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 10/14/2011

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #1C6711.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to obtain daily weight measurement to monitor the potential of fluid overload for one (1) of five (5) sampled residents (Resident #83). The findings are: Resident #83 was readmitted to the facility on 9/7/11 with diagnoses which included Congestive Heart Failure, Diastolic Dysfunction, Atrial Fibrillation, and Hypertension. Readmission orders included daily weights and physician notification with weight gain greater than 5 pounds (lbs.) over a 2 day period. Medications ordered included Lasix (a diuretic) 40 mg daily. A physician's order dated 9/8/11 repeated the direction to call the physician with a weight gain greater than 5 lbs. in 2 days. Review of the readmission Minimum Data Set	F 309	F 309 It is the policy of Pineville Rehabilitation & Living Center to provide the necessary care and service to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident # 83 is receiving a daily weight measurement to monitor the potential for fluid overload. Pineville Rehabilitation & Living Center has an established policy regarding weight management. Nursing staff were educated, effective 10/25/2011, of the weight management procedures, specifically related to weight measurement orders. The Weight Management Policy and Procedure was revised on 10/17/2011. The revision specifically addresses daily weight orders. Nursing staff have been educated, effective 10/25/2011, on the revised procedures and it has been implemented. Furthermore, a Daily Weight Log was implemented effective 10/17/2011. The Daily Weight Log will be used as a monitoring tool. Nursing staff were instructed to turn the log into the Administrator, effective 10/17/2011, on a daily basis for review. The Administrator is reviewing the logs for compliance for a period of 6 months.	10/25/2011

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

Pamela G. Locklear, LNHA — Administrator — 11-7-2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
NOV 8 2011
BY: ORA

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 10/14/2011

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 309	Continued From page 1 dated 9/13/11 revealed Resident #83 's assessment included shortness of breath upon exertion. The care plan updated on 9/23/11 listed the potential for Altered Respiratory Status/weight fluctuation/fluid volume overload as a problem with interventions which included assessment for signs and symptoms of overload (edema, shortness of breath, bounding pulse, and jugular vein distention). Review of Resident #83's September 2011 electronic Medication Administration Record (eMAR) revealed no documentation of weight on 9/8/11, 9/10/11, 9/11/11, 9/17/11 and 9/18/11. Resident #83's September 2011 weight range was 127.3 lbs. to 138.8 lbs. Review of nursing notes and nursing assistant record in September 2011 revealed documentation of weights on 9/8/11 and 9/10/11 with refusal of weight on 9/11/11. There were no documented weights on 9/17/11 and 9/18/11. Review of a physician's order dated 9/16/11 revealed the Lasix increased to 20mg at bedtime in addition to the 40 mg daily in response to notification of a 4.8 lbs. weight gain (from 134 lbs. on 9/13/11 to 138.8 lbs. on 9/15/11). Review of a physician's order dated 10/7/11 revealed early AM daily weights were to continue with physician notification of over 3 lbs. weight gain. Review of the October 2011 eMAR revealed no documentation of weight on 10/5/11. A weight gain of 2.8 lbs. was documented from 10/3/11 to 10/4/11 (132.5 lbs. on 10/3/11 and 135.3 lbs. on	F 309	In addition, the Director of Nursing Services (DON) and other members of the Nursing Leadership Team are performing weekly checks to ensure compliance. The DON & other Nursing Leadership team members are submitting a written report to the Administrator on a weekly basis for a period of 6 months. The Administrator will report findings to the Quality Assurance Committee on a monthly basis for a period of 6 months.	

