment. Resident #101 MDS Assessment sections of Cognition, Vision, Dental and Falls, were reviewed and analyzed by the MDS Coordinator to ensure accuracy of the resident's assessment. Resident #156 MDS Assessment sections of Cognition, Vision, Dental and Falls, were reviewed and analyzed by the MDS Coordinator to ensure accuracy of the resident's assessment. MDS Coordinators will be provided education by the Director of Clinical Operations, regarding Federal and State regulation to ensure MDS Assessment accuracy in the sections of Cognition, Vision, Dental and Falls. MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments following education by the Director of Clinical Operations and forward to ensure MDS Assessment accuracy in the sections of Cognition, Vision, Dental and Falls. Director of Nursing or designee, will conduct weekly 10% audits of the MDS Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 278	Continued From page 29 Resident #14 with adequate vision with no glasses, having clear speech, coded as being understood and understanding, but not able to participate in the BIMs due to rarely or never being understood. On 10/25/16 at 9:05 AM, Resident #14 was observed with no teeth or dentures in her mouth. On 10/27/2016 7:54 PM, MDS Coordinator #1 was interviewed and stated she looked into residents' mouths with a pin light to assess oral needs. She stated she could not recall that particular MDS but suspected that not marking edentulous was an error in understanding the MDS question. On 10/27/2016 7:05PM interview with the social worker revealed that she or one of her two assistants completed the MDS sections of vision and cognition. She stated that her cognition and ability to communicate does fluctuate during the day but that Resident #14 did have vision impairment and legally blindness should have been checked as severely impaired and that if she was understood and understands then the BIMs should have been conducted. She further stated that in the look back period, Resident #14 was not understood and understanding of the information if the BIMS could not be conducted. The Director of Nursing stated during interview on 10/27/16 at 7:35 PM that she expected the MDS to be completed accurately. 2. Resident #101 was admitted to the facility on 12/28/15. His diagnoses included anemia, dementia, diabetes, respiratory failure and renal failure.	F 278	shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 278	Continued From page 30	F 278		

The admission Minimum Data Set (MDS dated 01/04/16 coded him with having severely impaired cognition and having no dental problems and not marked edentulous.

On 10/25/16 at 2:58 PM Resident #101 was observed toothless. On 10/26/16 at 1:29 PM he was again observed toothless and he stated he had no teeth.

On 10/27/16 at 7:59 PM, MDS coordinator #2 stated she looked into the mouths of the residents to assess their dental status and thought she misread the MDS meaning for no teeth or tooth fragments, therefore miscoding the MDS.

The Director of Nursing stated during interview on 10/27/16 at 7:35 PM that she expected the MDS to be completed accurately.

3. Resident #156 was admitted to the facility on 03/11/16 with diagnoses including adult failure to thrive, glaucoma, dementia, and left lower extremity amputation.

The admission Minimum Data Set dated 03/17/16 coded him with intact cognition and moderately impaired vision.

On 10/26/16 at 8:27 PM, Resident #156 was observed feeding himself, eating with his fingers and fork appearing to need his fingers to guide the food onto his fork.

