| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 345415 | A. BUILDING: _____ B. WING _____ | 6/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| F 657 | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, family member and staff interviews, and record review the facility failed to revise a care plan regarding activities for 1 of 5 sampled residents reviewed for an ongoing activity program (Resident #53).<br><br>The findings included:<br><br>Resident #53 was admitted to the facility on 10/24/18 with diagnoses which included dementia.<br><br>Review of Resident #53's significant change Minimum Data Set (MDS) dated 02/22/19 revealed an assessment of short-term and long-term memory loss. The MDS indicated a prognosis of life of 6 months or less. The Activity Care Area Assessment (CAA) did not trigger.<br><br>Review of Resident #53's care plan dated 03/06/19 indicated Resident #53 relied on others for meeting emotional, intellectual and social needs. Interventions to maintain involvement in cognitive stimulation included use of an activity apron when out of bed, invitation to activities and provision of materials for individual activities as desired. The care plan listed music as a preference of Resident #53.<br><br>Observation on 06/11/19 at 8:53 AM and at 9:35 AM revealed Resident #53 asleep in bed.<br><br>Observation on 06/11/19 at 11:05 AM revealed Resident #53 seated in a geriatric chair in the hallway. Resident #53 did not respond to oral communication. Resident #53's eyes followed movement.<br><br>Observation on 06/11/19 at 12:47 AM revealed Resident #53 seated in a geriatric chair across from the |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 345415 | A. BUILDING: _____ B. WING _____ | 6/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PINEVILLE REHABILITATION AND LIVING CTR** | **1010 LAKEVIEW DRIVE PINEVILLE, NC** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **F 657** | Continued From Page 1 |

nursing station. Resident #53 did not respond to oral communication. Resident #53's eyes followed movement.

Telephone interview with Resident #53's family member on 06/12/19 at 10:00 AM revealed Resident #53 was hard of hearing and could not enjoy music. Resident #53's family member explained Resident #53 could no longer use the activity apron, do individual activities and enjoy group activities since a decline in health and admission to hospice care in February 2019.

Interview on 06/14/19 at 8:44 AM with Nurse Aide (NA) #2 revealed Resident #53 did not use an activity apron and required total assistance with all activities of daily living. NA #2 explained Resident #53 ate meals in the dining room and rarely responded to oral communication.

Interview with Nurse #1 on 06/14/19 at 8:50 AM revealed Resident #53 received frequent visits by family members and hospice staff. Nurse #1 reported she could not recall the last time Resident #53 used an activity apron.

Interview with the Activity Director on 06/14/19 at 9:36 AM revealed Resident #53 received one to one visits and attended group religious music events. The Activity Director reported the activity care plan was not revised to reflect Resident #53's current care plan interventions related to activities.

Interview with the Administrator on 06/14/19 at 9:40 AM revealed Resident #53's care plan should accurately reflect activity needs and interventions required.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PINEVILLE REHABILITATION AND LIVING CTR** | **1010 LAKEVIEW DRIVE PINEVILLE, NC 28134** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A recertification survey was conducted from 06/11/19 to 06/214/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID FV7S11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation. Event ID FV7S11.<br><br>An amended 2567 report was provided to the facility on 06/28/19 because the s/s of tag F-657 was changed to an A level citation. | F 000 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems. | F 636 | | 6/26/19 |

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

Electronically Signed | 06/27/2019

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

| (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 636 | Continued From page 1<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review, the facility failed to conduct a | F 636 | Regarding the alleged deficient practice of failure to conduct a comprehensive | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

