| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| E 037 SS=F | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures. | E 037 | | 8/19/22 |

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

Electronically Signed | 08/19/2022

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| E 037 | Continued From page 1 | E 037 | | |

(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| E 037 | Continued From page 2 | E 037 | | |

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

| 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 07/29/2022 |

| 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 037 | Continued From page 3 | E 037 | | |

(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency

| 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 07/29/2022 |

| 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 037 | Continued From page 4<br>preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to train agency staff on the facility's emergency preparedness (EP) policies and procedures for 2 of 2 sampled agency staff (Nurse #9 and Nurse #3).<br><br>The finding included:<br><br>A telephone interview was conducted with Nurse #9 on 7/28/2022 at 12:19PM. She revealed she had not received any training on the facility emergency preparedness plan. She stated she was an Agency Nurse that had worked at the facility for the past month.<br><br>An interview was conducted with Nurse #3 on 7/29/2022 at 9:27AM. She revealed she had not received any training on the facility emergency preparedness plan. She stated she was an Agency Nurse that had worked at the facility for the past 3 months on 7AM-3PM shift and the 11PM-7AM shift. She stated she worked on weekends.<br><br>The Director of Nursing (DON) was interviewed on 7/29/2022 at 3:47PM. DON stated Agency employees did not receive specific training on the facility emergency preparedness program or | E 037 | E-037<br>Regarding the alleged deficient practice of failure to train agency staff on the facility□s emergency preparedness policies and procedures for 2 of 2 sampled agency staff<br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>Maintenance Director in-serviced all agency staff on 07/30/2022-07/31/2022 on the facility Emergency Preparedness Plan.<br><br>(2) Identification of other residents:<br>All residents are at risk for this alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Notebooks containing the facility□s Emergency Preparedness Plan were put at each nurse□s station on 08/03/2022.<br>All agencies being used by the facility were notified on 08/03/2022 that their staff | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| E 037 | Continued From page 5<br>disaster training. She revealed the facility leaned strongly on the use of Agency staff that had worked at the facility in the past and would know what to do in an emergency. DON stated she would add the emergency preparedness policies to the computer for Agency staff to have access going forward.<br><br>An interview was conducted on 7/29/2022 at 3:00PM with the Administrator and Maintenance Director. The facility EP plan was reviewed. They revealed they could not locate any information on Agency Staff completing the Facility Emergency Preparedness training. The Administrator stated her expectation was for all staff, to include Agency staff, to be trained on emergency preparedness. | E 037 | would need to read the plan located in a binder at each nursing station and sign that they had done so prior to beginning their shift.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: HR Director/designee shall audit notebooks twice per week for 3 weeks then weekly x 3 months and will notify assigned agency of any noncompliance with procedure and anyone found in noncompliance with this process will be removed from the schedule. Findings will be reported to QAPI committee; audits will continue as determined by QA committee.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint investigation were conducted from 07/25/22 through 07/29/22. There were 12 intakes (NC0019415, NC190984, NC00191061, NC00190882, NC00190937, NC00190750, NC00189196, NC00188692, NC00188194, NC00187805, NC00185930, and NC00184670). There was a total of 47 allegations and 26 were substantiated. Event ID: LE4511. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and | F 550 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 550 | Continued From page 6<br>outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to treat a | F 550 | F-550 | |

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

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|---|---|---|---|---|
| F 550 | Continued From page 7<br>resident in a dignified and respectful manner when 1 of 1 staff member (Nurse #3) spoke to the resident in a perceived disrespectful manner and failed to promote the resident's dignity and privacy by not providing a cover for his urinary catheter for 1 of 1 resident (Resident # 64) reviewed for dignity and respect.<br><br>The findings included:<br><br>Resident #64 was admitted to the facility on 06/23/22 with diagnoses which included neurogenic bladder and urinary retention.<br><br>Review of Resident #64's admission Minimum Data Set (MDS) assessment dated 06/30/22 revealed he was cognitively intact. The MDS also revealed Resident #64 had an indwelling urinary catheter.<br><br>1.a. Observation of and interview with Resident #64 on 07/25/22 at 12:01 PM revealed him lying in bed on an air mattress. Resident #64 stated there had been an incident earlier in the morning of the power going off. Resident #64 stated when the power went off his air mattress had deflated, and he was lying on an iron bed with no support. He further stated he began to yell for assistance because it was causing him pain in his sacral wound and his back. Resident #64 stated Nurse #3 came into his room after his mattress had deflated and he said he used some choice words because he was upset about lying on an iron bed with no cushioning and asked what they were doing about it. He stated Nurse #3 told him he was "being mean" and if he "didn't like it at the facility maybe he needed to transfer somewhere else." Resident #64 indicated her tone and what she said to him made him "feel like crap." He | F 550 | Regarding the alleged deficient practice of failure to treat a resident in a dignified and respectful manner when 1 of 1 staff member spoke to the resident in a perceived disrespectful manner and failed to promote the resident□s dignity and privacy by not providing a cover for his urinary catheter for 1 of 1 resident reviewed for dignity and respect.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Care staff provided resident #64 with a privacy bag for urinary catheter on 7/29/22.<br>Nurse Managers conducted reeducation of care staff on treating residents in a dignified manner.<br>Agency Nurse #3 received reeducation on providing care to all residents in a dignified manner.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and designees conducted an audit of all Urinary catheter bags to ensure a privacy bag was in place. One additional resident was affected, a privacy bag was provided. The Director of Activities and Designees Conducted Interviews with residents regarding customer service to determine if any additional residents were affected. | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 550 | Continued From page 8<br>further indicated he had recorded the conversation with Nurse #3. Resident #64 stated after about 20 minutes of laying on the bed with no cushioning they finally found drop cords and plugged his bed in on a red outlet in the hallway that was generator powered to re-inflate his mattress.<br><br>Interview on 07/27/22 at 5:00 PM with Nurse #3 revealed she remembered the power going off on 07/25/22 early in the morning and remembered Resident #64 being very upset and in pain and using choice language. Nurse #3 did not recall telling him he was mean but stated she had told him, "you were not nice, and you were tough on the staff this morning." Nurse #3 stated he told her he was sorry for his language but said he was not happy at the facility, and she said she told him, "if you're not happy at the facility you should transfer somewhere else."<br><br>Interview on 07/29/22 at 5:36 PM with the Administrator and Director of Nursing (DON) revealed they had spoken with Nurse #3 about the incident with Resident #64. The Administrator stated Nurse #3 was a fabulous nurse and Resident #64 had said a lot of ugly things and then would come back days later and apologize for being ugly. The Administrator said she believed Nurse #3 was not being ugly but was trying to be helpful and offer options to the resident. The Administrator further stated Nurse #3 was an agency nurse but had been dependable and a good worker at the facility.<br><br>b. Observation of and interview with Resident #64 on 07/25/22 at 12:01 PM revealed him lying in bed with his urinary catheter bag hanging on the bed rail with no privacy cover draining yellow | F 550 | (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>The Director of nursing and designees will conduct an audit of Urinary catheter bags every week for 4 weeks and then once a month for 2 months. The Administrator, Director of Nursing and designees will interview residents once a week for 4 weeks, then once a month for 2 months to ensure care is consistently being provided in a dignified manner. DON and/or designee reeducated the nursing department to include agency staff to ensure all residents are treated in a dignified manner and privacy bags for urinary catheters are provided.<br>Policy for resident rights added to the agency staff orientation manual<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator and Director of Nursing will review Urinary privacy bag and Resident interview audits weekly times 4 weeks then monthly times 2 months to ensure continued compliance.<br><br>Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 550 | Continued From page 9<br>colored urine. The catheter bag was visible from the hallway.<br><br>Observation of and interview with Resident #64 on 07/26/22 at 4:00 PM revealed the resident lying in bed with his urinary catheter bag hanging on the bed rail with no privacy cover draining yellow colored urine. The catheter bag was visible from the hallway.<br><br>Observation of and interview with Resident #64 on 07/27/22 at 4:29 PM revealed the resident lying in bed with his catheter bag hanging on the bed rail with no privacy cover draining yellow colored urine. The catheter bag was visible from the hallway. Resident #64 stated he would rather not have his catheter visible from the hallway or visible to his family members when they visit him. He stated he would prefer his urinary catheter to be covered.<br><br>Interview with Nurse Aide (NA) #5 on 07/28/22 at 10:40 AM revealed she was assigned to Resident #64 on the 7:00 AM to 3:00 PM shift. NA #5 stated she had not noticed Resident #64's urinary catheter not having a privacy cover on it but after looking at it stated there needed to be a cover placed on the catheter bag. She stated she would report it to the nurse assigned to him.<br><br>Interview with Nurse #4 on 07/28/22 at 10:50 AM revealed Resident #64's urinary catheter needed to have a privacy cover placed on it and she would take care of it. She stated no one had brought it to her attention or she would have already covered it.<br><br>Interview with the Administrator and Director of Nursing (DON) revealed they would have | F 550 | any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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| F 550 | Continued From page 10<br>expected staff to have noticed the indwelling urinary catheter did not have a privacy cover on it and applied one to it. The DON explained staff was used to the urinary catheter bags at the facility which all had privacy covers on them and Resident #64 had been admitted from the hospital with his urinary catheter and bag. | F 550 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff, Resident and Nurse Practitioner interviews the facility failed to allowed a resident (Resident #10) who was assessed as being unable to self-administer medications safely to have 2 inhalers at bedside for 1 of 1 resident reviewed for self-administration of medications.<br><br>The finding included:<br><br>Resident #10 was admitted to the facility on 01/05/22.<br><br>A review of Resident #10's medical record revealed a physician order dated 04/18/22 for an Albuterol inhaler 2 puffs inhale orally every 6 hours as needed for shortness of breath and wheezing.<br><br>A review of Resident #10's Self-Administration assessment dated 04/18/22 revealed the Resident was evaluated as being unable to | F 554 | F-554<br><br>Regarding the alleged deficient practice of failure to allow a resident who was assessed as being unable to self-administer medications safely to have 2 inhalers at bedside for 1 of 1 resident reviewed for self-administration of medications.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>The Director of Nursing removed Inhalers at bedside for Resident # 10 on 7/25/22. Residents receiving inhaler treatment services have had their orders reviewed, assessment completed, and physicians notified of self-administration as appropriate. | 8/19/22 |

| 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 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 554 | Continued From page 11<br>self-administer medications safely. The assessment was completed by Nurse #2<br><br>The quarterly Minimum Data Set (MDS) assessment dated 04/21/22 revealed Resident #10 was cognitively intact.<br><br>A review of Resident #10's care plan revised on 05/31/22 revealed the Resident had shortness of breath and wheezing. The goal to not have complications related to shortness of breath would be attained by administering Albuterol inhaler as directed for shortness of breath. The care plan did not indicate that Resident #10 was able to self-administer the inhaler or that the inhaler could be left at bedside.<br><br>On 07/25/22 at 12:56 PM an interview and observation were made of Resident #10 in his room. On the Resident's overbed table laid 2 inhalers. 1) a blue unlabeled Ventolin Inhaler 90 mcg for which Resident #10 explained that a nurse gave him a couple days ago and told him that he could use the inhaler for wheezing and 2) a pink Albuterol Inhaler 90 mcg in a box labeled with the Resident's name and the directions to administer 2 puffs orally every six hours as needed for wheezing. The Resident explained that his daughter brought him the inhaler earlier that morning.<br><br>On 07/25/22 at 1:10 PM Nurse #1 was notified of the two inhalers on Resident #10 overbed table. The Nurse reviewed the Resident's medical record which indicated the Resident had no orders to self-medicate or that inhalers could be left at his bedside. Nurse #1 retrieved the inhalers and stated she would give the inhalers to Nurse #2 who was the Resident's Nurse that day and | F 554 | (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and Nurse Managers conducted reeducation of Clinical staff members on Self administration of medication policy. Reeducation completed by 8/19/22.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: The Self administration of medication policy will be added to new hire orientation and the agency staff orientation manual.<br><br>Licensed nurses to be educated by DON/designee on policy and procedure for self-administering medications, completed by 08/19/2022.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, Director of Nursing and Designees will conduct audits for medications left at Residents bedside once a week for 4 weeks, once every other week for 4 weeks and once a month for 4 months to ensure no additional residents are at risk of being affected. Any issues during monitoring will be addressed immediately. The | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 554 | Continued From page 12<br>was on her lunch break.<br><br>On 07/25/22 at 3:56 PM an interview was conducted with Nurse #2. The Nurse stated that Nurse #1 gave her the two inhalers that were in Resident #10's room and explained that the Resident informed her that his daughter brought one inhaler to him earlier that morning and the other inhaler was given to him by a nurse (which he did not know) a couple days ago so that his could use it when he became short of breath. The Nurse continued to explain that Resident #10 did not have an order to keep the inhalers at bedside and that he was not assessed as being able to self-administer his inhaler.<br><br>During a second interview with Nurse #2 on 07/26/22 at 9:17 AM the Nurse explained that she performed the Self-Administration assessment on Resident #10 on 04/18/22 and did not feel as if the Resident could mentally grasp how to administer his medications and would not be safe in doing so because the Resident's mood changed frequently and you never knew what kind of mood he would be in at any given time. The Nurse stated the facility educated the families not to bring medications to the residents and instead to give them to the nurses, but it did not always happen that way. As for the inhaler that the Resident stated was given to him by a nurse, Nurse #2 explained that she was unable to determine which nurse the Resident was talking about but nevertheless, Nurse #2 stated, the staff should have noticed the inhaler on his overbed table and notified the nurse.<br><br>An interview with the Director of Nursing (DON) conducted on 07/27/22 at 5:22 PM revealed if the residents want to keep their medications at their | F 554 | Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/19/2022 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 554 | Continued From page 13<br>bedside and self-medicate they had to be assessed to mentally and physically be able to do so and they had to have a physician order for each medication kept at their bedside. The DON stated she had already explained the procedure to Resident #10 and asked the Resident to notify his daughter not to bring medications from home. The DON also indicated that she educated the staff to monitor for medications left at the residents' bedside and to notify the nurses if they observed the medications at bedside. The DON indicated that the education of monitoring for medications left at bedside would be ongoing.<br><br>An interview was conducted with the Nurse Practitioner on 07/28/22 at 11:33 AM who explained that she expected the residents to have a specific order for any medication that was left at the residents' bedside for them to self-medicate. | F 554 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and observations the facility failed to implement a care plan intervention for 1 of 3 residents (Resident #34) reviewed for call lights.<br><br>The findings included:<br><br>Resident #34 was originally admitted to the facility | F 558 | F-558<br><br>Regarding the alleged deficient practice of failure to implement a care plan intervention for 1 of 3 residents reviewed for call lights.<br><br>(1) How corrective action will be | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 558 | Continued From page 14<br>on 12/08/21 with diagnoses which included aphasia, contracture to right hand and knee, muscle weakness, anxiety, and depression.<br><br>Review of Resident #34's quarterly Minimum Data Set (MDS) dated 06/09/22 revealed Resident #34 was not cognitively intact and required extensive assistance with one person assist for most activities of daily living (ADL).<br><br>Review of Resident #34's care plan dated 06/27/22 indicated Resident #34:<br>-Had a communication problem. The goal for Resident #34 was to maintain current level of communication function. Interventions included to keep Resident #34's call light in reach.<br>- Was at an increased risk of falls. The goal for Resident #34 was to be free of falls through the review date. Interventions included Resident #34 would have a working and reachable call light.<br>- Had an alteration in musculoskeletal status with contracture to right hand, arm, and knee. The goal was for Resident #34 to remain free of injuries or complications related to contractures to the right side. Interventions included to be sure Resident #34 call light is with in reach and respond promptly to all request for assistance.<br><br>An observation conducted on 07/25/22 at 11:15 AM revealed Resident #34 in bed. The observation further revealed Resident #34's call light on the floor an estimated of three feet from the resident's bed.<br><br>An observation conducted on 07/25/22 at 3:15 PM revealed Resident #34 in bed. The observation further revealed Resident #34's call light on the floor an estimated of three feet from the resident's bed. | F 558 | accomplished for resident(s) found to have been affected:<br><br>Care staff Placed call bell within reach on 7/26/22 for Resident #34<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and designees conducted on audit to ensure call bells were within residents reach on 8/1/22. No Additional residents were affected.<br><br>Nurse managers provided reeducation to direct care staff including licensed nurses, aides , and agency staff on the call bell policy and the importance of ensuring call bell is within reach of residents<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>To protect residents from similar occurrences the DON and/or designee initiated reeducation to the nursing department to ensure the resident call lights are within reach each time they enter the room.<br>The call light policy has been added to new hire orientation and the agency staff orientation manual<br><br>(4) Indicate how the facility plans to | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 558 | Continued From page 15<br><br>An observation conducted on 07/26/22 at 9:15 AM revealed Resident #34 in bed. The observation further revealed Resident #34's call light on the floor an estimated of three feet from the resident's bed.<br><br>An interview conducted with a Nurse Aide in training (TNA) #1 on 07/26/22 at 2:20 PM revealed Resident #34 was able to use the call light for assistance. TNA #1 further revealed he had observed Resident #34 call light in the floor on 7/26/22 at lunch and put it back in reach of the resident<br><br>An interview conducted with Nurse #6 on 07/29/22 at 7:00 AM revealed Resident #34 was able to use her call light for assistance. Nurse #6 further revealed Resident #34 was unable to speak and the call light was the only way for Resident #34 to ask for assistance. Nurse #6 did not observe the call light in the floor during third shift on 07/25/22, but stated Resident #34's call light was expected to be in reach at all times.<br><br>An interview conducted with the Director of Nursing (DON) and Administrator on 07/29/22 at 10:30 AM revealed Resident #34 used the call light for assistance sometimes. The DON and Administrator further revealed Resident #34's call light should have not been on the floor and expected it to be in reach. | F 558 | monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, Director of nursing and designees will monitor Residents once a week for 4 weeks and then once a month for 2 months to ensure all call bells are consistently within reach.<br>The Administrator and director of nursing will review monitoring logs once a month to ensure continued compliance.<br><br>Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination | F 561 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 561 | Continued From page 16<br>through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident, and staff interview the facility failed to honor a residents' preferences for bathing in a tub two times a week (Resident #80) and receiving a shower twice a week (Resident #19) for 2 of 3 residents reviewed for preferences.<br><br>The finding included:<br><br>1. Resident #80 was admitted to the facility on 07/20/22. | F 561 | F-561<br>Regarding the alleged deficient practice of failure to honor a residents preferences for bathing in a tub tow time a week and receiving a shower twice a week for 2 of 3 residents reviewed for preferences<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>Resident # 80 will be offered bathing options to include a tub bath and her | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 561 | Continued From page 17<br>Review of an admission assessment dated 07/20/22 indicated Resident #80 was alert and oriented.<br><br>There was no Minimum Data Set (MDS) information available for Resident #80.<br><br>Review of a facility shower schedule indicated Resident #80 was scheduled to receive a shower on Tuesday and Friday on second shift.<br><br>A review of the shower notebook revealed there was no shower documentation for Resident #80.<br><br>Review of an Occupational therapy Treatment Encounter Note dated 07/22/22 read in part; patient fearful of shower due to fall risk. Patient takes a bath at home and does not desire to take showers. The note was electronically signed by the Occupational Therapist (OT).<br><br>An observation and interview were conducted with Resident #80 on 07/25/22 at 11:47 AM. Resident #80 stated that she had not had a shower since her admission had no clue when her showers were scheduled. She stated, "I would rather have a bath twice a week in the morning after I eat my breakfast." Resident #80 indicated that she took baths regularly at home and would rather have a bath then a shower. Resident #80 expressed no concerns with her bathing needs being met and indicated her concern was focused on preferring baths over showers. She was observed to be clean and without any signs of odor.<br><br>The Administrator was interviewed on 07/27/22 at 12:21 PM. She stated that the facility had 2 bathtubs but that they were not in use and were | F 561 | choice will be honored accordingly. Resident # 19 received a shower on 8/2/2022.<br><br>(2) Identification of other residents: On 08/18/2022 the Director of Activities/designee completed interviews with all current residents with a BIMS of 10 or higher for bathing preferences. Care plans will be updated according to preferences by 08/19/2022<br><br>(3) What measure(s) will be put into place or systemic changes made to ensure that the identified issue does not re-occur in the future: Admissions Director/designee will ask for bathing preferences upon admission. These bathing preferences will be care planned by MDS Coordinator/designee. DON/designee will educate the CNAs on documentation of completed showers/refusals and the process of reporting to the nurse responsible for the resident prior to the end of shift. Resident self determination policy added to new hire orientation and to the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make that the solutions are achieved and sustained: Unit Nurse Managers/designee will begin monitoring of bathing to include documentation, completion of showers, and resident refusals during clinical morning meetings. The DON/designee will begin audits of bathing documentation | |

| 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 07/29/2022 |

| 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 561 | Continued From page 18<br>being used for storage. The Administrator stated that both tubs functioned, but they had not been used in two years. Observation of the bathtubs were made along with the Administrator and revealed a room off the main corridor of the facility that had 2 bathtubs each packed with stuff (brief and other supplies) approximately four to five feet high.<br><br>An observation and interview were conducted with Resident #80 on 07/28/22 at 11:59 AM. Resident #80 was sitting in a wheelchair in a gown and appeared clean without odors. She stated that one of the therapist had helped her take a shower and put on a clean gown. Resident #80 again stated, "I would rather have a bath, but the therapist told me they did not have a bathtub" so I agreed to take a shower.<br><br>The OT was interviewed on 07/28/22 at 12:02 PM. She stated that on 07/22/22 she attempted to assist Resident #80 with a shower, but she preferred a bath and did not want to take a shower. The OT stated she was not aware if the facility had a bathtub or not and after she made the comment about not wanting showers but wanting a bath, she had documented that in her note but had not reported that to anyone else in the facility. The OT stated that was also the only time she attempted to bathe Resident #80.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:02 AM. The DON stated that the therapist was working with Resident #80 on bathing as a part of her therapy and Resident #80 did not feel safe in the shower. The therapist obtained a shower bench and Resident #80 was agreeable to take a shower. The DON stated that they obtained the resident preferences during the | F 561 | 3 x per week for 4 weeks then weekly for 8 weeks. The DON/designee will present the finding of the audits to the IDT for recommendations and/or corrective actions. The DON/designee will present IDT corrections to the monthly QAPI committee for review, identification of trends and recommendations.<br><br>The family alleges compliance on 08/19/2022 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 561 | Continued From page 19 | F 561 | | |

72-hour care plan meeting with the whole team, and she would have to review the questions that were asked in that meeting so they could project and meet the resident needs.