On 10/26/16 at 9:10 AM, Resident #156 was interviewed, He stated that staff tell him where his food is on his plate and it is sometimes easier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 278	Continued From page 31 to eat with his fingers due to his poor vision. On 10/26/16 at 2:30 PM, Resdient #156 was observed attempting to play the wheel of fortune game in the activity room. staff had to guide his hands to spin the wheel and he stated he could not see the yellow papers on the wall, approximately 6 feet away, which contained the letters which were revealed from previous guesses. On 10/26/16 at 2:51 PM, Nurse Aide (NA) #1 stated that if all three lights are turned on in his room, Resident #156 was able to see shadows. Resident #156 stated during interview on 10/27/16 at 9:30 AM that he cannot not recognize staff visually and can't see to read. Interview with the Social Worker on 10/27/16 at 7:16 PM revealed that she and 2 other assistants complete the MDS for vision. She stated that being legally blind would make him severely impaired visually and the coding of him as having moderate impairment with vision was incorrect. The Director of Nursing stated during interview on 10/27/16 at 7:35 PM that she expected the MDS to be completed accurately.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 312	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nail care to keep nails trimmed, smooth and clean for 1 of 3 residents sampled for activities of daily living skills (Resident #101). The findings included: Resident #101 was admitted to the facility on 12/28/15. His diagnoses included respiratory failure, renal failure, diabetes and dementia. The admission Minimum Data Set (MDS) dated 01/04/16 coded him as having severely impaired cognition, having no behaviors, and requiring total assistance with hygiene. The quarterly MDSs dated 06/15/16 and 09/07/16 coded him with severely impaired cognition, and requiring extensive assistance with most activities of daily living skills (ADLs) including transfers, dressing, hygiene and toileting. The ADL plan of care established 01/11/16 and reviewed last on 09/14/16 included the problem of requiring assistance with ADLs. The goal was for him to assist with self care activities. Interventions included to assist him with ADLs by providing set up and allowing him to complete or assist as tolerated. On 10/25/16 at 2:53 PM Resident #101 was observed with brown debris under his long right middle fingernail and long fingernails on his left hand while in bed.	F 312	F312 Resident #101 nails were clipped and cleaned on 10/27/16. Facility wide observations conducted to ensure facility resident's nails were clipped and clean. Staff Development Coordinator to educate nurse aide staff to provide nail care during daily resident ADL care. Nurses to provide observation of nail care. Treatment Nurse or designee will observe weekly, 10% of facility residents, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 312	Continued From page 33	F 312		

On 10/26/16 at 8:32 AM he was observed eating in bed with debris still under the long right middle fingernail. On closer observation on 10/26/16 at 9:05 AM, the left hand was noted to have long fingernails on the ring finger. On 10/26/16 at 1:29 PM he was observed in his wheelchair The finger nail on the middle and thumb nails on the left hand were long. He stated the staff cut them.

On 10/26/16 at 6:33 PM Resident #101's right middle fingernail had dark debris under the nail and the left thumb, forefinger and ring fingers were observed with long nails.

On 10/26/16 at 7:00 PM Nurse Aide (NA) #2 stated he gave the resident a bed bath the night before.

On 10/27/16 at 8:55 AM his middle right fingernail was observed clean but torn half off leaving it jagged. The nails on the left hand remain long with the ring fingernail extending 1/4 inch beyond the nail bed. His nails remained the same when observed on 10/27/16 at 11:22 AM, and 3:06 PM.

On 10/27/16 at 3:06 PM NAs #1 and #4 stated that they tried to clean under the resident's nails when they find them dirty, however, nurses were responsible for trimming nails. NA #1 stated she had him yesterday and knew his nails were long but did not notice that today the middle fingernail was broken and jagged. They stated about 2 weeks ago an audit was completed and nail care was provided.