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 10/14/2011

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 309	Continued From page 2 10/4/110). On 10/6/11, the weight was 134.9 lbs. Resident #83's weight range was 131.3 lbs. to 138.5 lbs. from 10/1/11 to 10/13/11. Interview with Licensed Nurse (LN) #2 on 10/13/11 at 2:45 PM revealed Resident #83's daily weights should be documented on the eMARs. She explained the nursing assistant obtained and reported the weight to the Licensed Nurse. LN # 2 revealed Resident #83's daily weights were done every morning between breakfast and lunch since the resident preferred to sleep late in the morning. LN #2 reported she did not know if the physician was aware of the different times of weight measurement. Interview with the Nurse Practitioner (NP) on 1013/11 at 3:00PM revealed daily weights should be done if ordered but Resident #83's heart failure monitoring included labs in addition to observation of signs and symptoms. Interview with LN #1 on 10/13/11 at 3:35PM revealed daily weight documentation should be on the eMAR instead of the nursing notes and nursing assistant record. She reported there was no documentation of Resident #83's weights on 9/17/11, 9/18/11 and 10/10/11 on the eMARs, nursing notes and nursing assistant records. LN #1 explained early am weights would be taken during the morning with no specific time designated due to Resident #83's desire to sleep after breakfast. Interview with Nursing Assistant #1 on 10/14/11 at 8:02 AM revealed she weighed Resident #83 before lunch daily and reported the weight to the nurse. NA #1 explained the times of the daily	F 309		

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 10/14/2011

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 309	Continued From page 3 weight varied because Resident #83 slept after breakfast. NA #1 reported she did not receive direction to weigh Resident #83 before or after the breakfast meal. Interview with the Director of Nursing (DON) on 10/14/11 at 8:37 AM revealed daily weights should be documented on the eMAR. The DON reported early AM weights would be taken before lunch.	F 309		
F 371 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to maintain potentially hazardous hot foods on the breakfast tray line at least 135 degrees Fahrenheit and reheat potentially hazardous foods to at least 165 degrees Fahrenheit. Fried eggs, omelets and sausage patties on the breakfast tray line had an internal temperature less than 135 degrees Fahrenheit; sausage patties were reheated to a temperature of 145 degrees Fahrenheit. The findings are:	F 371	F 371 It is the policy of Pineville Rehabilitation & Living Center to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under sanitary conditions. The facility is maintaining potentially hazardous hot foods on the tray line at least 135 degrees Fahrenheit and reheating potentially hazardous foods to at least 165 degrees Fahrenheit. Pineville Rehabilitation & Living Center has an established policy regarding procuring, storing, preparing and serving food under sanitary conditions. The cook who failed to maintain potentially hazardous hot foods on the breakfast tray line was educated verbally on 10/13/2011 and then the employee received written education on 10/21/2011 as a follow up.	10/25/2011

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 10/14/2011

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 371	Continued From page 4 A facility policy "Holding Hot Foods", undated, recorded in part, "To ensure safety, hot foods must be held at 140 degrees or above. Reheat all foods to 165 degrees F for 15 seconds." On 10/13/11 at 7:15 AM, the breakfast tray line was observed. Five fried eggs, five omelets and approximately forty sausage patties were observed on the steam table during the meal service. Temperature monitoring occurred at 7:34 AM, fried eggs were observed at 128 degrees Fahrenheit (F), omelets and sausage patties were both observed at 130 degrees F. The dietary manager was observed to remove the fried eggs, omelets and sausage patties from the tray line. The sausage patties were placed in the steamer to reheat. The fried eggs and omelets were prepared to order for the remainder of the tray line. The sausage patties were observed reheated to 145 degrees F and placed back on the tray line for service at 7:48 AM. Dietary staff #1 confirmed during the observation that hot foods should be cooked to 140 degrees F. On 10/14/11 at 1:15 PM, the dietary manager was interviewed. He stated that hot foods should be served according to the temperatures recorded on the recipes. The facility recipes documented that fried eggs, omelets and sausage patties should be served at 140 degrees F. He further stated that temperature monitoring occurred at the beginning of the breakfast tray line and during the tray line. Thermometers were calibrated each morning prior to temperature monitoring. He stated that eggs and sausage should have been covered on the tray line, the sausage placed on the tray line in smaller batches and the fried eggs	F 371	All dietary staff were educated on the importance of maintaining potentially hazardous hot foods on the tray line at least 135 degrees Fahrenheit and reheating potentially hazardous foods to at least 165 degrees Fahrenheit verbally on 10/13/2011 then again received written education on 10/25/2011 as a follow up. The Food Preparation, Serving and Monitoring sections of our procedure, specifically related to food temperatures, were revised on 10/17/2011. All dietary staff has been educated and the revision has been implemented. Furthermore, the daily food temperature log was revised on 10/16/2011. All dietary staff has been educated on the procedure for daily temperatures and the log has been implemented. The revised daily food temperature log requires the cook to write down temperatures at various times prior to, during and at the end of the tray line. The daily food temperature log will be used as a monitoring tool. The cook is and will continue to turn the daily food temperature log into the Certified Dietary Manager (CDM) and the Administrator daily for review for a period of 6 months.	