2. Resident #19 was admitted to the facility on 04/01/22.

The quarterly Minimum Data Set assessment dated 05/07/22 indicated Resident #19 was cognitively intact and had no behaviors of rejection of care.

A review of the shower schedule for room 67-A revealed the shower days were scheduled for Tuesday and Friday first shift.

A review of the shower notebook revealed there were no shower sheets for Resident #19 in the notebook.

A review of Resident #19's medical record revealed there was no documentation of refusing his showers.

A review of Resident #19's Activities of Daily Living documentation for 07/2022 revealed there were no showers documented in the Resident's medical record.

An observation and interview were conducted with Resident #19 on 07/25/22 at 12:52 PM. The Resident was lying in bed and his hair appeared dry, not greasy, with his beard neatly trimmed and had no odors of incontinence or body odor. The Resident remarked how he had not had a shower in a while when asked about his showers. Resident #19 explained that he had not had a shower since he could not remember when and

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 561 | Continued From page 20 | F 561 | | |

that they only "washed him off if you could call it that". The Resident continued to explain that he was supposed to be given a shower twice a week but that he had never been taken to the shower room for his shower and that he had never refused his shower. Resident #19 indicated he did not know what his assigned shower days were because he had never been given a shower.

On 07/28/22 at 1:11 PM during an interview with Resident #19 the Resident explained that he did not get his shower on Tuesday (07/26/22) nor did the staff ask him if he wanted his shower. The Resident continued to explain that he would not have refused his shower and that he felt like the staff did not like to get him out of the bed to take him to the shower room.

On 07/29/22 (Friday) at 3:07 PM during an interview with Resident #19 the Resident explained that he did not get a shower that day on first shift but was given a bed bath instead. The Resident continued to explain that he was not offered his shower and did not ask because he was used to it by now.

An interview was conducted with Nurse Aide (NA) #3 on 07/28/22 at 4:07 PM who confirmed that she was the full time NA assigned to Resident #19 on first shift and worked on 07/08/22, 07/12/22, 07/15/22, 07/19/22, 07/22/22, 07/26/22 and 07/29/22 which were his scheduled shower days. The NA explained that Resident #19 was alert and oriented and you could believe what he said was true. The NA stated the Resident acted anxious when it came to his showers, so she always opted for giving him a bed bath. The NA explained that the shower schedules were in the shower notebook at the nursing station and when

| 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 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 561 | Continued From page 21 | F 561 | | |

she completed a shower/bath she wrote it on the shower sheet and put it in the shower notebook. The NA continued to explain that if a resident refused their shower then she wrote it on the shower sheet and reported it to the nurse so she could document their refusal.

An interview was conducted on 07/28/22 at 3:54 PM with Nurse Aide (NA) #1 who was assigned to Resident #19 on 07/01/22 (Friday) first shift. The NA explained that she worked the assignment by herself that day and did not give Resident #19 a shower but gave him a bed bath instead.

Several attempts were made without success to interview Nurse Aide #4 who worked on 07/05/22 first shift.

An interview was conducted with Unit Coordinator (UC) #1 on 07/28/22 at 10:19 AM. The UC explained that the facility utilized shower sheets that were kept in the shower notebook at the nursing station and the nurses were to sign the shower sheets when the residents' showers were given. The UC indicated if the residents refused their showers then the nurse aides were to notify the nurse and the nurse would document the refusal in the resident's medical record. The UC indicated she was not aware Resident #19 refusing his showers.

An interview was conducted with the Director of Nursing (DON) on 07/29/22 at 4:30 PM who explained that the facility could not find Resident #19's shower sheets to determine whether or not if the Resident had received showers nor could they find any documentation of showers in the Point of Care system that the facility utilized. The DON stated she knew they needed to work on

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 561 | Continued From page 22<br>this documentation. Nevertheless, the DON stated Resident #19 should be allowed to receive his showers as scheduled or as he preferred and indicated that if he refused his showers then the nurse aides should notify the nurse so the refusal could be documented.<br><br>During an interview with the Administrator and the Director of Nursing on 07/29/22 at 5:15 PM the Administrator explained that the residents were scheduled to receive two showers a week and Resident #19 should be given his showers as scheduled. | F 561 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. | F 578 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 578 | Continued From page 23<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 3 residents reviewed for advanced directives (Resident #19).<br><br>The finding included:<br><br>Resident #19 was admitted to the facility on 04/01/22.<br><br>A review of Resident #19's hard chart revealed a DNR form dated 04/01/22.<br><br>The quarterly Minimum Data Set assessment dated 05/07/22 indicated Resident #19 was cognitively intact.<br><br>A review of Resident #19's care plan revised on 05/31/22 indicated the Resident was at risk for | F 578 | F-578<br><br>Regarding the alleged deficient practice of failure to maintain accurate advanced directive throughout the medical record for 1 of 3 residents reviewed for advanced directives<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>On 7/26/22 The Director of Nursing confirmed Residents Code status for Resident #19 to be a DNR. On 7/2/22 a new order was received for resident #19 indicating DNR code status. On 7/25/22 MDS Nurse updated care plan to reflect resident #19 change in code status. | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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| F 578 | Continued From page 24<br>alteration in code status, the Resident was a Full Code.<br><br>A review of Resident #19's electronic health record revealed a physician order for a DNR (Do Not Resuscitate) dated 07/02/22.<br><br>On 07/26/22 at 4:42 PM during an interview with the Social Worker she stated the advanced directive process was completed by the Nurse Practitioner and the nursing department.<br><br>On 07/27/22 at 5:01 PM during an interview with the Director of Nursing (DON) she explained that the advanced directive process was discussed on admission with the resident or their responsible party during the admission paperwork then there was an advanced directive planning process by the Provider to discuss the code status who will initiate the appropriate paperwork.<br><br>During a meeting with the Administrator and the Director of Nursing (DON) on 07/29/22 at 5:42 PM the DON explained that they went over all the orders in the morning meeting and made sure all the paperwork involved in the new orders, including the care plans, were updated but stated in this case they missed updating Resident #19's care plan. | F 578 | (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>An audit was conducted on 8/2/22 of Residents code status to ensure additional residents were not affected. Education provided to licensed staff to review advance directives policy. Director of Nursing provided education to MDS Nurses regarding updated care plans to reflect changes in code status.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>To prevent similar occurrence of alleged deficient practice the DON and/or designee reeducated the nursing department staff on Advanced Directives and provided education to MDS nurses on care plan updates.<br>The Advance Directive policy to be added to new hire orientation and to the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Director and Nursing and designees will conduct audits of resident□s code status once a week for 4 week and then once a month for 2 months then the | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 578 | Continued From page 25 | F 578 | Administrator and Director of Nursing will review Code status Audits for continued compliance monthly. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/19/2022 | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the | F 580 | | 8/19/22 |

| 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 07/29/2022 |

| 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 580 | Continued From page 26<br>resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and Nurse Practitioner interviews the facility failed to report an abnormally high white blood cell count to the provider when it was available and two days later the resident was admitted to the hospital with systemic inflammatory response syndrome (SIRS) and altered mental status for 1 of 1 resident reviewed for hospitalizations. | F 580 | F-580<br><br>Regarding the alleged deficient practice of failure to report an abnormally high white blood cell count to the provider when it was available for 1 of 1 resident reviewed for hospitalizations. | |

| 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 07/29/2022 |

| 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 |
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| F 580 | Continued From page 27<br><br>The findings included:<br><br>Resident #52 was readmitted to the facility on 04/28/21 with diagnoses that included diabetes, malignant neoplasm of breast, mixed irritable bowel and others.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 06/21/22 revealed that Resident #52 was cognitively intact and required extensive assistance with activities of daily living.<br><br>Review of a physician order dated 07/12/22 read; complete blood count (CBC), comprehensive metabolic panel (CMP) and ammonia level. The blood work was not ordered STAT (immediately) but was collected on 07/15/22.<br><br>Review of Resident #52's medical record revealed Resident #52 was diagnosed with a Urinary Tract Infection (UTI) and was treated with Fosfomycin (antibiotic) 3 grams (gm) by mouth x 1 dose for acute urinary tract infection on 07/15/22.<br><br>Review of a laboratory reported dated 07/15/22 indicated that the blood was drawn on 07/15/22 and reported out on 07/15/22 at 5:19 PM. The results included: white blood cell (indication of infection) was 18 (normal 4.1-10.7)<br><br>Review of a history and physical from the local hospital dated 07/17/22 that Resident #52's assessment and plan included SIRS (favor urinary source), acute metabolic encephalopathy, along with other diagnoses.<br><br>Review of the facility's schedule for 07/15/22 | F 580 | (1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>The Director of Nursing reported abnormal Labs to Healthcare Provider on 7/17/22.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>Director of Nursing and Nurse managers conducted an audit on 8/3/22 of all abnormal lab x last 4 weeks and results reported to HCP<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Re-education provided to Licensed staff to include agency staff on Lab protocol including obtaining, reviewing, and reporting of abnormal results by Nurse managers. Reeducation completed by 8/19/22.<br>The Lab and Diagnostic Test results policy to be added to new hire orientation and the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 580 | Continued From page 28<br>indicated that Nurse #9 cared for Resident #52 from 3:00 PM-11:00 PM, and Nurse #3 cared for Resident #52 from 11:00 PM to 7:00 AM.<br><br>Review of the facility's schedule for 07/16/22 indicated that Nurse #10 cared for Resident #52 from 7:00 AM to 3:00 PM and Nurse #9 cared for Resident #52 from 3:00 PM to 11:00 PM.<br><br>Review of the facility's schedule for 07/17/22 indicated that Nurse #10 cared for Resident #52 from 7:00 AM to 3:00 PM, and Nurse #11 cared for Resident #52 from 3:00 PM to 11:00 PM.<br><br>Nurse #8 was interviewed on 07/26/22 at 4:58 PM. Nurse #8 stated that she was not familiar with Resident #52, and she only cared for her a couple of times. She stated that the other nurses and Nurse Aides (NAs) were reporting that she was confused. Nurse #8 stated that she did not know how the laboratory services worked at the facility and indicated that she did not have access to the laboratory system in the facility at all. Nurse #8 stated she did not notify the medical provider of any lab work or Resident #52's confusion because she assumed they already were aware. She stated she had "never gotten or reviewed lab reports" since she began working at the facility through an agency, "someone else has always taken care of those."<br><br>Nurse #11 was interviewed on 07/26/22 at 5:34 PM. Nurse #11 stated that Resident #52 was confused but she knew that she recently had urinary tract infection and had received an antibiotic, so I attributed her confused to the urinary tract infection. Nurse #11 stated that she did not see any lab work for Resident #52, and she did not have access to the lab system at the | F 580 | Administrator and Director of Nursing will review Abnormal lab results in clinical meeting to ensure continued compliance with notification to healthcare providers. Audits will be completed by the DON and/or designee to ensure that all residents lab results have been reviewed per policy 2 times per week x 4 weeks then weekly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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| F 580 | Continued From page 29 | F 580 | | |

facility. Nurse #11 further stated she never received any lab work to review and again was not sure how the lab process worked at the facility.

Nurse #10 was interviewed on 07/27/22 at 12:32 PM. Nurse #10 stated that she worked at the facility through an agency. She stated that Resident #52 had gotten more confused from the first time she cared for her until the time she discharged to the hospital. The staff had told Nurse #10 that Resident #52 had a urinary tract infection and received an antibiotic for that. Nurse #10 stated that she did not review any lab for Resident #52 and was not aware how the lab process worked at the facility. She stated, "I think the nurse practitioner gets them."

Nurse #3 was interviewed on 07/27/22 at 6:11 PM. Nurse #3 stated that she was aware of the urinalysis that was obtained for Resident #52, and she knew that she was extremely confused talking about things that did not make sense which she reported off to the morning (oncoming) nurse at 7:00 AM on 07/16/22 but could not recall who that nurse was. Nurse #3 stated that she did not review any labs for Resident #52, and she did not have access to the lab system in the facility and did not notify the provider of any lab reports.

Nurse #9 was interviewed on 07/28/22 at 12:19 PM. Nurse #9 stated that she worked at the facility through an agency about twice a week. Nurse #9 stated that she did not review any lab reports for Resident #52 nor was she aware that labs had been ordered. She did say that she was aware that Resident #52 had recently received an antibiotic for a urinary tract infection. Nurse #9 added that she did not have access to the lab

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 580 | Continued From page 30 | F 580 | | |

system to review labs if she wanted too and she had not notified the provider of any lab work because she had not seen any to report.

The Nurse Practitioner (NP) was interviewed on 07/27/22 at 4:31 PM. The NP stated that Resident #52 had been treated with an antibiotic the week before she went to the hospital. The NP stated she did not see any lab reports which were generally printed off and made available for review. She stated that Resident #52's white blood cell being 18 was significantly elevated and should have been called to the provider. The NP stated that if the lab was a critical value the lab would have notified the facility and/or the provider. Had the lab been reported to a provider Resident #52 would have been worked up to try and determine what was going on and probably would have started with a redraw of her lab work.

The Director of Nursing (DON) was interviewed on 07/28/22 at 3:34 PM. The DON stated she came over to the facility on Sunday 7/17/22 and called Resident #52's family and updated them on her condition and the CBC results from 07/15/22 and the family was upset that no one had acted upon the lab work. She stated she tired to explain to the family that the lab values did not report as critical but yes, they were abnormal and based off the way Resident #52 presented they were going to send her to the hospital for evaluation. The DON explained that the lab company came to the facility 3-4 times a week to draw labs that had been ordered. Once the lab had been drawn and processed at the lab, they were faxed over to the main nursing station, the main copier or they were called to the facility if they were critical values. Any of the nurses can take labs from the printer and turn them over to the provider but

| 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 07/29/2022 |

| 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 |
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| F 580 | Continued From page 31<br>noncritical values were not generally called to on call provider they generally were given to the provider when they return onsite. The DON stated when she saw Resident #52's white blood cell count was 18 and the staff were continuing to report confusion and so we made the decision to send her to the hospital. The DON stated that "our nurses are trained to process and enter lab orders" and some of the agency staff that come infrequently do not have access to the lab system. | F 580 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights | F 585 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 585 | Continued From page 32 | F 585 | | |

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 585 | Continued From page 33<br>abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews the facility failed to record and investigate a grievance for 1 of 7 residents (Resident #468) and failed to provide a written grievance summary for 1 of 7 residents (Resident #67) reviewed for grievances.<br><br>Findings included:<br><br>Review of the facility grievance policy, undated, | F 585 | F-585<br>Regarding the alleged deficient practice of failure to record and investigate a grievance for 1 of 7 residents and to provide a written grievance summary for 1 of 7 residents reviewed for grievances.<br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>DON met with Resident #67 on | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 585 | Continued From page 34<br>indicated a policy statement which stated all grievances and complaints filed with the facility would be investigated and corrective actions would be taken to resolve the grievance(s).<br><br>1. Resident #468 was admitted on 2/17/22.<br><br>Review of Resident #468's Minimum Data Set (MDS) revealed a comprehensive admission assessment dated 2/20/22. The resident was coded as cognitively intact.<br><br>Resident #468 was discharged home on 5/6/22.<br><br>Review of the facility grievances log from February 2022 through May 2022 revealed no recorded grievances for Resident #468.<br><br>During a telephone interview with Resident #468 on 7/26/22 at 2:20PM, she stated it took nursing staff a while to respond to her call light for incontinence needs and at times, she waited up to 30 minutes for staff to attend to her needs. Resident #468 indicated that she was aware of the time because of the clock that hung on the wall in front of her bed. Resident #468 added she reported the concern with call bell response time and incontinence care needs to the social worker and it did not get any better. She also explained no one followed up with her regarding her grievance.<br><br>During an interview with the Social Worker (SW) on 07/27/22 at 10:02 AM, she explained Resident #468 had a grievance regarding not receiving timely assistance with incontinence care and it was brought to morning meeting. The SW further explained the process would have been for nursing to talk to the resident and then do a call | F 585 | 08/17/2022 regarding his medication concern. Resident #67 was unable to provide exact details surrounding his concern. DON informed resident that he always has the right to receive the correct medication and if he ever has a question about any of his medications that he can always ask. Resident expressed understanding and appreciation of follow up. Resident # 468 discharged from the facility 5/6/2022, Social Worker was educated on the grievance policy on 8/18/2022.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br>Activities Director/Assistant interviewed all residents with a BIMS score of 12 or higher to ask about any concerns they have currently/outstanding. All noted concerns were placed on grievance forms and given to the appropriate department manager to be addressed per facility policy.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future<br>Administrator, Director of Nursing and /or designees educated all staff on 08/16/2022-08/19/2022 on resident rights to receive the right medication and reporting of medication errors. All staff educated on facility grievance policy on 08/16/2022-08/19/2022.<br>The Grievance/Complaints filing policy | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 585 | Continued From page 35<br>light audit or talk to the Nursing Assistant (NA) on that shift or other residents. The SW indicated there should have been a grievance filed per the process, but she was unsure whether one was filed.<br><br>An interview was conducted with the Director of Nursing (DON) on 07/27/22 at 10:20 AM. The DON explained she did not recall any grievance being reported in morning meeting regarding Resident #468. She added that the SW was the grievance official, and grievances were only filed if someone was having a concern that could not be resolved immediately.<br><br>A follow-up interview with the SW on 07/28/22 at 06:44 PM revealed she was the grievance official and responsible for maintaining the grievance log, however it was everyone's responsibility to file a grievance. The SW indicated the reason she did not document Resident #468's grievance on a form was because it was not reported to her directly by Resident # 468. She explained a NA reported to her verbally that Resident #468 had concerns regarding delayed call bell response and being left incontinent for long periods of time. The SW instructed the NA to retrieve a Grievance form from her later and file the grievance herself. The SW added the NA never came to obtain the grievance form and she forgot all about the grievance. The SW added she failed to fill out a grievance form or enter it on the log. However, the SW explained she brought it to morning meeting and thus brought it to the attention of the administrative staff and it should have been addressed and investigated.<br><br>During an interview with the Administrator on 07/29/22 at 09:43 AM, the Administrator indicated | F 585 | added to new hire orientation and new agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>Social Worker will monitor grievance logs weekly times 4 weeks and then monthly x 3 months.<br>All grievances for a 7-day period will be reviewed weekly at the facility Risk Meeting to ensure that they are addressed and followed up on per facility grievance policy. Any outstanding grievances will be discussed and addressed during the weekly facility Risk meetings. Grievance logs will be reviewed in the facility monthly QAPI meetings.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 585 | Continued From page 36 | F 585 | | |

that all department managers have grievance forms. She added whenever staff members came to the managers with a grievance, the manger was to write the grievance up. Then once it was written a copy was to be given to the SW and the original held by the manager for investigation. She explained the department managers had 5 days to investigate and resolve the grievance. The Administrator added a written communication was sent to the complainant once the concern was resolved. The Administrator stated the SW should have placed Resident #468's grievance on a from and forwarded the grievance to the DON for investigation.