On 10/27/16 at 3:17 PM the Director of Nursing (DON) stated that when she had extra staff, she assigned a nurse aide to trim and polish nails approximately 1 and a half weeks to 3 weeks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 312	Continued From page 34 ago. She further stated that nurses were responsible for trimming a resident's nails who was diabetic. On 10/27/16 at 3:20 PM the DON observed Resident #101's nails and stated that the nails needed to be trimmed and there were no excuses for them to be so long and jagged. On 10/27/16 at 3:24 PM Nurse #1 stated she had been aware of his long nails and that he really needed them trimmed badly. She further stated he sometimes ate with his fingers and his nails stayed dirty. She stated it had been about a month since she attempted to trim his nails.	F 312		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a renal diet for 1 of 1 resident sampled who received a renal diet (Resident #155). The findings included: Resident #155 was readmitted to the facility on 08/17/16. His diagnoses included end stage renal disease and diabetes. The admission Minimum Data Set dated 08/24/16 coded him with moderately impaired cognition and receiving a therapeutic diet. Review of physician orders revealed that on	F 367	F 367 Resident #155's diet order was reviewed by the Registered Dietician and determined that the correct diet was ordered. Registered Dietician reviewed current resident's diet orders to ensure correct diets were ordered. Tray line procedures updated to ensure residents receive correct diets as ordered. Tray cards will be checked for accuracy at tray set up, prior to plating up the meal, and prior to loading the meal into the cart for delivery. Nutrition Care Rep #1 will check tray card for diet and special equipment and also set up tray with	11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 367	Continued From page 35 09/13/16 Resident #155 was to receive a renal concentrated carbohydrate diet. On 10/26/16 at 4:32 PM, observations were made of the tray line preparation and then service. Review of the spread sheet for this meal revealed that breaded fried fish and macaroni and cheese was an alternate for a consistent carbohydrate entree and baked fish and green beans was the alternate for the renal diet. The cook was observed plating the food and the dietary aide at the end of the line reread the tray card, checked for drinks and accuracy, covered and placed the trays on the tray cart. On 10/26/16 at 5:48 PM, observations were made of Resident #155's plate being prepared and placed in the tray cart. Resident #155 plate consisted of fried fish and green beans. After 4 additional trays had been placed on the tray cart an interview was conducted with the cook and the dietary manager who revealed that a resident on a renal consistent carbohydrate diet was to receive the renal diet. The cook then asked where the baked fish was, and was informed it was in the steamer. The fried fish was then replaced by the baked fish. Both the cook and the dietary aide stated they had missed reading the correct diet.	F 367	appropriate dessert, condiments, and utensils. Cook will check tray card for the prescribed diet, any adaptive equipment, allergies and/or dislikes. Nutrition Care Rep #2 will check tray card for diet, special equipment, condiments, and ensures everything at this point is accurate according to the tray card and loads tray into cart for delivery. Dietary staff provided education by the General Manager, regarding the regulation to ensure diets were provided as ordered. Administrator or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 371	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 1 of 3 ice machines clean, maintain a clean microwave in 1 of 2 nourishment rooms, maintain food within safe date in the kitchen reach in, store bowls in a clean bin and wash hands and change gloves when going from dirty to clean when working in the dish machine area. The