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 10/14/2011

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 371	Continued From page 5 cooked to order to keep them hot. The dietary manager further stated that he expected dietary staff to follow safe food guidelines and reheat hot foods to 165 degrees. On 10/14/11 at 1:45 PM, an interview with dietary staff #1 revealed that she checked food temperatures thirty minutes before the start of the tray line and then just before the tray line started. Dietary staff #1 further stated that sometimes she checked food temperatures during the lunch tray line service in the main dining room. She usually did not check breakfast food temperatures during the tray line.	F 371	In addition, the Certified Dietary Manager (CDM) is performing random temperature checks (on a weekly basis) prior to, during and at the end of the tray line to ensure compliance. The CDM is performing a minimum of 3 random checks per week. The CDM is submitting a written report to the Administrator on a weekly basis for a period of 6 months. Furthermore, the Dietician will be monitoring for compliance. The Dietician will perform a minimum of 2 random checks per month to ensure food is being procured, stored, prepared and served under sanitary conditions. The Dietician will submit a written report to the Administrator on a monthly basis for a period of 3 months. The Administrator will report findings to the Quality Assurance Committee on a monthly basis for a period of 6 months.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility to accurately document the administration of a medication (prednisone) in the medical record for 1 of 10 sampled residents	F 514	F 514 It is the policy of Pineville Rehabilitation & Living Center to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized. The facility is documenting the administration of medications in an accurate manner.	10/25/2011

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 10/14/2011

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 514	Continued From page 6 reviewed for unnecessary medication. The findings are: Resident #153 was admitted to the facility in April 2011 from the hospital with a tapering order for prednisone (a steroid used to suppress inflammation). Admitting diagnoses included acute on chronic respiratory failure, severe chronic obstructive pulmonary disease, oxygen dependent 3 liters chronically, and obstructive chronic broncitis with exacerbation. Medical record review revealed Resident #153 was admitted with a physician's order dated 4/22/11 to receive prednisone, in part, 30 mg each morning (8 AM) for 4 days, this order was initiated on 4/23/11. Additionally, at the completion of this dosage, a physician's order dated 4/22/11, documented that Resident #153 was to receive prednisone 20 mg each morning (8 AM) for 4 days starting on 4/26/11. The April 2011 medication administration record (MAR) for Resident #153 documented he received prednisone 30 mg on 4/26/11 and prednisone 20 mg on 4/26/11 for a total of 50 mg of prednisone at 8 AM on 4/26/11. An interview on 10/14/11 at 11:00 AM with the director of nursing revealed that she expected nursing staff to administer medication as ordered or to clarify the physician's order. She further stated that a medication reconcilliation sheet was not completed since Resident #153 was expected to return to the facility from hospital and provided no documentation to support the dosage of prednisone Resident #153 received at 8 AM on 4/26/11.	F 514	Pineville Rehabilitation & Living Center has an established Documentation of Medication Administration policy. The nurse who failed to accurately document the administration of prednisone was verbally educated on 10/14/2011. Nursing staff were educated on the importance of documenting medications in an accurate manner verbally on 10/14/2011 then again written on 10/25/2011 as a follow up. The Director of Nursing Services (DON) and other members of the nursing leadership team are performing random weekly checks to ensure compliance. The DON & other Leadership Nurses are submitting a written report to the Administrator on a weekly basis for a period of 6 months. The Administrator will report findings to the Quality Assurance Committee on a monthly basis for a period of 6 months.	

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 10/14/2011

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 514	Continued From page 7 A telephone interview on 10/14/11 at 11:30 AM with licensed nurse #3 revealed he followed the order for prednisone as it was written and gave 30 mg of prednisone to Resident #153 at 8 AM on 4/26/11. Licensed nurse #3 further stated that if he documented on the MAR that Resident #153 received 50 mg of prednisone on 4/26/11, this was documented in error. The licensed nurse confirmed that the physician's order for prednisone should have been clarified by contacting the nurse manager or the physician.	F 514		