2. Resident# 67 was admitted to facility on 12/7/2018.

Resident# 67 had a quarterly Minimum Data Set (MDS) assessment dated 07/02/22 that indicated he was cognitively intact.

An interview with Resident #67 on 07/26/22 at 5:26 PM revealed on two occasions, he reportedly received the yellow pill at night instead of the white pill. When he corrected the nurse, she administered the correct medication. He complained to staff in the Resident Council (RC), about staff attempting to give him the wrong medication and received no follow-up.

A review of the RC minutes for May 2022 indicated Resident #67 voiced concern over a medication error. A review of the RC minutes for June and July further indicated no follow-up or outcome of his concern.

A review of the grievance log for May, June and July did not reflect #67's grievance.

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 585 | Continued From page 37<br><br>An interview with Nurse #2 on 07/28/22 at 2:25 PM indicated Resident #67 had mentioned that he received the wrong medication and encouraged him to report it since he was alert and oriented.<br><br>An interview with the Director of Nursing (DON) on 07/29/22 at 3:41 PM revealed she was aware of Resident #67's concern, spoke with him about the concern and did not follow-up in writing. The DON further stated the issue was brought to a morning meeting and she should have followed up, investigated it and documented the investigation.<br><br>During an interview with the Administrator on 07/29/22 at 09:43 AM, the Administrator indicated that all department managers have grievance forms. She added whenever staff members came to the managers with a grievance, the manger was to write the grievance up. Then once it was written a copy was to be given to the SW and the original held by the manager for investigation. She explained the department managers had 5 days to investigate and resolve the grievance. | F 585 | | |
| F 622 SS=B | Transfer and Discharge Requirements<br>CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br><br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate | F 622 | | 8/19/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 622 | Continued From page 38 | F 622 | | |

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 622 | Continued From page 39<br>medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to document a resident's discharge | F 622 | F-622 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 622 | Continued From page 40<br>in the medical record (Resident #52) for 1 of 1 resident reviewed for hospitalizations.<br><br>The finding included:<br><br>Resident #52 was readmitted to the facility on 04/28/21 with diagnoses that included diabetes, malignant neoplasm of breast, mixed irritable bowel and others.<br><br>There was no discharge Minimum Data Set (MDS) available for review.<br><br>Review of Resident #52's medical record revealed no order for transfer to the hospital and no documentation of why she was being transferred to the hospital.<br><br>Review of a history and physical from the local hospital dated 07/17/22 that Resident #52's assessment and plan included SIRS, acute metabolic encephalopathy, along with other diagnoses. The plan also indicated Resident #52 would be admitted to the hospital.<br><br>Nurse #4 was interviewed on 07/29/22 at 12:22 PM and confirmed that she was working the day Resident #52 was sent to the hospital which was 07/17/22. She stated that during the shift Resident #52 had to have a room change and went to Nurse #7's unit but she was assisting Nurse #7 in copying information and getting all the paperwork copied so they could transfer Resident #52 to the hospital as directed by the Director of Nursing (DON). She added that Nurse #7 should have made a note in the medical record and completed a change in condition form.<br><br>An attempt to speak to Nurse #7 was made on | F 622 | Regarding the alleged deficient practice of failing to document a resident□s discharge in the medical record for 1 of 1 resident reviewed for hospitalizations.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Late Entry progress note was completed on 7/28/22 for resident #52 by director of nursing, including reason for transfer. D/C MDS was completed by MDS Nurse and transmitted 8/3/22.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>Audit conducted by director of nursing and nurse managers on 8/18/22 of all hospital transfer x last 4 weeks included order to transfer and D/C MDS. No other residents noted to be affected by the alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Nurse Manger Re-educated Licensed staff to include agency staff that all transfers to hospital require an order completed by 08/21/2022.<br>Residents discharged to hospital will be reviewed by Clinical Management team on a weekly basis to ensure there is an | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 622 | Continued From page 41<br>07/29/22 at 12:22 PM with no success.<br><br>The DON was interviewed on 07/28/22 at 3:34 PM. The DON stated she came over to the facility on Sunday 7/17/22 and called Resident #52's family and updated them on her condition and the lab results from 07/15/22 and based off of the lab work and Resident #52's current condition they were going to transport her to the hospital for evaluation. The DON stated that she and Nurse #4 were getting the paperwork ready and that the change in condition form should have been complete and was an oversight as they "had a lot going on at that time" but we should have documented Resident #52's discharge in the medical record. | F 622 | order to transfer and d/c MDS is completed. The transfer or discharge emergency policy to be added to new hire orientation and to the new agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>Transfer/discharge audits will be reviewed weekly times 4 weeks then months x 2 months to ensure continued compliance by Administrator and Director of Nursing. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff | F 641 | F-641 | 8/19/22 |

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| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 641 | Continued From page 42<br>interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of cognition for 1 of 1 resident reviewed for MDS accuracy (Resident #13).<br><br>The findings included:<br><br>Resident# 13 was readmitted to the facility on 9/21/2020. The diagnoses included right side hemiplegia following a stroke, aphasia and dysphasia.<br><br>The quarterly MDS dated 7/19/22 revealed Resident# 13 was cognitively intact.<br><br>A revised Care Plan dated 6/23/22 indicated Resident #13 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to stroke. The Care Plan further indicated Resident #13 was cognitively impaired.<br><br>An interview with the Social Worker (SW) on 7/26/22 at 4:40 PM indicated she was responsible for conducting and entering the (Brief Interview for Mental Status) cognitive score into the Electronic Medical Record (EMR). She further indicated she conducted the cognitive interview for Resident #13 but could not provide an exact date and entered the incorrect BIMS score into the EMR. She stated she would speak with the MDS coordinator and submit a correction.<br><br>An interview with MDS Coordinator on 7/26/22 at 4:30 PM revealed they sometimes get behind on MDS reports due to performing other duties such as providing COVID tests to staff and assisting on the floor. She further explained that the SW was responsible for entering the cognitive score for Resident #13 and they would coordinate with the | F 641 | Regarding the alleged deficient practice of failure to accurately code the MDS assessment in the area of cognition for 1 of 1 resident reviewed for MDS accuracy.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>MDS coordinator corrected Resident #13 MDS on 07/27/2022 to reflect accurate assessment and coding in the area of cognition.<br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br>Director of Social Services and Therapy Manager (ST) completed a 100% facility audit of BIMS for accuracy on 08/16/2022. No other residents were found to be at risk for this alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Administrator provided education to Social Service Director on 08/08/2022 on protocol for accurately completing BIMS assessment and accurately coding BIMS assessment score on MDS.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: | |

| 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 07/29/2022 |

| 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 641 | Continued From page 43<br>SW to correct the BIMS score.<br><br>An observation on 7/27/22 of Resident #13 revealed she was lying in bed, awake, non-verbal and presented with a blank stare or intermittent eye contact. The Resident was unable to respond to questions, appeared well groomed, and pulled away from the nurse, who attempted to reposition her right hand. | F 641 | MDS/designee shall audit 5 random resident MDS for accurate coding of BIMS score per month x 1 month for assessment accurately reflect the resident□s status then 3 random resident MDS per month x 2 months for assessment accurately reflect the resident□s status using a Quality Improvement Tool and report finding to QA committee; audits will continue as determined by QA committee.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable. | F 655 | | 8/19/22 |

| 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 07/29/2022 |

| 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 655 | Continued From page 44<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to develop a baseline care plan that addressed interventions to promote healing of unstageable pressure ulcers that were present on admission for 1 of 6 residents reviewed for pressure ulcers (Resident #83).<br><br>The findings included:<br><br>Resident #83 was admitted to the facility on 07/15/22 with diagnoses that included unspecified fracture of right femur.<br><br>Review of nursing admission assessment dated 07/15/22 indicated that Resident #83 was alert | F 655 | F-655<br><br>Regarding the alleged deficient practice of failure to develop a baseline care plan that addressed interventions to promote healing of unstageable pressure ulcers that were present on admission for 1 of 6 residents reviewed for pressure ulcers.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>The Director of Nursing and Nurse Managers provided reeducation to | |

| 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 07/29/2022 |

| 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 655 | Continued From page 45<br>and oriented.<br><br>Review of a baseline care plan dated 07/15/22 indicated that Resident #83 had a history of skin issues, but no current skin issues were noted and no interventions for skin care were noted on the baseline care plan. The care plan was completed by Nurse #4.<br><br>Review of admission nursing assessment dated 07/15/22 indicated that Resident #83 had unstageable pressure ulcers to his right and left heel. The right heel measured: 7.0 centimeters (cm) x 5.0 cm and the left heel measured 7.5 cm x 5.0 cm. The assessment was completed by Nurse #4.<br><br>Nurse #4 was interviewed on 07/28/22 at 11:14 AM. She confirmed that she had admitted Resident #82 to the facility on 07/15/22 and completed the baseline care plan. She confirmed that he admitted with pressure ulcers to his bilateral heels and indicated she had also completed the nursing assessment where she measured and documented his wounds. Nurse #4 stated the baseline care plan was just a form on the computer that she clicked to answer the questions and she must have not clicked the correct button that indicated he had current wound issues.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:10 AM and stated that the admission nurse initiated the baseline care plan then they conducted a 72-hour care plan that we can add information to the baseline care plan if needed. The DON stated typically the nurse would summarize the current wound at the end of the baseline care plan and indicated that Nurse | F 655 | Licensed staff members on appropriate baseline care plans for residents with pressure ulcer. Reeducation was completed by 8/19/22<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>On 8/5/22, the Director of Nursing and Nurse Managers conducted an audit of all baseline care plans of residents admitted with Pressure ulcers x last 30 days. Audit revealed that no additional residents affected.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>To protect residents from similar occurrences the DON and/or designee reeducated licensed nurses regarding proper documentation on baseline care plans for residents admitted with pressure ulcers. Education with licensed nurses was completed by 08/19/2022.<br>Care plans-baseline policy to be added to new hire orientation and to the new agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, Director of Nursing | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 655 | Continued From page 46<br>#4 should have done so as well. | F 655 | and/or Designees will conduct audits of baseline care plan of residents admitted with pressure ulcers once a week for 4 weeks then monthly times 2 months to ensure no additional residents are at risk of being affected. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) 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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to provide shaving assistance (Resident #71, Resident #2), nail care (Residents #2, #14, and #30), and skin care (Resident #2) for 4 of 10 residents reviewed for activities of daily living for dependent residents.<br><br>The findings included: | F 677 | F-677<br><br>Regarding the alleged deficient practice of failure to provide shaving assistance, nail care, and skin care for 4 of 10 residents reviewed for activities of daily living for dependent residents.<br><br>(1) How corrective action will be | 8/19/22 |

| 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 07/29/2022 |

| 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 677 | Continued From page 47<br><br>1. Resident #71 was admitted to the facility on 07/20/22 with diagnoses which included acute dislocation of the shoulder related to fall, and muscle weakness.<br><br>Review of Resident #71's admission Minimum Data Set (MDS) assessment revealed it was in progress but not completed. The initial nursing assessment dated 07/20/22 revealed the resident was alert and oriented to person, place, time, and situation. Resident #71 required extensive assistance of 2 staff with bed mobility, transfers, dressing, and bathing, required extensive assistance of 1 staff member with personal hygiene, and was independent with eating once set up.<br><br>Review of Resident #71's baseline care plan dated 07/21/22 revealed there was no focus area for activities of daily living.<br><br>Observation of and interview with Resident #71 on 07/25/22 at 11:17 AM revealed the resident lying flat on her back in her bed and noted to have chin hairs on either side of her chin that were ½ to ¾ inches long. The resident stated she did not like having chin hairs and had asked her daughter to bring a razor to shave them but said her daughter had forgotten to bring the razor. Resident #71 was not aware the staff could shave her face for her and said no one had asked if she wanted the chin hairs shaved.<br><br>Observation of Resident #71 on 07/26/22 at 4:58 PM revealed she still had chin hairs that were ½ to ¾ inches long on either side of her chin. She stated staff had not offered to shave her chin for her. | F 677 | accomplished for resident(s) found to have been affected:<br><br>Care staff provided ADL assistance on 7/28/2022 for shaving Resident # 71 and Resident #2 on 8/15/2022. Care staff provided ADL nail care for Resident #2 on 8/2/2022, Resident #14 on 8/15/2022, and Resident #30 on 7/27/2022. Care staff provided ADL skin care for Resident #2.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>Nurse Managers provided reeducation on 8/19/2022 to clinical staff members on the proper completion and monitoring of ADL assistance for dependent residents. Audit conducted on 08/15/2022 for facial hair, nail care and skin care of all residents to ensure no additional residents were affected.<br>Facility policy prevention of pressure ulcer that includes management of dry skin to be added to new hire orientation and the agency orientation manual.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>All care staff to be educated by 08/19/2022 on ADL care to include honoring resident preferences related to facial hair, skin care, and nail care. The | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

| 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 677 | Continued From page 48<br><br>Observation of Resident #71 on 07/27/22 at 4:15 PM revealed she still had chin hairs that were ½ to ¾ inches long on either side of her chin. She stated staff had not offered to shave her chin for her.<br><br>Interview on 07/28/22 at 10:12 AM with Nurse Aide (NA) #2 revealed she had cared for Resident #71 on the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed Resident #71's chin hairs but stated when she saw them, they needed to be trimmed. NA #2 stated she would let Resident #71's nurse know she needed her chin shaved.<br><br>Interview on 07/28/22 at 10:44 AM with Nurse #4 revealed she was the charge nurse for the Rehab unit today. Nurse #4 went into Resident #71's room and stated her chin needed to be shaved and she would take care of it.<br><br>Interview on 07/29/22 with the Administrator and Director of Nursing revealed they would have expected the staff to have noticed Resident #71's chin hairs and shaved them for her. The DON stated shaving was part of the activities of daily living (ADL) care and should be done with bathing or as needed.<br><br>2.a. Resident #2 was admitted to the facility on 07/08/22 with diagnoses which included acute on chronic respiratory failure and anemia.<br><br>Resident #2's admission Minimum Data Set (MDS) assessment was in process but not completed. Resident #2's admission nursing assessment dated 07/08/22 revealed he was alert and oriented to person, place, time, and situation. | F 677 | care of fingernails policy was added to new hire orientation and to the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, Director of Nursing and/or designees will conduct weekly monitoring of residents facial hair, nailcare and reported dry skin weekly times 4 weeks, then once a month for 2 months. The Administrator, Director of Nursing and/or designee will review Hygiene Audits Monthly to ensure continued compliance. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

| 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 677 | Continued From page 49 | F 677 | | |

Resident #2 requires extensive assistance of 2 staff with bed mobility, and transfers and requires extensive assistance of 1 staff with dressing, and toilet use and limited assistance of 1 staff with personal hygiene, and independent with eating after set-up.

Resident #2's baseline care plan dated 07/10/22 revealed there was no focus area for activities of daily living.

Observation of and interview with Resident #2 on 07/25/22 at 3:29 PM revealed him sitting up in his wheelchair in his room. Resident #2 stated he had not been shaved or had his beard trimmed since admission to the facility. He stated he would like to be shaved and was used to shaving daily and would also like to have his beard trimmed but stated staff had not offered to shave him or trim his beard.

Observation of Resident #2 on 07/26/22 at 5:00 PM revealed him resting in bed with head of bed elevated at 90 degrees. Resident #2 stated no one had offered to shave him or trim his beard yet and said he had been bathed but had not been shaved.

Observation of Resident #2 on 07/27/22 at 5:24 PM revealed him up in his wheelchair and appeared to be sleeping with his eyes closed. Resident #2 was observed to still not be shaved and his beard had not been trimmed.

Interview on 07/28/22 at 10:12 AM with NA #2 revealed she was assigned to care for Resident #2 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed that Resident #2 needed to be shaved but stated she would talk to

| 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 07/29/2022 |

| 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 677 | Continued From page 50 | F 677 | | |

the nurse about it. She stated it was not her he had asked about getting shaved and having his beard trimmed. NA #2 stated she would see if she could make him an appointment with the beautician to get his beard trimmed.

Interview on 07/28/22 at 10:40 AM with Nurse #4 revealed she was not aware that Resident #2 wanted to be shaved and wanted his beard trimmed. She stated she was not sure who he had asked about getting it done. Nurse #4 stated she would shave him and get him an appointment with the beautician to trim his beard.

Interview on 07/29/22 at 5:15 PM with the Administrator and Director of Nursing (DON) revealed it was their expectation that residents be shaved as requested on their bath days and as needed. The Administrator stated if staff could not trim Resident #2's beard they could make an appointment with the beautician to have it trimmed.

b. Observation of and interview with Resident #2 on 07/25/22 at 3:29 PM revealed him sitting up in his wheelchair in his room. Resident #2's fingernails were noted to be ¼ to ½ inch beyond the end of his fingers and jagged on some of his fingers. Resident #2 stated he would like to have his nails trimmed and had asked about it and someone (he couldn't remember who) was going to come back and trim them for him but never did. He stated he would still like for them to be trimmed.

Observation of Resident #2 on 07/26/22 at 5:00 PM revealed him resting in bed with head of bed elevated at 90 degrees. Resident #2 stated he still had not had his fingernails trimmed and

| 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 07/29/2022 |

| 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 677 | Continued From page 51 | F 677 | | |

would like for them to be done.

Observation of Resident #2 on 07/27/22 at 5:24 PM revealed him up in his wheelchair and appeared to be sleeping with his eyes closed. Resident #2 was observed to still have fingernails ¼ to ½ inch beyond the end of his fingers and jagged on some of his fingers.

Interview on 07/28/22 at 10:12 AM with NA #2 revealed she was assigned to care for Resident #2 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed that Resident #2 needed to have his fingernails trimmed. She stated that was usually done by the activities department and they would need to refer him to them for his fingernails.

Interview on 07/28/22 at 10:40 AM with Nurse #4 revealed she was not aware that Resident #2 needed to have his fingernails trimmed. She stated she was not sure who he had asked about getting it done. Nurse #4 stated she could trim his nails, or they could refer him to activities to get them trimmed and filed.

Interview on 07/29/22 at 5:15 PM with the Administrator and Director of Nursing (DON) revealed it was their expectation that residents have their nails trimmed on bath days and as needed. The DON stated this was usually done by the activities department unless the resident was diabetic and then the nurses would trim their nails.

c. Observation of and interview with Resident #2 on 07/25/22 at 3:29 PM revealed him sitting up in his wheelchair in his room. Resident #2's legs were swollen and dry and flaky and the skin was

| 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 07/29/2022 |

| 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 677 | Continued From page 52 | F 677 | | |

coming off his legs and was on his bed sheets and on the floor under his feet. He stated he would like to have some cream rubbed on them, so they were not so dry and flaky. Resident #2 further stated he could feel the flakes on his bed when he got back into his bed from where the skin had come off his legs. Resident #2 indicated he had asked someone (could not remember who he asked) about some cream for his legs.

Observation of Resident #2 on 07/26/22 at 5:00 PM revealed him resting in bed with head of bed elevated at 90 degrees. Resident #2 stated he still had not had any cream applied to his legs and the skin was still flaking off in chunks. The dead skin was visible on his bed sheets.