findings included: 1. On 10/26/16 at 1:33 PM the dietary aide was observed in the dish machine area loading and unloading the dish machine. The Dietary aide was wearing plastic gloves. She was observed rinsing and loading dirty dish items, then using hand sanitizer, which she quickly rubbed over her gloves and moving to unload the clean items that had passed through the dish machine. She repeated this process at least 5 times where she always used hand sanitizer over her gloves between the dirty and clean dish handling. On 10/26/16 at 1:56 PM the Dietary Manager was interviewed an stated that she expected staff to change gloves and wash their hands when moving between the dirty dishes and touching the clean dishes. She stated that if hands were visibly soiled, soap and water was to be used and if not visibly soiled hand sanitizer was acceptable. She further stated using sanitizer on gloves was not acceptable. On 10/26/16 at 2:00 PM, the dietary aide stated	F 371	F 371 On 10/27/16, the ice machine and microwave was cleaned. In addition, out of date food in the kitchen reach in was discarded and bowls were washed and placed in clean bins. Kitchen protocol updated to define staff responsibility for cleaning. For the ice machines, maintenance schedule changed to bimonthly cleaning, with the General Manager observing weekly and notifying Maintenance if more frequent cleaning was required. For the microwave, Environmental Services will clean the interior and exterior of the microwave. For the bowls, after clean racks go through the dish machine, new bowl racks were purchased for bowls to air dry. For the food expiration dates, the Utility Stocker is responsible for checking the food expiration dates and the Cook assumes this responsibility in the absence of a Utility Stocker. In addition, dish machine procedures were updated to ensure staff loading dishes on the dirty side and go to the clean side of the dishes, must first remove gloves, perform hand hygiene, and replace gloves. Dietary staff provided education by the General Manager, regarding the regulation to ensure proper hand hygiene, food storage, and food sanitation. Housekeeping and maintenance staff provided education by the Facility Safety	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 371	Continued From page 37 she was trained to use hand sanitizer when going from the dirty side of the dish machine to the clean side of the dish machine. She further stated she was unaware that using hand sanitizer on top of gloves was not appropriate. 2. During the initial tour on 10/24/16 at 11:00 AM the nourishment room located on the 200 hall was observed and found to have dried food spills inside sides and ceiling of the microwave. When rechecked on 10 /24/2016 at 4:59 PM, on 10/26/16 at 11:48 AM, 10/27/16 at 9:58 AM, and on 10/27/16 at 11:50 AM the dried spills in the microwave remained. On 10/26/16 at 1:43 PM the Dietary Manager stated that housekeeping staff were responsible for keeping the microwaves in the nourishment rooms clean. On 10/26/16 at 11:48 PM, a dietary aide was observed stocking the refrigerator in the nourishment room. She stated that she was not sure who was responsible for the cleanliness of the equipment in the nourishment rooms but thought it was housekeeping. On 10/27/16 at 10:02 AM a housekeeper on the 200 hall was interviewed. She stated that she wiped the counters, removed the trash, mopped the floor, replaced soap and paper products in the nourishment room. She stated she wiped the coffee pot off but was not sure who was responsible for the microwave and refrigerators. On 10/27/2016 at 1:55 PM, the Housekeeping Supervisor stated the housekeepers were to wipe off the outside of the microwave and dietary staff were responsible for the cleanliness of the inside	F 371	Officer, regarding the regulation to ensure cleanliness of equipment. Administrator or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 371	Continued From page 38	F 371		