| (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 636 | Continued From page 2<br>comprehensive assessment to identify and analyze how condition affected function and quality of life related to falls for 1 of 6 sampled residents at risk for falls (Resident #54) and related to activities for 1 of 5 sampled residents reviewed for an ongoing activity program (Resident #42).<br><br>The findings included:<br><br>1. Resident #54 was admitted to the facility on 03/16/17 with diagnoses which included osteoporosis and macular degeneration.<br><br>Review of Resident #54's annual Minimum Data Set (MDS) dated 12/10/18 revealed an assessment of moderately impaired cognition with severely impaired vision. The MDS indicated Resident #54 required the limited assistance of one person with transfers and walking. The MDS indicated Resident #54's balance was not steady moving from a seated to standing position and when walking. The MDS indicated Resident #54 had one fall with injury since the prior assessment. The MDS indicated a Falls Care Area Assessment (CAA) among the areas that triggered for further analysis.<br><br>Review of Resident #54's Falls CAA dated 12/18/18 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to falls. There was no documentation of input from Resident #54's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.<br><br>Observation on 06/11/19 at 12:04 PM revealed | F 636 | assessment to identify and analyze how condition affected function and quality of life related to:<br>1 – falls for resident #54: 12/18/2018 falls CAA included no documentation of findings with a description of problem, contributing or risk factors and no analysis of findings supporting decision to care plan. The 12/18/2018 MDS assessment was reviewed and the falls CAA corrected by MDS coordinator on 06/26/19.<br>2 – activities for resident #42: 11/14/2018 activity CAA revealed no documentation of findings with any description of the problem, contributing factors, risk factors, and no documentation of an analysis of findings supporting decision to proceed to the care plan. The 11/14/2018 MDS assessment was reviewed and the activities CAA corrected by MDS coordinator on 6/26/19.<br>MDS nurses audited all current residents with care areas triggered for activities and falls on the most recent MDS assessments to ensure completion and adequate documentation beginning 06/17/19 with audit completed by 06/19/2019.<br>Director of Nursing educated MDS nurses and Activities Director regarding required components of documentation for triggered care area assessments on 06/19/2019.<br>Administrator or Director of Nursing will review all residents' MDS assessments with fall and activity care areas triggered for assessment to ensure adequate documentation is included in the assessment for two weeks; then, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

| (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 636 | Continued From page 3<br>Resident #54 ambulated independently with a walker to the bathroom.<br><br>Interview with Nurse Aide #1 on 06/13/19 at 11:02 AM revealed Resident #54 required physical assistance to ambulate with a walker to prevent falls. NA #1 explained Resident #54's vision was poor and Resident #54 usually used the call light to request assistance to the bathroom.<br><br>Interview on 06/14/19 at 10:25 AM with the MDS Coordinator revealed the MDS nurse who completed the Falls CAA for Resident #54 no longer worked at the facility. The MDS Coordinator confirmed the Falls CAA did not contain a description of the problem, contributing factors, risk factors related to falls and analysis of findings.<br><br>Interview with the Administrator on 06/14/19 at 10:54 AM revealed he expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.<br><br>2. Resident #42 was admitted to the facility on 10/26/18 with diagnoses which included Alzheimer's Disease and glaucoma with vision loss of the left eye.<br><br>Review of Resident #42's admission Minimum Data Set (MDS) dated 11/05/18 revealed an assessment of severely impaired cognition with little interest or pleasure in doing things. The MDS indicated music, doing things with groups of people, participation in religious activities and to go outside when the weather was good was very important to Resident #42. The MDS indicated an | F 636 | administrator, director of nursing or MDS RN will audit five residents (or 100% if less than 5) with fall or activity CAAs triggered per week x four weeks with report to monthly QAPI committee; then, administrator, director of nursing or MDS RN will audit five fall or activity CAAs per month x three months with report to monthly QAPI committee and then same will audit five per quarter x two quarters with report to monthly QAPI committee to include findings, recommendations and/or trends noted.<br>The QAPI committee will evaluate efficacy of plan and make changes as appropriate. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

| (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 636 | Continued From page 4<br>Activity Care Area Assessment (CAA) among the areas that triggered for further analysis.<br><br>Review of Resident #42's Activity CAA dated 11/14/18 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to activities. There was no documentation of input from Resident #42's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.<br><br>Interview with the Activity Director on 06/14/19 at 9:30 AM revealed she conducted the assessment of Resident #42's activity needs. The Activity Director did not provide a reason for the lack of documentation of a description of the problems, contributing factors, risk factors and an analysis of findings.<br><br>Interview with the Administrator on 06/14/19 at 09:35 AM revealed he expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings. | F 636 | | |