Observation of Resident #2 on 07/27/22 at 5:24 PM revealed him up in his wheelchair and appeared to be sleeping with his eyes closed. Resident #2 was observed to still have flaky skin and there were flakes of skin under his feet and on his bed sheets.

Interview on 07/28/22 at 10:12 AM with NA #2 revealed she was assigned to care for Resident #2 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had noticed that Resident #2 had dry flaky skin but stated she had not found any cream in his room to apply to his legs. She stated she had not asked the nurse about cream but stated he needed some applied to his legs.

Interview on 07/28/22 at 10:40 AM with Nurse #4 revealed she was not aware that Resident #2 needed cream for his legs. Nurse #4 stated after seeing his legs that he needed some cream for them, and she would contact the physician and get some ordered for him.

| 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 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 677 | Continued From page 53 | F 677 | | |

Interview on 07/29/22 at 5:15 PM with the Administrator and Director of Nursing (DON) revealed it was their expectation that residents with visibly dry flaky skin have cream that can be applied to their skin. The DON stated someone should have noticed his skin and the flakes of skin in his bed and called the provider for an order for cream.

3. Resident #14 was admitted to the facility on 5/2/18. Diagnoses included diabetes and peripheral neuropathy.

A quarterly Minimum Data Set dated 5/3/22 assessed Resident #14 was cognitively intact and had no behaviors. The resident required extensive staff assistance with activities of daily living (ADL) to include dressing and bathing and total staff assistance with personal hygiene.

Review of Resident #14's care plan dated 6/6/22 revealed a care plan problem regarding ADL self-care performance deficit related to disease process. The interventions included extensive assistance with hygiene/grooming.

An observation of Resident #14 was made on 7/26/22 at 3:09 PM. Resident #14's nails on his bilateral hands were approximately ½ inch in length with black debris under every nail.

An interview with Resident #14 was conducted on 7/26/22 at 3:10 PM, he indicated he had asked for his nails to be trimmed last week and the nursing assistant told him they would be right back, but they never came back. He added he could not remember the last time his nails were trimmed, and he could feel the nails digging into

| 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 07/29/2022 |

| 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 677 | Continued From page 54 | F 677 | | |

his palms.

Another observation of Resident #14 was made on 7/27/22 at 10:18 AM and his nails were elongated with black debris under the nail.

Interview with Nursing Assistant (NA) #6 on 7/26/22 at 3:27 PM revealed he was assigned to Resident #14 and was not able to trim his nails because he was a diabetic. NA #6 stated he could clean under the nails of diabetic residents. NA #6 added he did notice the debris under the resident's nails on 7/25/22 but did not clean under the nails and did not ask the resident if he wanted his nails cleaned.

An interview was conducted with Nurse #2 on 7/27/22 at 10:47 AM, Nurse #2 explained that the staff nurses were responsible for nail care for residents who were diabetic. She added that if the resident was not a diabetic the Activities Department was responsible for the nail care. Nurse #2 indicated the nurses trimmed diabetic resident's nails when they noticed a problem with the nails. Nurse #2 further indicated of Resident #14's nails they should have been trimmed and as he was a diabetic, she should have trimmed them. She stated it was very hard to get to things like nail care and she just did not have the time.

An interview was conducted with the Unit Coordinator #2 on 7/28/22 at 5:15 PM and she indicated nail care was the responsibility of the NAs for non-diabetic residents which included trimming and cleaning under the nails. She added the Nurse was responsible for ensuring the NAs provide nail care. She added she was uncertain of the Activity Department's role in nail care. She explained that Resident #14 was able to inform

| 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 07/29/2022 |

| 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 677 | Continued From page 55 | F 677 | | |

staff if he wanted his nails trimmed however, he should not have to ask for nail care, the Nurse should have ensured it was done.

On 7/29/22 at 9:02 AM an interview was conducted with the Director of Nursing (DON) which revealed the nursing staff should have provided Resident #14 with nail care.

4. Resident #30 was admitted to the facility on 7/16/19 with diagnosis of peripheral vascular disease, lymphedema, dementia and anemia.

A quarterly Minimum Data Set dated 6/9/22 assessed Resident #30 was cognitively intact and had no behaviors. The resident required extensive staff assistance with activities of daily living (ADL) to include dressing and personal hygiene and total assistance with bathing.

Review of Resident #30's care plan dated 6/23/22 revealed a care plan problem which read resident preferred to keep his nails long. The intervention included he would have no related skin injuries through the next review.

An observation of Resident #30 was conducted on 7/25/22 at 11:56 AM. Resident #30's bilateral fingernails were observed to be thick, yellowish in color and over ½ inch in length with the thumb nails at least ¾ inch in length. The fingernails were noted with black and brownish colored debris embedded throughout the entire length of the nails of all fingers.

An interview was conducted with Resident #30 on 7/25/22 at 3:48 PM. Resident #30 indicated that he would like to have his nails trimmed. He added that the Activity Director had trimmed them in the

| 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 07/29/2022 |

| 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 677 | Continued From page 56 | F 677 | | |

past.

An observation of Resident #30 on 7/27/22 at 10:18 AM revealed the fingernails on both hands were still elongated with black and brownish colored debris lodged under the nails of all fingers.

An interview was conducted with Nurse #2 on 7/27/22 at 10:47 AM revealed diabetic nail care was done by the nursing staff, however Resident #30 was not a diabetic and the Activity Department did nail care for residents who were not diabetic, but the nursing assistants should clean under the nails as needed with care. Nurse #2 indicated during her observation of Resident #30 nails that they were too long.

An interview was conducted with the Activity Director on 7/26/22 at 4:09 PM. The Activity Director indicated that her department did nail care for all the residents who were not diabetic and that the diabetic residents were done by the nursing staff. She explained that her department did nail care weekly prior to COVID. She added it was just herself and two assistants and they did nail care twice a month and currently it was whenever they could and as needed.

Review of the Activity daily log dated 4/8/22 indicated Resident #30's nails were trimmed by the Activity Department. The Activity daily log dated 5/18/22 indicated Resident #30 was taken outside to the nail salon. Further review of Activity daily log dated 6/13/22, 6/24/22, 7/20/22 and 7/24/22 did not have Resident #30 listed as receiving nail care.

A follow up interview was conducted with the

| 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 07/29/2022 |

| 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 677 | Continued From page 57 | F 677 | | |

Activity Director on 7/29/22 at 9:09 AM which revealed Resident #30 typically asked for his nails to be trimmed but he never refused.

An interview was conducted with the Unit Coordinator #2 on 7/28/22 at 5:15 PM and she indicated nail care was the responsibility of the NAs for non-diabetic residents which included trimming and cleaning under the nails. She added the Nurse is responsible for ensuring the NAs provide nail care. She added she was uncertain of the Activity Departments role in nail care. She explained that Resident #30 was able to inform staff if he wanted his nails trimmed however, he should not have to ask for nail care the Nurse should have ensured it was done.

An interview was conducted with the Activity Assistant on 07/27/22 at 11:12 AM. The Activity Assistant revealed she usually trimmed Resident #30's nails. She added she trimmed them in April but in May she felt concerned by the thickness of the nails and asked if he could be seen outside for services. She explained the transportation aide took him to a salon and his nails were trimmed by the salon staff. She indicated, while observing Resident #30's nails, they are dirty and need to be trimmed. The Activity Assistant stated on 7/24/22 when she was trimming nails, she did not look at his nails and was not made aware by the nursing staff that he needed his nails trimmed, however she added she would not feel comfortable trimming his nails.

An interview was conducted with the Transportation aide on 7/29/22 at 8:15 AM. She revealed she took him to a nail salon and his nails were trimmed in May. The Transportation aide revealed that Resident #30 was not on a regular

| 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 07/29/2022 |

| 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 677 | Continued From page 58<br>rotation at the nail salon and since May she was not asked to schedule him for nail trimming at the salon.<br><br>An interview with Nursing Assistant #6 (NA) was conducted on 7/27/22 at 11:58 AM. NA #6 revealed he was assigned to Resident #30 and knew his nails needed cleaning however he did not have the supplies to clean the nails. NA #6 added it was his responsibility to trim and clean Resident #30's nails.<br><br>An interview was conducted with the Supply Clerk on 7/27/22 at 4:54 PM which revealed there was no shortage of nail care supplies. The Supply Clerk indicated she ordered in bulk and had plenty of nail clipper, nail files and orange sticks in house.<br><br>An interview was conducted on 7/29/22 at 8:55 AM with the Director of Nursing (DON). The DON stated nail care was ultimately the NA's responsibility. She explained the activity department offered nail care as a part of their programs as well. The DON indicated that Resident #30's fingernails were thick and discolored which made it difficult to cut them safely with standard nail clippers. The DON added she was not sure why they did not have Resident #30 on a routine schedule at the nail salon, since the facility was aware that his fingernails were an issue. She continued to explain the direct care staff should have communicated that his nails needed attention and that they were unable to trim them due to the condition of the nails. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25 | F 684 | | 8/19/22 |

| 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 07/29/2022 |

| 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 684 | Continued From page 59<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff, and Nurse Practitioner interview the facility failed to check a blood glucose level before breakfast as ordered by the provider for 1 of 5 residents observed during medication administration (Resident #83).<br><br>The Findings included:<br><br>Resident #83 was admitted to the facility on 07/15/22 with diagnoses that included diabetes.<br><br>No Minimum Data Set (MDS) information was available for Resident #83.<br><br>Review of Resident #83's admission assessment dated 07/15/22 indicated he was alert and oriented.<br><br>Review of a physician order dated 07/15/22 read: Accucheck (fingerstick glucose) before meals.<br><br>An observation was made on 07/27/22 at 9:29 AM, Nurse #5 entered Resident #83's room to check his blood glucose level. When she entered the room there was no breakfast tray in the room and Resident #83 and his family member stated | F 684 | F-684<br><br>Regarding the alleged deficient practice of failure to check a blood glucose level before breakfast as ordered during medication administration.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Director of Nursing notified NP of failure to check BS prior to meal for Resident #83. Resident #83 assessed for adverse reaction related to alleged deficient practice. No adverse reactions noted for resident #83.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and designees conducted an audit including an interview | |

| 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 07/29/2022 |

| 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 684 | Continued From page 60<br>that breakfast had already been delivered and the tray collected. Nurse #5 proceeded to explain to Resident #83 and his family member that she had gotten a late start this morning and that was why she was checking Resident #83 glucose level after he had eaten his breakfast. Nurse #5 proceeded to check Resident #83's fingerstick which was 156.<br><br>Nurse #5 was interviewed on 07/28/22 at 10:36 AM. Nurse #5 stated that when she arrived for duty on 07/27/22 she got report on a different unit then sometime later realized that she was supposed to be on the unit where Resident #83 resided. She explained that put her behind and that was why she checked Resident #83's glucose level after he had eaten his breakfast. She further explained that was her first time working on the unit where Resident #83's resided, and she just got a late start and was not familiar with all the resident on that unit, so she was really taking her time.<br><br>The Nurse Practitioner (NP) was interviewed on 07/28/22 at 12:38 PM. The NP stated glucose checks were ordered prior to the meal so that the correct dose of insulin could be given. She stated that checking after the resident eats does not give us a clear picture the glucose level. The NP again stated that she would expect Resident #83's glucose level to be checked before he ate this meal and not after.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 10:48 AM. The DON stated that glucose levels ideally would be checked prior to the meal and not after. | F 684 | of alert residents with Blood Glucose monitoring before meals completed by 08/19/2022. The Audit revealed no other residents were affected. The systematic changes stated below have been put into place to prevent any risk of additional residents being affected.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>To protect residents from similar occurrences, completed by 08/19/2022, the Director of Nursing and Nurse managers re-educated all licensed nursing staff to include agency staff on blood sugar monitoring before meals. The obtaining fingerstick glucose level policy will be added to new hire orientation and to the new agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator and Director of Nursing or designees will monitor audits of compliance with monitoring blood glucose before meals every week for 4 weeks and then every month x 2 months.<br>Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for | |

| 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 07/29/2022 |

| 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 684 | Continued From page 61 | F 684 | any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident, staff, and Wound Nurse Practitioner interviews the facility failed to implement interventions to promote healing of unstageable pressure ulcers for 1 of 6 residents reviewed with pressure ulcers (Resident #83).<br><br>The finding included:<br><br>Resident #83 was admitted to the facility on 07/15/22 with diagnoses that included unspecified | F 686 | F-686<br><br>Regarding the alleged deficient practice of failure to implement interventions to promote healing of unstageable pressure ulcers for 1 of 6 residents reviewed with pressure ulcers.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected: | 8/19/22 |

| 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 07/29/2022 |

| 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 686 | Continued From page 62<br>fracture of right femur.<br><br>Review of nursing admission assessment dated 07/15/22 indicated that Resident #83 was alert and oriented.<br><br>Review of a baseline care plan dated 07/15/22 indicated that Resident #83 had a history of skin issues, but no current skin issues were noted.<br><br>Review of admission nursing assessment dated 07/15/22 indicated that Resident #83 had unstageable pressure ulcers to his right and left heel. The right heel measured: 7.0 centimeters (cm) x 5.0 cm and the left heel measured 7.5 cm x 5.0 cm.<br><br>No Minimum Data Set (MDS) information was available for Resident #83.<br><br>Review of a physician order dated 07/16/22 read: paint bilateral heels with betadine and wrap with kerlix (gauze) daily and as needed.<br><br>Review of a Wound Evaluation and Management report dated 07/20/22 read in part; plan of treatment: will initiate proper wound management to include frequent repositioning and offloading. Please float heels on a pillow until boots can be obtained. The right heel measured: 7.0 cm x 4.6 cm and the left heel measured 6.7 cm x 5.9 cm.<br><br>Review of a care plan dated 07/25/22 read in part, Resident #83 has pressure ulcer related to history of ulcers, immobility, and incontinence. The interventions included: administer medications as ordered, administer treatments as ordered, follow facility protocols for prevention/treatment of skin breakdown, monitor | F 686 | On 07/29/2022 DON offloaded resident□s heels with pillows. On 8/17/22, the Director of Nursing secured order to offload heels to promote wound healing.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and Nurse Managers conducted an audit of all residents with pressure ulcers that requires a repositioning device to promote wound healing completed by 08/19/2022. Audit indicated no additional residents at risk of begin affected by alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>The Director of Nursing and Nurse Managers will conduct reeducation of Licensed staff members to include agency staff of pressure ulcer healing and on offloading devices completed by 08/19/2022. Weekly audit to be completed by DON and/or designee to review positioning devices for residents with pressure ulcers that require offloading to promote healing. The Prevention of pressure ulcer policy to be added to new hire orientation and the new agency orientation manual. | |

| 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 07/29/2022 |

| 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 |
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| F 686 | Continued From page 63<br>nutritional intake, monitor changes in skin, obtain and monitor lab work, the requires a pressure reducing mattress, and weekly treatment documentation to included measurement of each area of skin breakdown.<br><br>An observation and interview with Resident #83 were conducted on 07/25/22 at 3:19 PM. Resident #83 was resting in bed and was awake and alert. His bilateral heels were resting on the mattress, and each contained a dressing that was soiled with yellow dried drainage. There was a pillowcase under his bilateral heels that was also soiled with dried yellow drainage. Resident #83 stated that he was waiting on someone to come and change the dressing to his bilateral heels. He stated "that wound doctor told me to keep my heels elevated and off the bed" but no one will take care of that for me. There were 2 pillows sitting in a chair at the end of Resident #83's bed.<br><br>An observation of Resident #83 was made on 07/26/22 at 9:08 AM. He was in bed with bilateral heels resting on the mattress. There were 2 pillows in a chair at the end of Resident #83's bed.<br><br>An observation and interview were conducted with Resident #83 on 07/27/22 at 9:43 AM along with Nurse #5. Resident #83 was resting in bed and Nurse #5 was administering his morning medications. Resident #83's bilateral heels were resting on the mattress. Resident #83 told Nurse #5 "my heels need to be elevated at all times" to which Nurse #5 replied "I am going to find you a pillow" to put under them. As Nurse #5 exited Resident #83's room she stated, "his heels need to be elevated on something." There were 2 pillows in a chair at the end of Resident #83's | F 686 | (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator and Director of Nursing will monitor positioning device audit for residents with pressure ulcers once per week times 4 weeks and then once a month for 2 months for compliance and effectiveness of current interventions. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 686 | Continued From page 64 | F 686 | | |

bed.

An observation of wound care was made with the Wound Nurse Practitioner (WNP) and Unit Coordinator (UC) #2 on 07/27/22 at 10:14 AM. Resident #83 was resting in bed and his bilateral heels were resting on the mattress. The WNP asked Resident #83 if he was keeping his heels elevated on pillows as she was pulling back the sheet to which both heels were resting on the mattress. Resident #83 proceeded to tell the WNP that he has asked the nurse (Nurse #5) to elevated them and she stated she was going to get a pillow, but she had never returned. The WNP again stated to Resident #83 how important it was to keep his heels off the mattress and "floated" on a pillow or wedge as that would help with the pain and promote good wound healing. The WNP measured the right heel which was noted to be 6.5 cm x 5.1 cm and his left heel measured 6.6 cm x 4.5 cm. The WNP stated that this was only the second time she had evaluated Resident #83's wound and there was not significant change in their presentation. UC #2 stated that she rounded with the WNP most weeks and once her notes were available were reviewed and any new orders or change were transcribed and carried out for completion.

Nurse #5 was interviewed on 07/27/22 at 12: 33 PM. Nurse #5 stated that she had gotten busy an forgot to get a pillow to put under Resident #83's heels, she explained this was her first time working the unit and was not familiar with Resident 83's wound. She added she would review the treatment record for any ordered treatments that she needed to complete.

Nurse Aide (NA) #5 was interviewed on 07/28/22

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 686 | Continued From page 65<br>at 10:03 AM and confirmed that she was caring for Resident #83. She stated she did not know if Resident #83's heels should be elevated or not. She stated that from time to time he complained of pain in his heels. Resident #83 pulled the sheet up to reveal his bilateral heels resting on the mattress and he stated to NA #5 "I tell them all the time they need to be elevated all the time." NA #5 was also unaware of where to find the information on Resident #83 and stated the facility did not have a care guide or Kardex for her to review. She would rely on the nurse to communicate any needed information.<br><br>An observation of Resident #83 was made on 07/29/22 at 9:24 Am. Resident #83 was in bed, and he was noted to have a pillow under his right shin however bilateral heels rested on the mattress. There was one pillow in a chair at the end of Resident #83's bed.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:10 AM. The DON stated that all residents were on a pressure reducing mattress and had a wheelchair cushion. She stated that if a resident admitted with a wound, it was assessed and if they had significant wound, we would request an air mattress and have therapy assist with positioning devices. The DON explained when we float heels on pillow it was not uncommon for the pillow to come out and pressure relieving boots were difficult to obtain at this time but had been ordered. | F 686 | | |
| F 687 SS=E | Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment | F 687 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 66<br>and care to maintain mobility and good foot health, the facility must:<br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to provide nailcare for toenails for 4 of 10 residents reviewed for foot care (Residents #14, #71, #2 and #64).<br><br>The findings included:<br><br>1. Resident #14 was admitted to the facility on 5/2/18 with diagnoses of diabetes and peripheral neuropathy.<br><br>Review of Resident #14's physician order dated 12/9/20 revealed a referral for podiatrist. The order further stated toenail debridement for Diabetes.<br><br>Review of Resident #14's medical record revealed a podiatry note dated 11/22/21 for follow-up foot care with general notes that read onychomycosis (fungal infection) to bilateral # 1-5. The note described the toenails as brittle, elongated and thick. Recommendations included debridement every 61 days to minimize pain, pressure and infection of risk.<br><br>Review of podiatry note dated 4/19/22 documented resident was not seen due to being | F 687 | F-687<br><br>Regarding the alleged deficient practice of failure to provide nailcare for toenails for 4 of 10 residents reviewed for foot care.<br><br>(1)How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Resident #14 was seen by Podiatry on 8/8/22 and Toenail care provided. Resident #71 is no longer a Resident in the Facility. Resident #2 and Resident #64 have been added to the August Podiatry list.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>An Audit of all residents in need of Toenail care was completed on 8/15/22 and with residents noted for need of toenail care added to the podiatry list for visit on 09/02/2022. | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 67<br>out of the building<br><br>A quarterly Minimum Data Set dated 5/3/22 assessed Resident #14 was cognitively intact and had no behaviors. The resident required extensive staff assistance with activities of daily living (ADL) to include dressing and bathing and total staff assistance with personal hygiene.<br><br>Review of Resident #14's weekly nursing skin assessment dated 7/22/22 did not mention toenail concerns.<br><br>An interview was conducted with Resident #14 on 7/25/22 at 3:56 PM. Resident #14 stated he would like someone to cut his toenails because they are too long. Resident #14 indicated the nursing staff stated the NA could not trim his toenails and that he had to wait on a doctor. He added he had not seen a doctor for his feet in a long time and could not state when the last time was that he was seen by the podiatrist.<br><br>During an observation of Resident #14 on 7/26/22 at 3:09 PM, the resident was noted in bed with feet exposed. Resident #14's toenails were yellow, thick, and elongated. The great toenail of both feet was approximately an inch in length with black debris under the nail plate. The right foot digits 2-5's toenails were approximately ½ inch and curving over the toes. The left foot digits 2-5's toenails were approximately ¼ inch in length.<br><br>An interview was conducted with Nurse #2 on 07/27/22 at 10:47 AM. Nurse #2 indicated diabetic toenails were trimmed by the podiatrist. The nurse added that Podiatry came to the facility, but she could not recall the last time they | F 687 | (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Nurse Managers reeducation of care staff on proper toenail care and to report any concerns regarding toenail care to Director of Nursing or Designee on 8/19/2022.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Director of Nursing and or designees will conduct toenail audits of every week for 4 weeks and then once a month for 2 months. The Administrator and Director of Nursing to review audit every month to ensure continued compliance. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 68 | F 687 | | |

had been out to the facility. Nurse #2 stated regarding her skin assessment of Resident #14 on 7/22/22 she did not notice the length of his toenails on the assessment because she did not look at his feet during her assessment.