of the microwave.

On 10/27/16 at 2:10 PM the Administrator stated during interview that housekeeping staff were responsible for cleaning the inside of the microwaves. At this time both the Housekeeping Supervisor and the Administrator observed the 200 hall microwave with the dried food splatter on the inside sides and ceiling. The Housekeeping Manager again stated dietary staff was responsible and the Administrator stated that she was mistaken and it was a housekeeping responsibility.

3. During initial tour of the kitchen beginning on 10/24/16 at 10:34 AM, 3 of 4 plastic bins which stored clean plastic bowls was found to have dried loose debris in the bottom, in direct contact with the bowls. The Dietary Supervisor, present at this time stated the bins were supposed to be cleaned with the bowls and she removed them for cleaning at this time.

On 10/26/16 at 1:43 PM the Dietary Manager stated that she had ordered and implemented using new plastic racks for the bowls to air dry and store as of 10/26/16.

4. During initial tour of the kitchen beginning on 10/24/16 at 10:34 AM, there was tray of individual food items in the cooler. On the tray with other foods ready for service were 2 plated cookies and a slice of apple pie with a shelf life that had the date that they could be served until 10/23/16. The Dietary Supervisor present at this observation stated that the cooler was to be checked daily and the outdated foods discarded. She discarded these food items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 371	Continued From page 39 5. During initial tour of the kitchen beginning on 10/24/16 at 10:34 AM, the ice machine was noted with a dark stained plastic ridge on the inside over the ice. The Dietary Supervisor, present at this observations took an alcohol wipe and rubbed some dark debris off the plastic bar. The Dietary Supervisor stated the ice machine was cleaned by the maintenance department who maintained a cleaning schedule. On 10/26/16 at 1:55 PM, the Dietary Manager stated she checked the ice machine weekly to ensure it was clean using a towel. She stated the plastic was actually stained not soiled. The plastic was observed at this time and noted stained but the darker residue had been removed. She stated that when she noted the towel she checked the machine with was soiled, she would have maintenance clean the ice machine, but that did not happen often. On 10/27/16 at 2:48 PM, the Maintenance Supervisor stated that the ice machine was on a quarterly cleaning schedule and was about due for a cleaning. He further stated that he had not been asked to clean the ice machine this week.	F 371		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		11/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 520	Continued From page 40 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. 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 these interventions that the committee put in place in October of 2015. This was for two recited deficiencies which were originally cited in September of 2015 on a recertification and complaint survey and subsequently recited in October of 2016 on the current recertification and complaint survey. The deficiencies were in the areas of housekeeping and maintenance services and food procure/store/prep/serve. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to:	F 520	F 520 The facility maintains Quality Assessment and Assurance Committee (QAPI) with members including the Administrator, Director of Nursing, Medical Director, and three additional staff from nursing and/or Interdisciplinary team. Corrective Action Plan and plan for monitoring to sustain an effective Quality Assurance Program, to be reviewed with the QAPI Committee. Corrective Action: F253 Resident rooms #111, #112, #200, #201, #203, #302, #312, #316, #324, #326, #327, #407 and #409, will have wood and laminate replaced. Damaged wood and laminate on the edges of smoke prevention doors (100 Hall adjacent to the lobby area) will have wood and laminate replaced.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 520	Continued From page 41 1. F 253 Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations and staff interviews the facility failed to repair 13 resident doors with broken and splintered laminate and wood on 4 of 4 resident hallways (Resident Rooms #111, #112, #200, #201, #203, #302, #312, #316, #324, #326, #327, #407 and #409); failed to repair damaged wood and laminate on the edges of smoke prevention doors on 1 of 4 resident hallways (100 Hall adjacent to the lobby area); and failed to clean a soiled broda chair for 1 resident (Resident #14) on 1 of 4 resident hallways (300 Hall). F253 was originally cited during the September 11, 2015 recertification survey for failing to label bathing basins and bedpans. 2. F371 Food procure/store/prep/serve. Based on observations and staff interviews, the facility failed to maintain 1 of 3 ice machines clean, maintain a clean microwave in 1 of 2 nourishment rooms, maintain food within safe dates in the reach in cooler, store bowls in a clean bin and wash hands and change gloves when going from dirty to clean when working in the dish machine area. F371 was originally cited during the September 11, 2015 recertification and complaint survey for failing to maintain and serve food at the required temperature, maintain milk at 41 degrees F or below on the tray line, remove soiled gloves and complete hand hygiene prior to plating, and sanitize a soiled thermometer in between use.	F 520	Resident #14's broda chair was cleaned on 10/27/16. Facility wide observations conducted to ensure wood and laminate on doors was in good repair and broda chairs were clean. Housekeeping and maintenance staff will be provided education by the Facility Safety Officer, regarding the regulation to ensure wood and laminate on doors in good repair and broda chairs clean. Admissions Coordinator or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Corrective Action: F371 On 10/27/16, the ice machine and microwave was cleaned. In addition, out of date food in the kitchen reach in was discarded and bowls were washed and placed in clean bins. Kitchen protocol updated to define staff responsibility to maintain clean ice machines, clean microwaves, store clean dishes and observe and act upon, food expiration dates. In addition, dish machine procedures were updated to ensure proper hand hygiene was in place for staff working in the dish machine area. Dietary staff provided education by the General Manager, regarding the regulation to ensure proper hand hygiene, food storage, and food sanitation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 520	Continued From page 42 An interview was conducted on 10/27/2016 at 8:19 PM with the Administrator. The administrator stated the previous tags were about portion size and the current tag was about sanitation. The last environmental tag was about bathing basins not being labeled and not related to soiled wheelchairs or resident doors. The administrator went on to say the facility needed to review their dietary contract and implement a plan of correction with expectations that will meet the facility's standards.	F 520	Housekeeping and maintenance staff provided education by the Facility Safety Officer, regarding the regulation to ensure cleanliness of equipment. Administrator or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	