An interview was conducted with NA #6 on 7/26/22 at 3:27 PM which revealed he reported the length of the toenails to Nurse #6 this week and did not trim toenails.

An interview was conducted with the Representative of Podiatry on 7/27/22 at 3:17 PM. The Representative explained the podiatrist usually visited the facility every 9 weeks, but the company had lost a lot of podiatrists and had to stretch out the visits to 10 weeks. She added the facility was scheduled to be visited on 8/8/22. She did not state having anything in her facility notes which would have prohibited the Podiatrist from visiting the facility. The Scheduler indicated the service had not been able to get into the building because they did not have enough podiatrist, but the facility could always have requested a referral for an outside podiatrist. She explained everyone was aware that if the resident wanted services prior to their scheduled visit the facility can request an outside referral which does not have to be emergent at no cost to them.

Interview with the Social Worker (SW) on 7/27/22 at 4:45 PM. The SW explained she was responsible for ancillary services and scheduled podiatry every 3 months. The SW indicated she was not aware that there was a shortage of podiatrist and was not aware she could obtain a referral from podiatry for residents to be seen by an alternate podiatrist. The SW added that residents new to podiatry services were added by

| 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 07/29/2022 |

| 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 687 | Continued From page 69 | F 687 | | |

her and those who had been seen prior by podiatry were automatically added by podiatry. She further added that podiatry sent her a list prior to their visit of all residents to be seen as well as their podiatry notes after the visit was completed. She explained with the next podiatry visit being 16 weeks from the last visit she would have tried to find another podiatrist. The SW revealed she was not aware Resident #14 was last seen by podiatry services on 11/22/21 and she thought he had been seen on 4/19/22. She stated if she had been aware, she would have tried to find an alternate podiatrist to have seen Resident #14.

An interview was conducted with the Administrator and Director of Nursing (DON) on 7/29/22 at 5:15 PM which revealed it was their expectation that residents have their toenails trimmed by the podiatrist as needed. The DON stated this was usually done by podiatry and the nurses did not trim anyone's toenails.

2. Resident #71 was admitted to the facility on 07/20/22 with diagnoses which included acute dislocation of the shoulder related to fall, and muscle weakness.

Review of Resident #71's admission Minimum Data Set (MDS) assessment revealed it was in progress but not completed. The initial nursing assessment dated 07/20/22 revealed the resident was alert and oriented to person, place, time, and situation. Resident #71 required extensive assistance of 2 staff with bed mobility, transfers, dressing, and bathing, required extensive assistance of 1 staff member with personal hygiene, and was independent with eating once set up.

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 70 | F 687 | | |

Review of Resident #71's baseline care plan dated 07/21/22 revealed there was no focus area for activities of daily living.

Observation of and interview with Resident #71 on 07/25/22 at 11:17 AM revealed the resident lying flat on her back in her bed with her feet out of the covers. Her toenails were noted to be ¼ to ½ inch beyond the end of her toes. One of the nails had grown over her toe and extended to the back of her toe. The resident stated she would like to have her toenails trimmed and said her family had done it for her when she was at home. Resident #71 was not aware the staff could trim her toenails or refer her to the podiatrist to have them trimmed.

Observation of Resident #71 on 07/26/22 at 4:58 PM revealed she still had toenails ¼ to ½ inch beyond the end of her toes and wanted her toenails trimmed.

Observation of Resident #71 on 07/27/22 at 4:15 PM revealed she still had toenails that were ¼ to ½ inch beyond the end of her toes. She stated staff had not offered to trim her toenails or refer her to the podiatrist to have them trimmed.

Review of the podiatry list on 07/27/22 at 5:23 PM for August 8, 2022, revealed Resident #71 was not on the list of residents to be seen.

Interview on 07/28/22 at 10:12 AM with Nurse Aide (NA) #2 revealed she had cared for Resident #71 on the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed Resident #71's toenails but stated when she saw them, they needed to be trimmed. NA #2 stated she would

| 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 07/29/2022 |

| 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 687 | Continued From page 71 | F 687 | | |

let Resident #71's nurse know she needed her toenails trimmed.

Interview on 07/28/22 at 10:44 AM with Nurse #4 revealed she was the charge nurse for the Rehab unit today. Nurse #4 went into Resident #71's room and stated her toenails needed to be trimmed and she would refer her to the podiatrist to get them trimmed. She stated the nurses did not trim toenails at the facility.

Interview on 07/29/22 with the Administrator and Director of Nursing revealed they would have expected the staff to have noticed Resident #71's toenails needed to be trimmed and referred her to podiatry to have them done. The DON stated the podiatrist trims everyone's toenails at the facility, not the nurses. The Administrator stated they usually went room to room before podiatry came and made referrals based on needs of residents but stated someone should have already referred her to be seen on the next appointment.

3. Resident #2 was admitted to the facility on 07/08/22 with diagnoses which included acute on chronic respiratory failure and anemia.

Resident #2's admission Minimum Data Set (MDS) assessment was in process but not completed. Resident #2's admission nursing assessment dated 07/08/22 revealed he was alert and oriented to person, place, time, and situation. Resident #2 requires extensive assistance of 2 staff with bed mobility, and transfers and requires extensive assistance of 1 staff with dressing, and toilet use and limited assistance of 1 staff with personal hygiene, and independent with eating after set-up.

| 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 07/29/2022 |

| 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 687 | Continued From page 72 | F 687 | | |

Resident #2's baseline care plan dated 07/10/22 revealed there was no focus area for activities of daily living.

Observation of and interview with Resident #2 on 07/25/22 at 3:29 PM revealed him sitting up in his wheelchair in his room. Resident #2's toenails were noted to be ¼ to ½ inch beyond the end of his toes. Resident #2 stated he would like to have his toenails trimmed and had asked about getting them trimmed (he couldn't remember who he had asked about trimming his toenails). He stated he would still like for them to be trimmed because he could not reach his toenails to trim them himself.

Observation of Resident #2 on 07/26/22 at 5:00 PM revealed him resting in bed with head of bed elevated at 90 degrees. Resident #2 stated he still had not had his toenails trimmed and would like for them to be done.

Observation of Resident #2 on 07/27/22 at 5:24 PM revealed him up in his wheelchair and appeared to be sleeping with his eyes closed. Resident #2 was observed to still have toenails ¼ to ½ inch beyond the end of his toes and some of them were thick.

Review of the podiatry list on 07/27/22 at 5:23 PM for August 8, 2022, revealed Resident #2 was not on the list of residents to be seen.

Interview on 07/28/22 at 10:12 AM with NA #2 revealed she was assigned to care for Resident #2 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed that Resident #2 needed to have his toenails trimmed. She stated that was usually done by the podiatrist and they

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 73 | F 687 | | |

would need to refer him to get his toenails trimmed.

Interview on 07/28/22 at 10:40 AM with Nurse #4 revealed she was not aware that Resident #2 needed to have his toenails trimmed. She stated she was not sure who he had asked about getting it done but since they were thick, he would need to be referred to podiatry to get them trimmed. Nurse #4 stated she could refer him to be seen by podiatry. She further stated the nurses did not trim toenails they were all done by podiatry.

Interview on 07/29/22 at 5:15 PM with the Administrator and Director of Nursing (DON) revealed it was their expectation that residents have their toenails trimmed by podiatry as needed. The DON stated this was usually done by the podiatrist and the nurses did not trim anyone's toenails. The Administrator stated they usually went room to room before podiatry came and made referrals based on needs of residents but stated someone should have already referred him to be seen on the next appointment.

4. Resident #64 was admitted to the facility on 06/23/22 with diagnoses which included acute embolism and thrombosis of the left lower extremity deep vein, and type II diabetes mellitus.

Review of Resident #64's admission Minimum Data Set (MDS) assessment dated 06/30/22 revealed he was cognitively intact and required limited assistance of 1 staff with bed mobility, dressing and personal hygiene, required extensive assistance of 2 staff with transfers, required extensive assistance of 1 staff with bathing and was independent with eating after set-up.

| 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 07/29/2022 |

| 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 |
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| F 687 | Continued From page 74 | F 687 | | |

Resident #64's care plan dated 06/25/22 revealed there was no focus area for activities of daily living (ADL).

Observation of and interview with Resident #64 on 07/25/22 at 12:01 PM revealed his feet uncovered and his toenails that were ¼ to ½ inch from the end of his toes. He stated he had trimmed his fingernails himself but could not get down to do his toenails and would like for them to be trimmed. Resident #64 further stated no one had offered to trim his toenails.

Observation of Resident #64 on 07/26/22 at 4:00 PM with his toes uncovered revealed his toenails still had not been trimmed. He stated he would like for his toenails to be trimmed but said no one had offered to trim them for him.

Observation of Resident #64 on 07/27/22 at 4:29 PM with his toes uncovered revealed his toenails still had not been trimmed. He stated he would like to have his toenails trimmed but no one had offered to trim them for him.

Review of the podiatry list on 07/27/22 at 5:23 PM for August 8, 2022, revealed Resident #64 was not on the list of residents to be seen.

Interview on 07/28/22 at 10:12 AM with NA #5 revealed she was assigned to care for Resident #64 during the 7:00 AM to 3:00 PM shift. NA #5 stated she had not noticed that Resident #64 needed to have his toenails trimmed. She stated that was usually done by the podiatrist and they would need to refer him to get his toenails trimmed.

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 687 | Continued From page 75<br>Interview on 07/28/22 at 10:40 AM with Nurse #4 revealed she was not aware that Resident #64 needed to have his toenails trimmed. Nurse #4 stated she could refer him to be seen by podiatry. She further stated the nurses did not trim toenails they were all done by podiatry.<br><br>Interview on 07/29/22 at 5:15 PM with the Administrator and Director of Nursing (DON) revealed it was their expectation that residents have their toenails trimmed by podiatry as needed. The DON stated this was usually done by the podiatrist and the nurses did not trim anyone's toenails. The Administrator stated they usually went room to room before podiatry came and made referrals based on needs of residents but stated someone should have already referred him to be seen on the next appointment. | F 687 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; | F 692 | | 8/19/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 692 | Continued From page 76<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff, Registered Dietitian and Nurse Practitioner interviews the facility failed to assess interventions for significant weight loss and have systems in place to identify further weight loss for 1 of 1 resident reviewed for weight loss (Resident #41).<br><br>The findings included:<br><br>Resident #41 was readmitted to the facility on 3/4/2022 with diagnoses of infection following a procedure, gangrene, and peritonitis.<br><br>A review of weights revealed Resident #41's readmission weight on 3/4/2022 was 152.8 lbs and on 7/14/2022 her weight was 132.2 lbs, for a total of 20.6 lb weight loss or 13.16% weight loss in a 4-month period.<br><br>Review of the care plan dated 3/21/22 revealed Resident #41 was at nutritional risk related to poor appetite and intake, weight loss, increased nutritional needs for wound healing, interventions included: provide and serve supplements as ordered, monitor/record/report to medical provider signs and symptoms of malnutrition, and significant weight loss of 3 pounds in 1 week, > 5% weight loss in 1 month, >7.5% weight loss in 3 months and 10% weight loss in 6 months.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated 6/28/2022, Resident #41 was coded as cognitively intact and required extensive | F 692 | F-692<br><br>Regarding the alleged deficient practice of failure to assess interventions for significant weight loss and have systems in place to identify further weight loss for 1 of 1 resident reviewed for weight loss.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>MDS nurse reviewed lists of food preferences with resident on 07/26/2022. Resident was placed on Weekly Weights for 4 weeks. Director of Nursing discussed weight loss of resident #41 with NP on 8/12/22. Medical evaluation requested on 8/17/22 by Director of Nursing.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and designees conducted an Audit of Residents for weight losses on 08/12/2022. Healthcare providers notified of all noted significant weight losses on 08/12/2022 for review and recommendation. | |

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

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|---|---|---|---|---|
| F 692 | Continued From page 77<br>assistance of one person for activities of daily living and was independent for eating, she was coded for weight loss.<br><br>A dietary review was conducted by the Registered Dietitian on 6/28/2022 revealed Resident #41 was on a regular diet with no chewing or swallowing deficits; fed herself, had an average intake average of 28% of meals. Significant weight loss since admission weight of 205 lbs on 1/11/2022; relatively stable during past 2 months. Albumin 2.2 (Low), total protein 4.9 (low). Recommendation was to start medication pass supplement 120 ml (milliliters) by mouth twice a day to provide 480 kilocalories, 20 grams of protein to promote weight gain, wound healing, and liquid protein 30 ml twice a day to promote wound healing.<br><br>A review of the physician orders dated 6/28/2022 for Resident #41 revealed the following:<br>High protein nutritional supplement 2.0 give 120 milliliters (ml) two times a day for supplement<br><br>A telephone interview was conducted with the Registered Dietitian (RD) on 7/28/2022 at 9:32AM. The RD revealed she believed Resident #41's last weight was questionable, and she did not ask for a reweight and stated she was familiar with Resident #41 and felt Resident #41's weight was stable. She stated Resident #41 recently had covid-19 and this affected her sense of taste, and she did not feel Resident #41 was nutritionally deficient. The RD further stated she thought she had informed the NP about Resident #41's weight loss, but she was not sure. She revealed she did discuss Resident #41's weight loss with the nursing staff. | F 692 | (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Dietary manager and/or designee to provide resident with a Menu each week. Residents that are determined to have weight loss will be discussed in the weekly Risk meeting. Reweights of residents with 5lbs weight difference from previous weight will be completed to ensure accuracy of weights. Healthcare providers will be notified of weight changes greater than 5% monthly by the Director of nursing and /or designee. All Residents with greater than 5% weight loss per month will be reviewed by Dietician weekly and will be on weekly weights 4 weeks.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Residents<br><br>Audit of weight losses and interventions will be completed by DON, Unit Nurse Managers and/or designee weekly times 4 weeks then monthly times 2 months. DON and/or designee will review monthly weight losses in QAPI for effectiveness of interventions. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 692 | Continued From page 78<br>An interview was conducted with the Nurse Practitioner (NP) on 7/27/2022 at 4:53PM. NP stated she was concerned about Resident #41's weight loss and had spoken to her about eating her meals and not just snack foods. NP revealed she did not realize that Resident #42 had such a significant amount of weight loss but had been told by staff several months ago she was losing weight. She stated she expected the Registered Dietitian to inform her when a resident had a significant weight loss. The NP stated Resident #41 recently had Covid-19 and that had affected her sense of taste and her appetite.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/29/2022 at 3:47PM. DON stated since March 2022 when Resident #41 was readmitted to the facility she had a 20-pound weight loss. The DON revealed she spoke to the RD regarding Resident #41's weight loss and a supplement was ordered, and Resident #41's food preferences were reviewed with her. DON revealed she expected nursing staff and the RD to notify the medical provider of resident weight loss, so that the weight loss was addressed by the medical provider. | F 692 | Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. | F 695 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 695 | Continued From page 79<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident, staff and Nurse Practitioner interviews the facility failed to have a physician order for the use of oxygen for 1 of 1 resident reviewed with oxygen (Resident #12).<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on 07/14/21 with diagnoses that included chronic obstructive pulmonary disease.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 07/06/22 revealed that Resident #12 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #12 required oxygen during the assessment reference period.<br><br>Review of the Resident #12's physician orders revealed no active order for oxygen use.<br><br>An observation and interview were conducted with Resident #12 on 07/25/22 at 12:20 PM. Resident #12 was resting in bed and was observed to have a nasal cannula in his nose that was connected to concentrator that was set to deliver 2 liters of oxygen. Resident #12 stated he had been on oxygen for a while and usually received 2-3 liters.<br><br>An observation of Resident #12 was made on 07/27/22 at 4:38 PM. Resident #12 was resting in bed and was observed to have a nasal cannula in his nose that was connected to concentrator that was set to deliver 2 liters of oxygen. | F 695 | F-695<br><br>Regarding the alleged deficient practice of failure to have a physician order for the use of oxygen for 1 of 1 resident reviewed with oxygen.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>The Director of Nursing obtained ordered for Oxygen for resident #12 on 7/28/22. Resident #12 was assessed for any adverse reactions to alleged deficient practice with no adverse reactions noted.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and Nurse Managers conducted an audit of all residents on oxygen completed by 08/19/2022. Audit indicated 0 additional residents at risk of begin affected.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>The Director of Nursing and Nurse Managers conducted reeducation of Licensed staff members including agency | |

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|---|---|---|---|
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|---|---|
| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 695 | Continued From page 80<br>An observation of Resident #12 was made on 07/28/22 at 8:48 AM. Resident #12 was resting in bed and was observed to have a nasal cannula in his nose that was connected to a concentrator that was set to deliver 2 liters of oxygen.<br><br>Nurse #2 was interviewed on 07/28/22 at 10:32 AM. Nurse #2 confirmed that she regularly cared for and was familiar with Resident #12. She stated that he had worn oxygen for about a year and generally required between 2-3 liters of oxygen. Nurse #2 reviewed Resident #12's physician orders and confirmed that there was no order but again stated that he "definitely needed the oxygen."<br><br>The Nurse Practitioner (NP) was interviewed on 07/28/22 at 12:54 PM. The NP stated that when she started at the facility 4 months ago Resident #12 was already on oxygen. She stated that 2 liters appeared to be sufficient for Resident #12 after reviewing his pulse oximeter (amount of oxygen in the blood) reading that were recorded as 90-99%. The NP again confirmed that the facility did not utilize standing orders and all orders should come through the providers. She stated that Resident #12 should have an order for oxygen, and she would take care of the order right now.<br><br>The Director of Nursing (DON) was interviewed on 07/28/22 at 9:51 AM and stated that the facility had no standing orders. They had 24-hour access to providers and anything that needed an order should be called to the providers and an order obtained.<br><br>The DON was interviewed again on 07/29/22 at 11:37 AM. The DON stated that whenever | F 695 | staff on oxygen administration policy on 8/19/2022.<br>Oxygen administration policy to be added to new hire orientation and to new agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, DON and/or designees with conduct oxygen use audits once per week x 4 weeks then once a month for 2 months for compliance and effectiveness of current interventions. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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| F 695 | Continued From page 81<br>Resident #12 first required the oxygen the staff should have contacted the provider to obtain the order. | F 695 | | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by: | F 726 | | 8/19/22 |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 726 | Continued From page 82<br>Based on observations, record review, and staff interview the facility failed to ensure they had competent nursing staff trained in disinfecting of glucometers for 1 of 4 nurses (Nurse #5) observed on medication pass and failed to ensure they had competent nurses trained on the process for obtaining, reviewing, and reporting on laboratory reports for 5 of 5 nurses reviewed (Nurses #8, #11, #10, #3, and #9).<br><br>The findings included:<br><br>1. An observation of Nurse #5 obtaining Resident #83's blood sugar was made on 07/27/22 at 9:39 AM. Once she obtained the blood sugar, Nurse #5 exited Resident #83's room and returned to her medication cart where she sanitized her hands. Nurse #5 then opened the top drawer of the medication cart and obtained an alcohol pad and proceeded to clean the glucometer that she had just used to check Resident #83's blood sugar with for approximately 10 seconds before placing the glucometer back in the drawer on the medication cart. When Nurse #5 opened the medication cart to place the glucometer there was a container of bleach wipes in the drawer.<br><br>Nurse #5 was interviewed on 07/27/22 at 9:55 AM who confirmed she worked at the facility through an agency and that she was not sure of what the policy or procedure was at the facility for cleaning glucometers. She stated that in the past she had used bleach wipes on the glucometer and after she did that the glucometer did not work anymore so since then she has always used the alcohol pads to clean the glucometer. Nurse #5 stated "no one showed me what to do I just try to clean them with something." | F 726 | F-726<br><br>Regarding the alleged deficient practice of failure to ensure they had competent nursing staff trained in disinfecting of glucometers for 1 of 4 nurses observed on medication pass and failed to ensure they had competent nurses trained on the process for obtaining, reviewing, and reporting on laboratory reports for 5 of 5 nurses reviewed.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Glucometer used for resident #83 was properly disinfected as per policy by the Director of Nursing. The Director of Nursing reviewed abnormal lab results for the last 7 days with HCP on call on 7/17/22. Agency nurse #5 was informed of the alleged infection control deficiency and was put on the facility do not return list with the agency.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and Nurse Managers provided reeducation of Licensed staff, agency staff on the policy of proper disinfection of Glucometers initiated on 07/27/2022 and completed on 07/28/2022. The DON and Unit Nurse Managers completed reeducation on proper lab procedure for obtaining, | |

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

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|---|---|---|---|---|
| F 726 | Continued From page 83<br>Unit Coordinator (UC) #2 was interviewed on 07/27/22 at 4:58 PM. UC #2 stated that the glucometers should be disinfected with bleach wipes that were on all the medication carts. UC #2 stated that when agency staff came to the facility to work, they got a "rough draft" of the building. They got report on their assignment and the off going nurse would show them around the facility but that was about the extent of their orientation.<br><br>The DON was interviewed on 07/28/22 at 3:34 PM who confirmed that the glucometer should have been cleaned/disinfected with bleach disinfecting wipes that were on each of the medication carts in the facility. The DON stated that all the staff had been educated on the cleaning practices and were aware that the glucometers were to be disinfected with the bleach wipes that were on the medication carts.<br><br>A follow up interview was conducted with the DON along with the Administrator on 07/29/22 at 10:48 AM. The DON stated that when agency staff came to work at the facility, they received education on the facility, but she could not say that she had trained all the agency staff on appropriate practices for disinfecting the glucometers and stated, "I believe that is a standard you find out what the policy is for cleaning glucometers."<br><br>2. Resident #52 was readmitted to the facility on 04/28/21 with diagnoses that included diabetes.<br><br>Review of a physician order dated 07/12/22 read; complete blood count (CBC).<br><br>Review of a laboratory reported dated 07/15/22 | F 726 | reviewing, and reporting of abnormal lab results completed by 08/19/2022. The Director of Nursing and Nurse Managers conducted audit on Clinical staffs knowledge of Glucose monitor cleaning. Audit revealed no other residents were at risk of being affected. The Director of Nursing and Nurse Managers conducted an audit of all abnormal lab reporting on 08/19/2022 and no additional residents were affected.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Labs will be reviewed twice per week by the clinical management team for compliance with reporting abnormal labs. DON and/or unit managers provided an individualized glucometer to all diabetic residents requiring blood glucose. The obtaining a fingerstick glucose level policy that includes proper glucometer cleaning instructions will be added to new hire orientation and to the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Administrator, Director of Nursing and/or designees will conduct audits of Licensed staff members knowledge of the proper process of glucometer cleaning and policy of obtaining, reviewing, and reporting of abnormal labs to HCP once a | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 726 | Continued From page 84<br>indicated that the blood was drawn on 07/15/22 and reported out on 07/15/22 at 5:19 PM. The results included: white blood cell (indication of infection) was 18 (normal was 4.1-10.7).<br><br>Nurse #8 was interviewed on 07/26/22 at 4:58 PM. Nurse #8 stated that she was not familiar with Resident #52, and she only cared for her a couple of times. Nurse #8 stated that she did not know how the laboratory services worked at the facility and indicated that she did not have access to the laboratory system in the facility at all. She stated she had "never gotten or reviewed lab reports" since she began working at the facility through an agency, "someone else has always taken care of those" but did not know who.<br><br>Nurse #11 was interviewed on 07/26/22 at 5:34 PM. Nurse #11 stated that Resident #52 was confused but she knew that she recently had urinary tract infection and had received an antibiotic. Nurse #11 stated that she did not see any lab work for Resident #52, and she did not have access to the lab system at the facility. Nurse #11 further stated she never received any lab work to review and again was not sure how the lab process worked at the facility.<br><br>Nurse #10 was interviewed on 07/27/22 at 12:32 PM. Nurse #10 stated that she worked at the facility through an agency. She stated that Resident #52 had gotten more confused from the first time she cared for her until the time she discharged to the hospital. Nurse #10 stated that she did not review any labs for Resident #52 and was not aware how the lab process worked at the facility. She stated, "I think the nurse practitioner gets them." | F 726 | week for 4 weeks and once a month for 2 months to ensure no additional residents are at risk of being affected. The Administrator and Director of Nursing will monitor audits once a month for compliance and effectiveness of current interventions. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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|---|---|---|---|---|
| F 726 | Continued From page 85 | F 726 | | |

Nurse #3 was interviewed on 07/27/22 at 6:11 PM. Nurse #3 stated that she was aware of the urinalysis that was obtained for Resident #52, and she knew that she was extremely confused. Nurse #3 stated that she did not review any labs for Resident #52, and she did not have access to the lab system in the facility.

Nurse #9 was interviewed on 07/28/22 at 12:19 PM. Nurse #9 stated that she worked at the facility through an agency about twice a week. She stated that she was aware that Resident #52 had recently had a urinary tract infection. Nurse #9 stated that she did not review any lab reports for Resident #52 nor was she aware that labs had been ordered. Nurse #9 added that she did not have access to the lab system to review labs if she wanted too.

Unit Coordinator (UC) #2 was interviewed on 07/27/22 at 4:58 PM. UC #2 stated that when agency staff came to the facility to work, they got a "rough draft" of the building. They got report on their assignment and the off going nurse would show them around. She further stated she did not believe that the agency staff had access to the lab system but added if there was a critical lab value the lab would contact the supervisor on call. UC #2 stated that when she was in the building, she would get the lab reports off the printer and give to the providers for review and on the weekend, it would be who ever was supervising during that time.

The Director of Nursing (DON) was interviewed on 07/28/22 at 3:34 PM. The DON stated she came over to the facility on Sunday 7/17/22 and called Resident #52's family and updated them on her condition and the CBC results from 07/15/22

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 726 | Continued From page 86<br>and the family was upset that no one had acted upon the lab work. She stated she tried to explain to the family that the lab values did not report as critical but yes, they were abnormal and based off the way Resident #52 presented they were going to send her to the hospital for evaluation. The DON explained that the lab company came to the facility 3-4 times a week to draw labs that had been ordered. Once the lab had been drawn and processed at the lab, they were faxed over to the main nursing station, the main copier or they were called to the facility if they were critical values. Any of the nurse can take labs from the printer and turn them over to the provider but noncritical values were not generally called to on call provider they generally were given to the provider when they return onsite. The DON stated that "our nurses are trained to process and enter lab orders" and some of the agency staff that come infrequently do not have access to the lab system. | F 726 | | |
| F 742 SS=D | Treatment/Srvcs Mental/Psychoscial Concerns<br>CFR(s): 483.40(b)(1)<br><br>§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-<br>§483.40(b)(1)<br>A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff | F 742 | F-742 | 8/19/22 |

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|---|---|---|---|---|
| F 742 | Continued From page 87<br>interview the facility failed to ensure a resident who experienced flashbacks of past trauma resulting in distress and who expressed verbal statements of wanting to harm himself had been assessed for his emotional and psychosocial needs. The facility also failed to ensure the assessed needs were incorporated into a plan of care with individualized care approaches to direct the staff on how to provide care to the resident.<br><br>The findings included:<br><br>Resident #84 was admitted to the facility on 06/27/22 with diagnoses that included anxiety and depression.<br><br>Review of a physician order dated 06/28/22 read; Clonazepam (used to treat anxiety) 0.5 milligrams (mg) by mouth two times a day for anxiety for 10 days.<br><br>Review of the admission Minimum Data Set (MDS) dated 07/04/22 indicated that Resident #84 had a level 2 Preadmission Screening and Resident Review (PASRR) for other related conditions and was cognitively intact. The MDS further indicated that Resident #84 had verbal behaviors that occurred 1 to 3 days during the assessment reference period and required extensive to total assistance with activities of daily living. Resident #84 also received 5 days of an antianxiety medication during the assessment reference period.<br><br>Review of Resident #84's care plan revealed no care plan with interventions that addressed his flashbacks of past trauma or comments of wanting to harm himself. | F 742 | Regarding the alleged deficient practice of failure to ensure a resident who experienced flashbacks of past trauma resulting in distress and who expressed verbal statements of wanting to harm himself had been assessed for his emotional and psychosocial needs.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Resident #84 was evaluated by medical professional on 7/20/22, 7/27/22, 7/28/22, 8/1/22, 8/2/22, 8/4/22, 8/8/22, 8/12/22. Resident was evaluated by Psychiatry on 8/10/22. Care Plan was updated to reflect individualized care approaches for direct staff on 8/3/22 and 8/18/22. Education was provided to direct care staff, including licensed nurses, nurse aides, agency staff on individualized care approaches on how to provide care to resident. Education completed by 8/19/22.<br><br>(2)How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>Director of Social Services completed an Audit of Trauma assessments for all Residents by 08/20/2021.<br>Residents with identified past traumatic experiences will have individualized care approach interventions for the direct care staff on how to provide care to the resident incorporated into their Plan of | |

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|---|---|---|---|---|
| F 742 | Continued From page 88<br>Review of a physician order dated 07/07/22 read; Clonazepam 0.5 mg by mouth three times a day for anxiety x 14 days.<br><br>Review of a physician order dated 07/11/22 read; Depakote Sprinkles 125 mg give 2 capsules two times a day for agitation.<br><br>Review of a Behavior Care Area Assessment dated 07/19/22 read in part, Resident #84 is alert and oriented and able to understand and communicate needs. He has had some behaviors of yelling out and making demands of staff.<br><br>Review of a physician order dated 07/22/22 read; Clonazepam 1 mg by mouth three times a day for anxiety.<br><br>Prior to a wound dressing observation with the Wound Nurse Practitioner (WNP) on 07/27/22 at 12:10 PM the WNP stated that Resident #84 had post traumatic stress syndrome and that last week during his wound care he reported a suicidal ideation and that she had immediately reported it the Director of Nursing (DON) even before they (the WNP and Unit Coordinator (UC #2) completed wound care and so they approached him gently. Upon entering Resident #84's room for wound care he was noted to be resting with his eyes closed and was snoring from time to time. During the entire wound procedure of Resident #84's left lower leg he was noted to be sleeping and did not arouse.<br><br>An observation of Resident #84 was made on 07/27/22 at 12:41 PM. Resident #84 was in bed with his eyes open and stated, "oh, oh I am going to get hit by a torpedo" Resident #84 was assured he was safe and there was no torpedo in the | F 742 | Care<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Education provided to staff on signs and symptoms of past trauma is to be reported to Administrator, Director of Nursing, and/or designee. Residents with reported signs of past trauma will be referred to HCP and a new trauma assessment will be obtained, with interventions care planned. Trauma informed care policy will be added to new hire orientation and agency orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Director of Social Services will complete Brief Trauma Questionnaire assessment within one week of admission. The Brief trauma questionnaires evaluate historical traumatic experiences that the resident may have experienced in their lifetime.<br><br>An Audit of trauma assessments will be completed every week for 4 weeks and then once a month for 2 months. Administrator and Director of Nursing will review Trauma assessment audits once a month to ensure continued compliance. Interventions for Residents with identified past trauma will be reviewed for | |

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|---|---|---|---|
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| F 742 | Continued From page 89<br>facility he replied, "I am on the Liberty ship and there is torpedo coming." Resident #84 was again assured he was not on the Liberty ship to which he replied, "I am on the ship, and it will get hit by the torpedo too."<br><br>The Social Worker (SW) was interviewed on 07/27/22 at 12:48 PM. The SW stated that Resident #84 was a patient of the Veterans Administration (VA). She stated that she knew he had served in the military and that recently had made a comment about wanting to harm himself and she had gone to speak to him, and he stated he wanted to talk to someone but that he would never harm himself. The SW stated that UC #2 had reached out the VA and was unable to get him seen so the Nurse Practitioner (NP) had added Depakote about 2 weeks ago. The SW was unaware what the DON had done about the suicidal comment that Resident #84 made and stated that since Resident #84 had been in the facility he had not been seen by any psychiatric services and she was also unaware of why he had a level 2 PASRR.<br><br>The DON was interviewed on 07/27/22 at 2:55 PM. The DON stated that Resident #84 had behaviors the entire time he had been at the facility, he was extremely impatient and would yell constantly. She stated that she had been working with the VA to get his psychiatric situation handled because it was impeding his ability to participate with therapy. The DON stated that the other day staff went to provide wound care and he made a comment about "why don't you bring me a gun" and the comment was reported to the Nurse Practitioner (NP) who spoke to Resident #84, and he stated that the only reason he made those comments was because it would get him some | F 742 | effectiveness in interventions monthly.<br><br>Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

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|---|---|---|---|---|
| F 742 | Continued From page 90 | F 742 | | |

attention. The DON stated that this was the first time she was aware that Resident #84 had made comments about harming himself and indicated that when Resident #84 first came to the facility they tried to get him admitted to inpatient psychiatric services at the VA and they denied him and scheduled a virtual visit with Resident #84 for some time in August. The DON stated that Resident #84 had not seen the psychiatric services onsite because they must get approval from the VA to pay for the services.

A follow up interview with the WNP was conducted on 07/27/22 at 3:33 PM. The WNP stated that during her visit on 07/20/22 Resident #84 was hypervigilant and was anxious and stated, "just let me die bring me a handgun and I will take care of it myself." The WNP stated that she immediately notified the DON, and the medical provider was notified. She further confirmed that Resident #84 had slept through the wound care on 07/27/22.

The NP was interviewed on 07/27/22 at 4:21 PM and stated that she was made aware of the comment made to the WNP by Resident #84 about harming himself, and she went and spoke to the resident. She stated that Resident #84 stated that he was just talking crazy, and he would not do anything to harm himself and that he did not want to die. After the NP spoke to Resident #84, she stated she went to the DON and asked what they could do for Resident #84 about possibly increasing the time the staff went into his room and she stated the DON said she would communicate with corporate and see what they could do about that. The NP stated that UC #2 had arranged for an outpatient virtual visit with the psychiatric folks at the VA for some time in

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|---|---|
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|---|---|---|---|---|
| F 742 | Continued From page 91 | F 742 | | |

August. She indicated that she was not aware of any other mental illness he had besides depression and anxiety but stated she had entered an order for a psychiatric evaluation at the facility and she was not sure why that had not been done yet except for he was a VA patient so that may have something to do with it. The NP again stated she thought Resident #84 was stable and an emergency room (ER) visit was not necessary so had made some medication adjustments and she believed he was tolerating them well and hollering less.

UC #2 was interviewed on 07/27/22 at 4:53 PM and stated that the WNP had told her about the statements that Resident #84 had made last week prior to wound care and that she had notified the DON. UC #2 stated that when Resident #84 came to the facility she had called the VA for authorization for Resident #84 to see the wound care provider and the onsite psychiatry services and they approved the wound care but not the psychiatry services. UC #2 stated that was prior to Resident #84 making comments about harming himself and she had not called for authorization again after he made those statements because he already had outpatient virtual visit set up for some time in August.

An interview with Resident #84's family member was conducted on 07/28/22 at 9:15 AM. The family member stated that Resident #84 had served in the war when he was 17 and suffered from post-traumatic stress disorder from that. She stated that before Resident #84 was in the hospital and before he was in facility's he was at home and did not receive any psychiatric services, but he has always been a hyper impatient person. The family member stated that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 742 | Continued From page 92 | F 742 | | |

yesterday 07/27/22 the facility called to tell her that Resident #84 had made some suicidal comments a week ago but that was the first she had heard about it. She also stated that she was not aware of any past suicidal ideations or attempts that Resident #84 had.

An observation of Resident #84 was made on 07/28/22 at 10:29 AM. He was resting in bed with his eyes closed and he appeared to be sleeping. Resident #84 did not respond to a knock on the door nor to verbal stimuli. His breakfast tray was on his bedside table with his milk unopened, cereal untouched, and his eggs untouched.

MDS Nurse #1 was interviewed on 07/28/22 at 3:00 PM who stated that they discussed new orders and anything that had occurred during the previous 24-hour period in the daily clinical meeting and any care plans that needed to be initiated or updated were done so at that time. MDS Nurse #1 stated she did not recall and had no knowledge of Resident #84's comments about harming himself or she would have initiated a care plan with very specific interventions like increase observations and possible the need for a one-on-one sitter.

The Administrator and DON were interviewed on 07/29/22 at 11:25 AM. The Administrator stated that the team had discussed Resident #84 in great lengths. She stated on 06/30/22 they had sent Resident #84 to the ER for a wound evaluation and verbally asked the hospital to have psychiatry evaluate him and they refused and sent him back, so we got in touch with the VA and asked for them to evaluate him and they set up virtual outpatient visit for some time in August. Later, after he made a comment about wanting to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| F 742 | Continued From page 93<br>harm himself to the WNP the NP evaluated him and determined he was not suicidal. The DON stated that "we know he has a history of attention seeking behaviors and I don't like calling it suicidal ideations because it is not that." The virtual outpatient visits were scheduled prior to the threat of suicide and the DON added "if I refer him to the psychiatric doctor onsite, they would be curious about a payor source." The DON stated that they had made medication adjustments without sedating him and the behaviors "are a far cry better then it was." The Administrator and DON stated that the delusion Resident #84 had during the week were new an that maybe he had a urinary tract infection and the provider addressed that and ordered test. | F 742 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff, and Nurse Practitioner interview the facility to have a medication error rate of less than 5% as evidenced by 4 medication administration errors out of 26 opportunities which gave the facility a medication error rate of 15.38%. This affected 1 of 5 residents observed during medication administration (Resident #83).<br><br>The findings included:<br><br>Review of physician orders dated July 2022 | F 759 | F-759<br><br>Regarding the alleged deficient practice of having a medication error rate of 15.38%<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>The Director of Nursing Notified Resident and NP on 7/29/22 of alleged Medication errors for Resident #5. Resident exhibited | 8/19/22 |

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| F 759 | Continued From page 94<br>revealed the following orders: Humulin 70/30 (insulin) 45 units subcutaneously (sq) one time a day before breakfast, Aspirin 81 milligrams (mg) by mouth every day for coronary artery disease, Heparin Sodium (blood thinner) 5000 units sq every 8 hours, and Calcium Carbonate/Vitamin D3 600/400 mg by mouth everyday as a supplement.<br><br>An observation of Nurse #5 preparing Resident #83's medication was made on 07/27/22 at 9:17 AM. Nurse #5 was observed to draw up Humulin 70/30 45 units of insulin into a syringe. Nurse #5 then began placing Resident #83's pills into a medicine cup that included: Aspirin 325 mg. Nurse #5 stated that she did not have the Heparin 5000 units or the Calcium carbonate/Vitamin D, so she was going to omit those medications because they were unavailable. At 9:29 AM Nurse #5 entered Resident #83's room to administer his medications. When she entered the room there was no breakfast tray in the room and Resident #83 and his family member stated that breakfast had already been delivered and the tray collected. Nurse #5 proceeded to explain to Resident #83 and his family member that she had gotten a late start this morning and that was why she was giving Resident #83 his insulin late after he had eaten his breakfast. Resident #83 indicated he was reluctant to take the insulin as he had already eaten. With much encouragement from Nurse #5 Resident #83 allowed the injection to be given and Resident #83 took his medications including the Aspirin 325 mg.<br><br>Review of an Electronic Medication Administration Record (EMAR) progress note dated 07/27/22 at 9:56 AM read Calcium Carbonate/Vitamin D 600/400 mg medication | F 759 | no adverse reactions.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>All Residents had the potential to be affected by this alleged deficiency. Nurse managers conducted reeducation to licensed staff to include agency and medication aides regarding medication administration policy and on proper process to report a medication error. Education was completed by 8/19/22<br><br>Agency Nurse # 5 was informed of alleged medication errors and was removed from our staffing.<br>MAR to Med cart review was completed for all medication carts for medication accuracy and availability.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Nurses to include agency nurses and medication aides have been educated on medication administration policy and on procedure of obtaining medication when not available. Nurses , agency nurses and medication aides will administer medications as ordered.<br>Administering Medication policy to be | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 759 | Continued From page 95<br>unavailable at this time. Heparin Sodium medication on order and will be here later today. The progress note was electronically signed by Nurse #5.<br><br>Nurse #5 was interviewed on 07/28/22 at 10:36 AM. Nurse #5 stated that when she arrived for duty on 07/27/22 she got report on a different unit then sometime later realized that she was supposed to be on the unit where Resident #83 resided. She explained that put her behind and that was why she administered Resident #83's insulin after he had eaten his breakfast. She further explained that was her first time working on the unit where Resident #83's resided and she just overlooked the Aspirin 81 mg order, and she gave the first Aspirin she came to on the medication cart which was Aspirin 325 mg. Nurse #5 also confirmed that she did not have the Heparin Sodium and so she omitted that dose but stated it came in later that day so Resident #83 only missed one dose and she forgot to go look for the Calcium Carbonate and so that too was omitted from Resident #83's medication on 07/27/22.<br><br>The Nurse Practitioner (NP) was interviewed on 07/28/22 at 12:38 PM. The NP stated that insulin should be given before the Resident ate or at the time of the meal but not after. She stated that Resident #83's sugar was 84 the following morning but that was fine for him and did not believe having his insulin administered after breakfast caused him any ill effects. The NP stated that she was not made aware that Resident #83's Heparin Sodium or Calcium Carbonate were unavailable and that missing one dose of those medication would not cause him any harm but stated she would like to be notified | F 759 | added to new hire orientation and to the agency orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Director of Nursing, Pharmacy Consultant and designees will conduct Med pass observation with licensed staff once a week of 3 nurses for 4 weeks and then of 2 nurses once a month for 2 months. DON or designee provide education on Med pass observation results. The Administrator and director of nursing will review Med pass observation Audits every month for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 759 | Continued From page 96<br>of the missed doses of medication. When informed of the Aspirin order she stated that medications should be given as ordered by the provider.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 10:48 AM. The DON stated that all mediation should be given as order and if the medication was unavailable there was a process to be followed. The DON stated that if there was a medication that was unavailable the staff should notify the pharmacy, and have it sent to the facility as soon as possible and they should also check the facility's back up medication supply because she believed that it contained the heparin that Resident #83 required. | F 759 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of | F 761 | | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 761 | Continued From page 97<br>the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interview the facility failed to store controlled substances in a permanently affixed compartment of the refrigerator for 2 of 2 medication rooms (East and West wing) and failed to remove expired medication from 1 of 1 central supply room.<br><br>The findings included:<br><br>1a. An observation of the East wing medication room was made on 07/29/22 at 9:47 AM along with Nurse #5. The refrigerator was not locked and contained a metal lock box that was locked but was lying on a shelf in the refrigerator. The metal lock box was not permanently affixed and was removeable.<br><br>Nurse #5 was interviewed on 07/29/22 at 9:48 AM who confirmed that the metal lock box was the controlled substance back up and she did not know the combination to open the metal box she would have to get it from another staff member. Nurse #5 was not aware of who was responsible for the metal lock box that contained controlled substances.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:38 AM. The DON stated that they had issues with the refrigerator on East wing recently and the refrigerator had to be replaced. | F 761 | F-761<br><br>Regarding the alleged deficient practice of failure to store controlled substances in a permanently affixed compartment of the refrigerator for 2 of 2 and to remove expired medication from 1 of 1 central supply room<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>On 07/29/2022 the Director of Maintenance was educated on requirement for Narcotic Boxes to be Affixed to the refrigerator in Medication rooms. The Director of Maintenance securely affixed each narcotic box to both refrigerators in each medication room on 07/29/2022. Manager of Central Supply was educated on importance of maintaining Supply room with unexpired OTC meds. Expired OTC meds were removed from supply room on 7/29/22. No residents were directly affected by this allegation.<br><br>(2) How corrective action will be accomplished for resident(s) having the | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 761 | Continued From page 98<br>She confirmed that the metal lock box contained controlled substances and should be permanently affixed to the refrigerator as they had been in the past.<br><br>1b. An observation of the West wing medication room was made on 07/29/22 at 10:00 AM along with Unit Coordinator (UC) #1. The refrigerator was not locked and there was a metal lock box that was locked and lying on a shelf in the refrigerator. The metal lock box was not permanently affixed and was removeable. UC #1 removed the metal lock box and took it to the nursing station to open it before returning it to the refrigerator. The metal lock box contained a bottle of Lorazepam (controlled substance) 2 milligram/milliliter that had been opened and a bottle of Dronabinol (controlled substance) 10 mg.<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:38 AM. She confirmed that the metal lock box contained controlled substances and should be permanently affixed to the refrigerator as they had been in the past.<br><br>2. An observation of the Central Supply room along with the Supply Clerk (SC) was made on 07/29/22 at 9:40 AM. The observation revealed 5 10-ounce bottles of magnesium citrate that expired 03/22 that were on the shelf and available for use.<br><br>The SC was interviewed on 07/29/22 at 9:42 AM who stated that she stocked the supply room every Monday and Friday and checked expiration dates during those times. The SC stated that she overlooked those bottles during the restocking times and stated she would discard them. | F 761 | potential to be affected by the same issue needing to be addressed:<br><br>This alleged deficient practice had potential to affect all residents with narcotics that required refrigeration storage or utilized OTC medications. Audit conducted on 7/29/22 indicated that no residents were affected.<br>Nurse Managers conducted reeducation with licensed staff to include agency staff on the proper storage of narcotics and on verifying expiration dates of medications prior to administering completed by 08/19/2022.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>Maintenance Director made a physical change to the mounting hardware of the narcotic box within the refrigerator by permanently affixing the box to the refrigerators in both medication rooms. Controlled substance/medication storage to be added to new hire orientation as well to the agency orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>The Director of Nursing and/or designees will monitor monthly to ensure that narcotics stored in the refrigerator are maintained in an affixed box. Central | |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

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

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|---|---|---|---|---|
| F 761 | Continued From page 99<br><br>The Director of Nursing (DON) was interviewed on 07/29/22 at 11:38 AM. The DON stated that the SC ordered and stocked the supply room, but it was always the responsibility of the nurse to check the expiration date before they open and begin using the medication. | F 761 | Supply manager will conduct weekly audit of Supply room for expired OTC medications for 4 weeks and then monthly for 2 months.<br>The Administrator and Director of nursing will monitor audits monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, and a test tray, the facility failed to serve food that was appetizing in appearance and temperature for 3 of 4 residents (Resident #64, Resident #71, and Resident #12) | F 804 | F-804<br>Regarding the alleged deficient practice of failure to serve food that was appetizing in appearance and temperature for 3 of 4 residents reviewed with food concerns. | 8/19/22 |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 804 | Continued From page 100<br>reviewed with food concerns.<br><br>The findings included:<br><br>Review of the resident council minutes revealed on 12/28/21 the residents in attendance stated they "would like better quality of food." On 03/24/22 the residents stated, "the food isn't warm when delivered to the rooms." On 05/26/22 the residents discussed likes and dislikes about the food with the Dietary Manager, but no details were provided in the minutes.<br><br>Upon initial interviews with Resident #64, Resident #71 and Resident #12, the residents complained about the food being cold and not being appetizing in appearance. The resident's used descriptions such as "awful, cold, tastes horrible, not fit to eat."<br><br>The test tray was plated and left the kitchen on the last trays to be served to residents. The last trays arrived on the hall at 12:25 PM and the last tray was served to a resident at 12:34 PM.<br><br>The test tray was sampled on 07/28/22 at 12:37 PM after the last of the lunch trays on the hall had been served. The Dietary Manager was present when the lid of the tray was removed. There was no visible steam observed when the lid was lifted and there was no butter for the roll and no salt or pepper. The chicken pot pie, salad and homemade Ranch dressing were tasted by the Surveyor and Dietary Manager and the chicken pot pie was barely warm and the liquid in the chicken pot pie was congealed from not being hot enough to liquify. The salad was not cold but more like room temperature as well as the Ranch salad dressing. | F 804 | (1) How corrective action will be accomplished for resident(s) found to have been affected:<br>In service with dietary staff held on 08/03/2022 by Registered Dietician re: monitoring of food temps on service line; following recipes for all menu items to assure palatability; attention to presentation and serving sizes; and following scheduled service times for tray delivery to halls-coordinated with nursing staff.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br>Resident interviews conducted by dietary staff/designee to obtain resident preferences and address concerns. Weekly menus provided to residents to encourage alternate selection if desired. Temperature checked and recorded at each meal at time of service.<br><br>(3) What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not re-occur in the future:<br>Dietary manager/designee will monitor meal tray delivery times and coordinate with nursing staff to facilitate efficient delivery. A facility announcement will be made to alert all staff to trays entering the halls at each meal. Dietary manager/designee will meet with new admits within 24 hours of admission to obtain preferences and with long term care residents monthly to review menus | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 804 | Continued From page 101<br><br>An interview with the Dietary Manager on 07/28/22 at 12:40 PM revealed she thought the food could have been warmer and the salad could have been colder for the residents. She stated it could have been warmer if there had been a plate base on the test tray and if their cart had been big enough to accommodate all the trays. The Dietary Manager further stated she was not sure why the test tray was plated on a Styrofoam plate instead of a regular plate and did not have a plate base. The Dietary Manager indicated she had ordered a larger cart for the resident trays and had ordered more plate bases as well as a plate warmer but stated the items had not come in yet. The Dietary Manager further indicated she had heard concerns about cold food, but said she believed it was because the food sat on the hallway too long waiting to be delivered to the residents. She explained the resident trays were all served with a heated base and cover to keep the food warm but when it sat on the hallways it was difficult to keep the food warm until it reached the residents. The Dietary Manager further stated there were more staff assisting with passing trays today than there usually was on other days. According to the Dietary Manager they had followed the recipe for the chicken pot pie they were provided, and it had a crust but scooping it made it difficult to see the crust in the portions.<br><br>1. Resident #64 was admitted to the facility on 06/23/22.<br><br>Review of an admission Minimum Data Set (MDS) assessment dated 06/30/22 revealed Resident #64 was cognitively intact. The MDS also revealed the resident was on nutrition or | F 804 | and address concerns.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Dietary manager/designee will check temperature of a test tray twice per week x 4 weeks then weekly times 2 months. Dietary manager/designee will interview residents for preference and concerns on admission and as needed to update. Dietary manager/designee will record and monitor temperature records at times of food service. Dietary manager/designee will assure proper functioning of equipment used in service of food to maintain temperature. Dietary manager/designee will monitor and record times of tray line service and delivery to improve quality of delivered meals. Any issues during monitoring will be reported during morning meeting to be addressed as an IDT team. The Dietary manager/designee will report findings of the monitoring process to the facility QAPI committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

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

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|---|---|---|---|---|
| F 804 | Continued From page 102 | F 804 | | |

hydration intervention to manage skin problems for stage IV pressure ulcer.

An interview on 07/28/22 at 1:00 PM with Resident #64 revealed he had not eaten his lunch because it "tasted so bad." Resident #64 stated it looked like a "big glob" and just was not appetizing to look at and did not taste good. He stated he took a couple of bites but could not eat it and just ate his roll. Resident #64 indicated the food was barely warm and the carrots were mushy and barely warm, and he just could not eat the meal. The resident further stated this meal was just another example of the food at the facility that was just not "fit to eat." Resident #64 indicated he at least could order something to eat but other residents just had to eat what they were served.

2. Resident #71 was admitted to the facility on 07/20/22.

Review of an admission nursing progress note dated 07/20/22 revealed Resident #71 was alert and oriented to person, place, time, and situation. Resident #71 was being provided nutritional interventions to manage skin problems for stage IV pressure ulcer. According to the physician's initial exam there was concern about deterioration of her pressure ulcer related to her poor intake.

An interview on 07/28/22 at 1:07 PM with Resident #71 revealed she loved chicken pot pie but did not eat lunch because "it looked awful." Resident #71 stated she had never seen a chicken pot pie that didn't have a crust and said when she looked at it, she told them to take the tray out of her room and she would call her daughter to bring her something to eat. She

| 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 07/29/2022 |

| 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 804 | Continued From page 103 | F 804 | | |

further stated if not for her family member bringing her food to eat, she would not be eating because the food at the facility was just barely warm and not appetizing. Resident #71 indicated she was used to hot meals and she had yet to receive one at the facility.

An interview on 07/29/22 at 5:32 PM with the Administrator revealed it was her expectation that food be warm and palatable for all the residents. She explained they had identified the need for a larger cart, more plate bases and a plate warmer and said all these items had been ordered but not delivered.

3. Resident # 12 was admitted to the facility on 07/14/21.

Review of a quarterly Minimum Data Set (MDS) dated 07/06/22 revealed that Resident #12 was cognitively intact.

A test tray was conducted on 07/28/22 at 12:34 PM with the Dietary Manager (DM) that consisted of chicken pot pie, salad and a dinner roll. The food was served on a Styrofoam plate without a bottom plate warmer and when the lid was removed there was no visible steam, there was also no butter for the roll, and no salt or pepper. The chicken pie was tasted and had good flavor but was room temperature at best. The liquid that was used in the chicken pie was congealed from not being hot enough to liquify.

An interview was conducted with the DM on 07/28/22 at 12:28 PM. The DM could not answer why the food was served on a Styrofoam plate without a bottom plate warmer. She did say that the plate warmers were on order but had not

| 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 07/29/2022 |

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

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| F 804 | Continued From page 104<br>arrived yet. The DM tasted the chicken pie and agreed that it had good flavor but stated that it "could have been warmer." The DM stated she had heard concerns about cold food, but she believed it was not because the food was cold when it left the kitchen but because it sat on the hallway too long waiting to be delivered to the residents.<br><br>An interview with Resident #12 was conducted on 07/28/22 at 12:44 PM. Resident #12 was resting in bed and there was no lunch tray on his bedside table. When asked if he enjoyed the chicken pie he stated, "is that what that was, it looked like slop to me." He further stated he could not eat it after taking a bite or two because it was cold and tasted like freeze dried food and had eaten his left over from the previous night when he ordered take out.<br><br>The Administrator was interviewed on 07/29/22 at 11:43 AM. The Administrator stated that during her experience in health care the residents either loved the food or they hated the food but "we can never please them all." She stated that they offered an alternate meal if the resident did not like what was served and explained that the bottom of the plate warmers had been on order but had not come in yet, which may have affected how warm the meal was. | F 804 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, | F 812 | | 8/19/22 |

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|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 812 | Continued From page 105<br>state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, and staff interviews the facility failed to label and date opened food for 2 of 2 nourishment room refrigerators (Morrow and Restore) and failed to defrost 1 of 2 nourishment room freezers (Restore). The facility also failed to ensure dietary staff covered facial hair while working in the kitchen.<br><br>The findings included:<br><br>On 07/25/22 at 11:15 AM an observation was made of the Morrow Nourishment room refrigerator accompanied by the Dietary Manager. The discovery yielded:<br><br>*2 unlabeled and undated sandwiches<br>*1 unlabeled and undated sub sandwich<br>*1 undated and opened carton Ready to drink chocolate flavored lactose drink approximately one fourth remaining in carton. The indication on the carton revealed to keep 3 days after opening.<br>*1 unlabeled and undated cup of opened applesauce | F 812 | F-812<br>Regarding the alleged deficient practice of failure to label and date opened food for 2 of 2 nourishment room refrigerators and to defrost 1 of 2 nourishment room freezers and to ensure dietary staff covered facial hair while working in the kitchen.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>Maintenance Director cleaned out and defrosted all nourishment room refrigerators on 07/26/2022. Dietary Director cleaned out all nourishment room refrigerators on 08/16/2022. Cook #1 was educated by Dietary Manager on appropriate beard guard used on 07/27/2022.<br><br>(2) How corrective action will be accomplished for resident(s) having the | |

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|---|---|---|---|---|
| F 812 | Continued From page 106<br><br>An observation of the small Restore Nourishment room refrigerator and freezer was made on 07/25/22 at 11:30 AM and accompanied by the Dietary Manager. The freezer had a buildup of ice approximately two inches thick on all four sides on the inside of the freezer. There was an unlabeled and undated ice cream sandwich bar that appeared to be freezer burnt that barely fit in the freezer.<br><br>An interview was conducted with the Dietary Manager (DM) on 07/25/22 at 11:35 AM. The DM explained that all food stored in the residents' refrigerator should be dated when open and labeled with the resident's name. The DM stated the prepared food should only be kept for 3 days in the refrigerator then discarded. The DM stated the Maintenance Supervisor was responsible for defrosting the nourishment room freezers.<br><br>During an interview with the Maintenance Supervisor (MS) on 07/25/22 at 4:26 PM the MS explained that it was his responsibility to defrost the residents' refrigerators and he did not know that the small refrigerator on the Restore unit was for residents but thought the refrigerator was for medications, therefore he had not defrosted the freezer.<br><br>During an interview with the Administrator and the Director of Nursing (DON) on 07/29/22 at 5:15 PM the DON explained that the Housekeeping department was responsible for cleaning the nourishment room refrigerators every day and the Maintenance Supervisor was responsible for defrosting the freezers on an as needed basis.<br><br>2. On 07/27/22 at 11:31 AM during a tour in the | F 812 | potential to be affected by the same issue needing to be addressed:<br>All residents are at risk for this alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br>Registered Dietician completed an all-dietary staff in-service on 08/08/2022 on appropriate beard guard use. To protect the residents from similar occurrences on 08/16/2022 the Registered Dietician re-educated all dietary staff regarding the requirements for proper storage, dating and labeling of food items as well as wearing of beard guards and PPE in the dietary department.<br>The Preventing Foodborne illness-Employee hygiene and sanitary practice Policy to be added to orientation for dietary new staff. Refrigerator and freezer Policy to be reviewed with all new dietary new hires and posted in the dietary manager office.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br>Dietary Manager/designee will clean out both nourishment room refrigerators weekly and report to maintenance when they need to be defrosted and audit compliance for beard guard use for dietary employees weekly x 4 weeks then monthly for 3 months. A log will be kept on each refrigerator to document clean | |

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| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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|---|---|---|---|---|
| F 812 | Continued From page 107<br>kitchen an observation was made of Cook #1 who was plating the meal trays behind the steam line. The Cook wore a beard guard that only covered approximately one fourth of his beard leaving the top and bottom portions of his beard uncovered. The Cook stopped the plating and went behind the wall and adjusted his beard guard over his beard. After adjusting the beard guard, the Cook continued to plate the meal trays all the while the beard guard worked its way back to the uncovered position on the Cook's face. At 12:17 PM the Dietary Manager (DM) approached the Cook and told him to fix the beard guard because it was not covering his entire beard and the Cook stopped plating the food and went behind the wall and came back with his beard guard in place covering the entire beard and his face mask was over the beard guard which held the beard guard in place.<br><br>An interview was conducted with the Dietary Manager (DM) on 07/27/22 at 12:37 PM who explained that the straps on the Cook's beard guard were stretched which made keeping the beard guard in place impossible so he adjusted the straps and placed his face mask over the beard guard to ensure it would stay in place. The DM indicated her expectation was that the male Cook wear the beard guard the correct way to ensure his entire beard was covered.<br><br>During a meeting with the Administrator and Director of Nursing on 07/29/22 at 5:15 PM the Administrator stated it was her expectation for dietary staff to completely cover their beards. | F 812 | outs/defrost. Dietary manager/designee will check the logs and the refrigerators weekly times 4 weeks for compliance then monthly for 3 months. Findings will be reported to the QA committee; audits will continue as determined by QA committee.<br><br>The facility alleges compliance on 08/19/2022 | |
| F 814 SS=F | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4) | F 814 | | 8/19/22 |

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|---|---|---|---|---|
| F 814 | Continued From page 108<br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility failed to ensure the area around the dumpster was free of debris for 1 of 1 dumpster reviewed.<br><br>The finding included:<br><br>During an observation of the dumpster area on 07/25/22 at 10:56 AM and accompanied by the Dietary Manager (DM) the discovery revealed one dumpster that contained bags of trash and cardboard. The area on the ground around the dumpster was littered with debris that include bags of trash that included used briefs and flattened cardboard boxes. Most of the cardboard appeared to have been wet then dried to the ground. Scattered debris consisted of loose used briefs, gloves, papers, plastic bottles, screws and one 102-ounce tomato can.<br><br>An interview conducted with the Dietary Manager on 07/25/22 at 10:30 AM revealed the dumpsters were emptied every day and Housekeeping was responsible to keep the area around the dumpster clean.<br><br>An interview was conducted with the Maintenance Supervisor (MS) on 07/25/22 at 11:14 AM. The MS explained that the dumpster was emptied six days a week and it was his responsibility to keep the area around the dumpster clean. The MS also explained that the last time he thoroughly cleaned the area around the dumpster was last Monday 07/18/22. | F 814 | F-814<br>Regarding the alleged deficient practice of failure to ensure the area around the dumpster was free of debris for 1 of 1 dumpster reviewed.<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>Maintenance Director cleaned the area around the dumpster on 07/25/2022. Compliance rounds were added to TELS for Maintenance Director monitoring to prevent further occurrence.<br><br>(2) Identification of other residents:<br>No residents were found at risk for this alleged deficient practice.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br>All housekeeping staff were in-serviced on 08/17/2022-08/18/2022 by District Housekeeping Manager/Housekeeping Supervisor on ensuring that the trash/dumpster area outside of the facility near the laundry room is cleaned daily to include picking up trash debris around the dumpster that has fallen or is behind the trash dumpster.<br>Food-related garbage and refuse disposal policy will be added to new hire orientation and to the agency staff orientation | |

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|---|---|---|---|---|
| F 814 | Continued From page 109<br>During an interview with the Housekeeping Supervisor (HS) on 07/25/22 at 12:24 PM the HS explained that it was the Maintenance Supervisor's responsibility to keep the dumpster area clean, but everyone should clean up after themselves when they took the trash to the dumpster.<br><br>An interview was conducted on 07/29/22 at 5:15 PM with the Director of Nursing (DON) and Administrator. The DON explained that there was a huge clean up around the dumpster on Monday 07/18/22 by the Maintenance Supervisor but that it was everyone's responsibility to pick up after themselves when they dispose of trash. | F 814 | manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Housekeeping supervisor/designee will be using Dumpster Cleaning Audit Tool check the trash dumpster area daily for the next 60 days for morning and afternoon checks to ensure that all trash/debris around the dumpster is disposed of properly. Findings of these audits will be reported to the QAPI committee; audits will continue as determined by QA committee.<br><br>The facility alleges compliance on 08/19/2022. | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and | F 842 | | 8/19/22 |

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|---|---|---|---|---|
| F 842 | Continued From page 110<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided; | F 842 | | |

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|---|---|---|---|---|
| F 842 | Continued From page 111<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to maintain a complete and accurate medical record by failing to document the completion of wound care (Resident #42) for 1 of 6 residents reviewed for pressure ulcers.<br><br>The findings included:<br><br>Review of Resident #42's physician orders revealed a treatment order dated 6/18/2022. This order read: Sacral wound treatment orders: cleanse wound with wound cleaner, next apply acetic moistened gauze 4 x 4's to entire wound bed, then apply gauze over the soaked gauze, then cover with abdominal pads to entire area every day shift.<br><br>Review of Treatment Administration Record for July 2022 revealed no documentation of treatment completion for 10 of the 29 days reviewed. The dates of missed documentation were 7/4, 7/5/,7/7, 7/9, 7/13, 7/16, 7/17, 7/21, 7/23, and 7/25/2022.<br><br>On 7/29/2022 at 11:13AM an interview was conducted with Nurse #8. She stated she was familiar with Resident #42 and had provided his wound treatments. Nurse #8 revealed she was Resident #42's assigned Nurse on July 21st and July 23rd and provided his wound treatments to | F 842 | F-842<br><br>Regarding the alleged deficient practice of failure to maintain a complete and accurate medical record by failing to document the completion of wound care for 1 of 6 residents reviewed for pressure ulcers<br><br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br><br>Nurse managers provided reeducation to Licensed Staff on the importance of proper documentations of Treatment Administration Records by 08/19/2022.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br><br>The Director of Nursing and Nurse managers conducted an audit of Treatment records for Residents with Pressure ulcers for accurate documentation on 08/12/2022. All licensed nursing staff including agency staff reeducated on proper documentation | |

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|---|---|---|---|---|
| F 842 | Continued From page 112<br>his sacrum but did not document that she had completed the treatments. She stated she forgot to sign that she had completed the treatments, but she knew she had completed them because his wound was large, and she always made sure she did them. Nurse #8 stated she just got busy and forgot to sign that she had completed the treatments.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/29/2022 at 3:47PM. She stated the Unit Managers are responsible for checking the TARs for missing initials monthly. DON revealed she did not realize that Resident #42's TARs had missing initials until this survey. She stated she had called the facility every shift to remind staff to sign their TARs before leaving their shift. DON stated her expectation was for staff to complete the ordered treatments and then document the completion of the treatment on the TAR. She further indicated documentation for refusals must be signed on the TAR by the Nurse and an explanation given for the refusal. | F 842 | processes by 08/19/2022.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br><br>The Director of Nursing and Designees will review Treatment records for Residents with Pressure ulcers twice weekly. Any licensed staff member noted to be noncompliant with alleged deficient practice may be subject to disciplinary action per facility policy.<br>Wound care policy to be added to new hire orientation and to the agency staff orientation manual.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br><br>Audit of treatment records with residents with pressure ulcers will be completed by DON, Unit Nurse Mangers and/or designee weekly times 4 weeks then monthly times 2 months.<br>The Administrator and Director of Nursing will review audits once a month to ensure compliance. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 842 | Continued From page 113 | F 842 | The facility alleges compliance on 08/21/2022 | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 880 | | 8/19/22 |

| 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 07/29/2022 |

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|---|---|---|---|---|
| F 880 | Continued From page 114<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview the facility failed to implement the Center for Disease Control and Prevention (CDC) guidelines for use of personal protective | F 880 | F-880<br>Regarding the alleged deficient practice of failing to implement the CDC guideline for use of PPE when 1 of 2 nurses failed to | |

| 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 07/29/2022 |

| 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 880 | Continued From page 115<br>equipment (PPE) when 1 of 2 nurses (Nurse #5) failed to discard her mask and eye protection after entering and exiting a Covid positive patients room (Resident #16) and then entering a non-COVID positive patients room, Nurse #5 also failed to disinfect a glucometer (used to check a resident's blood glucose level) after use per the manufacture's recommendations which resulted in the potential for cross contamination for 1 of 6 residents observed during medication administration (Resident #83). In addition, 1 of 2 nurse aides (NA #2) failed to perform hand hygiene after providing incontinent care and before touching clean bedding and assisting with wound care for 1 of 6 residents (Resident #71) reviewed for pressure ulcers.<br><br>The findings included:<br><br>The Centers for Disease Control and Prevention (CDC) guideline entitled, "Interim Infection Control and Prevention Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, "updated on 02/23/21 indicated in part:<br><br>"The PPE (personal protective equipment) recommended when caring for a patient with suspected or confirmed COVID-19 includes the following:<br><br>1. Respirator - Put on N95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or | F 880 | discard her mask and eye protection after entering and exiting a Covid positive patients room.<br>(1) How corrective action will be accomplished for resident(s) found to have been affected:<br>The Director of Nursing reviewed and educated on the infection control policy for Covid isolation and hand hygiene with Nurse #5 and NA #2 in relation to alleged breach of infection prevention policy related to residents #16, #83 and #71.<br><br>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br>The Administrator, DON and designees began conducting audits on appropriate hand hygiene and proper donning and doffing of PPE for Covid isolation rooms.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br>To protect residents on similar occurrences, by 08/19/2022 the DON/designee has provided reeducation to all clinical staff on proper PPE donning and doffing and hand hygiene.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:<br>The Administrator, DON and/or designees will complete daily Hand Hygiene and PPE audits for 7 days, then twice a week for 2 weeks, then once a week for 4 | |

| 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 07/29/2022 |

| 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 880 | Continued From page 116<br>re-use. Perform hand hygiene after removing the respirator or facemask.<br><br>2. Eye protection - Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to the manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or re-use.<br><br>1. Resident #16 was readmitted to the facility on 06/28/22. Her current diagnoses included COVID-19.<br><br>Review of a physician order dated 07/21/22 read; Enhanced Droplet Precautions due to COVID.<br><br>A continuous observation was made on 07/27/22 at 10:02 AM with Nurse #5. Nurse #5 was observed at her medication cart with a N95 respirator in place along with a face shield. She was preparing Resident #16's medications. Once Nurse #5 had finished preparing Resident #16's medication she donned a gown and gloves along with her N95 and face shield and entered Resident #16's room to administer her medications. There was a sign on Resident #16's door that read in part, Special Airborne Contact Precautions. All healthcare personnel must: Wear N95 or higher-level respirator before entering the room and remove after exiting. After Resident #16 had taken her medication Nurse #5 removed | F 880 | weeks followed by monthly for 2 months. The Administrator and DON will review audits monthly to ensure continued compliance. Any issues noted during the monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility QAPI Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Please see DPOC attachment<br>Please see DPOC2 attachment<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

| 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 880 | Continued From page 117 | F 880 | | |

her gown and gloves and exited the room and returned to her medication cart where she sanitized her hands. Nurse #5 then proceed to push her medication cart down the hallway to continue her medication pass and entered the next residents rooms which was a non-Covid positive room on the hallway.

Nurse #5 was interviewed on 07/28/22 at 10:36 AM who confirmed that Resident #16 was COVID positive. Nurse #5 confirmed that she had donned a gown and gloves when entering Resident #16's room on 07/27/22 at 10:02 AM to administer her medications. She stated that when she exited the room, she had removed her gown and gloves and used hand sanitizer. When asked if she should have changed her N95 respirator and her face shield she replied, "I really don't know but that is a good question that I need to ask."

The Director of Nursing (DON) was interviewed on 07/29/22 at 10:48 AM. The DON confirmed she was also the facility's infection preventionist. The DON stated that Nurse #5 should have changed her N95 respirator and her face shield when she exited Resident #16's room. She stated that the facility had plenty of personal protective equipment and there was no reason not to change both when she was finished in the room.

2. Review of a facility policy titled "Obtaining a fingerstick glucose level" revised on October 2011 read in part, clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standard of practice.

An observation of Nurse #5 preparing Resident #83's medication was made on 07/27/22 at 9:39

| 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 07/29/2022 |

| 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 880 | Continued From page 118 | F 880 | | |

AM. Nurse #5 dispensed medication into a cup and before entering Resident #83's room she grabbed a glucometer (used to check blood sugar) and entered Resident #83's room. Nurse #5 administered the medication in the cup and then proceeded to check Resident #83's blood sugar with the glucometer she had brought into the room with her. Once she obtained the blood sugar, Nurse #5 exited Resident #83's room and returned to her medication cart where she sanitized her hands. Nurse #5 then opened the top drawer of the medication cart and obtained an alcohol pad and proceeded to clean the glucometer that she had just used to check Resident #83's blood sugar with for approximately 10 seconds before placing the glucometer back in the drawer on the medication cart. When Nurse #5 opened the medication cart to place the glucometer there was a container of bleach wipes in the drawer.

Nurse #5 was interviewed on 07/27/22 at 9:55 AM who confirmed she worked at the facility through an agency and that she was not sure of what the policy or procedure was at the facility for cleaning glucometers. She stated that in the past she had used bleach wipes on the glucometer and after she did that the glucometer did not work anymore so since then she has always used the alcohol pads to clean the glucometer. Nurse #5 stated that not all residents had their own glucometer, she stated that she had 3 glucometers on her medication cart, and she rotated using them but always cleaned them with alcohol after each use. Nurse #5 confirmed that Resident #83 was the last fingerstick she had to check until lunch time.

The Director of Nursing (DON) was notified of the above observation on 07/27/22 at 12:12 PM.

| 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 07/29/2022 |

| 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 880 | Continued From page 119 | F 880 | | |

The DON was interviewed on 07/29/22 at 10:48 AM who confirmed that the glucometer should have been cleaned/disinfected with bleach disinfecting wipes that were on each of the medication carts in the facility. The DON stated that most of the long-term residents in the facility had their own glucometer. She explained that the Resident #83 was a new resident in the facility and that the staff should have just gotten him his own glucometer because that was the goal of the facility for each resident that required a fingerstick to have their own that was kept in their room. The DON stated that all the staff had been educated on the cleaning practices and were aware that the glucometers were to be disinfected with the bleach wipes that were on the medication carts.

3. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Hand Hygiene Guidance," last reviewed on 1/30/20 indicated the following information: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately after glove removal. Gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene during patient care, if moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs.

The facility's policy entitled, "Handwashing/Hand Hygiene Policy," last revised on 09/22/21 indicated the following statements: This facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62%

| 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 07/29/2022 |

| 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 880 | Continued From page 120 | F 880 | | |

alcohol; or alternatively, soap and water for the following situations: b. before and after direct contact with residents, h. before moving from a contaminated body site to a clean body site during resident care, i. after contact with a resident's intact skin, j. after contact with blood or body fluids, and m. after removing gloves.

An observation of incontinence care by Nurse Aide (NA) #2 prior to a resident's wound care was made on 07/28/22 at 10:18 AM. NA #2 was observed using alcohol-based hand rub (ABHR) prior to donning her gloves to perform incontinence care. The resident was held on her side by Unit Coordinator (UC) #2 while NA #2 cleaned her from a bowel movement. NA #2 cleaned the resident using wipes and after she was completely cleaned, NA #2 folded a sheet and placed under the resident for positioning and placed a clean brief on top of the sheet and moved the resident's pillow to rest under her arms with the same gloves. NA #2 then removed her gloves and without sanitizing her hands donned a new pair of gloves and proceeded to hold Resident #71 on her side for UC #2 to complete her wound care. After the wound care was completed NA #2 removed her gloves and sanitized her hands.

An interview on 07/28/22 at 2:35 PM with NA #2 revealed she did not realize she had not sanitized her hands prior to changing her gloves when incontinence care was completed. NA #2 knew she was supposed to sanitize her hands after removing her gloves and prior to putting on new gloves. NA #2 also stated she knew she was supposed to remove her gloves, sanitize her hands, and put on new gloves after performing the resident's incontinence care. She further

| 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 07/29/2022 |

| 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 880 | Continued From page 121<br>stated she was trying to hurry so UC #2 could complete Resident #71's wound care and just forgot to sanitize her hands after performing incontinence care and prior to assisting with the residents wound care.<br><br>An interview on 07/28/22 at 2:50 PM with UC #2 revealed she was not aware NA #2 had not sanitized her hands after completing incontinence care and prior to donning new gloves to assist with wound care. UC #2 stated employees received education continuously on hand hygiene and the importance of performing hand hygiene prior to procedures and once they are completed.<br><br>An interview on 07/29/22 at 5:32 PM with the Administrator and Director of Nursing revealed they would have expected NA #2 to have performed hand hygiene after removing her gloves from incontinence care and prior to donning new gloves to place a draw sheet on the resident's bed and assist with wound care. | F 880 | | |
| F 925 SS=E | Maintains Effective Pest Control Program<br>CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident and staff interviews, the facility failed to implement an effective pest control program to control the presence of flies and gnats in the hallway and resident rooms. This was evident in 1 of 1 resident care hall and 5 of 46 resident rooms (Rooms 16, 29, 30, 51 and 52). | F 925 | F-925<br>Regarding the alleged deficient practice of failure to implement an effective pest control program to control the presence of flies and gnats in the hallway and resident rooms.<br><br>(1) How corrective action will be | 8/19/22 |

| 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 07/29/2022 |

| 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 925 | Continued From page 122<br>The findings included:<br><br>An observation on 07/25/22 at 3:22 PM revealed a fly in the hallway outside room 37 that landed on a computer and was swatted away.<br><br>An observation on 07/25/22 at 3:40 PM revealed a fly outside room 56 in the hallway flying around.<br><br>An observation on 07/25/22 at 4:08 PM revealed a fly outside of room 46 that kept landing on a computer and was swatted away several times.<br><br>An observation on 07/25/22 at 4:11 PM revealed a fly on the table outside room 40 and 42.<br><br>An observation on 07/26/22 at :19 AM revealed a fly in the hallway at the nurses station and was swatted away during an interview with Nurse #2.<br><br>An observation and interview on 07/27/22 at 9:39 AM revealed Nurse #5 swat a gnat away while giving a resident medication during a med pass observation. An interview with Resident #83 who resided in room 30 revealed the gnats bothered him especially when they landed on something he was going to eat.<br><br>An observation on 07/27/22 at 12:15 PM revealed a fly observed falling into a resident's tea on her lunch tray. The resident was alerted there was a fly in her tea, and she requested a new cup of tea from staff. Resident #31 who resided in room 51 stated flies were bad to be flying around in the rooms during meals.<br><br>An observation on 07/27/22 at 12:41 PM of Room 52 where Resident #84 resided revealed a dead roach in the shower in the resident's bathroom. | F 925 | accomplished for resident(s) found to have been affected:<br>Pest control company performed routine maintenance on pest control lights on 08/12/2022. Current pest control company was given notice of facility ending contract on 08/17/2022, new pest control contract signed with date of start scheduled for 09/19/2022.<br><br>(2) How facility corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:<br>Maintenance conducted a facility audit to determine location(s) of concern within the facility of pest control need(s). On 08/12/2022 the source of the gnats was determined to be in unused part of the facility related to recent water damage. Exterminator on site on 08/12/2022 and completed a full facility extermination for gnats along with routine maintenance of pest control lights.<br><br>(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:<br>Exterminator will be in the facility at least weekly to problem solve/treat any pest concerns. Pest monitoring has been added to the facility guardian angel room rounds for monitoring by department managers on a weekly basis.<br><br>(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: | |

| 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 07/29/2022 |

| 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 925 | Continued From page 123<br><br>An interview on 07/27/22 at 2:19 PM with Nurse Aide (NA) #7 revealed several residents had complained about water bugs and roaches in their rooms. NA #7 stated several of the residents were terrified of the roaches being in their rooms. NA #7 explained when residents complained about bugs in their rooms that she would tell the Maintenance Director and he would either spray or have the exterminator come out and treat the area. According to NA #7 bugs had been an ongoing issue at the facility.<br><br>During an interview on 07/27/22 at 4:29 PM with Resident #64 who resided in room 29-B, a gnat landed on the resident's nose, and he had to swat it away from his face. Resident #64 stated there were always gnats in his room flying around. Resident #64 stated there were bugs crawling around in the room at night and had seen them but couldn ' t tell what kind of bugs they were. There was no fruit or open food noted in the resident's room.<br><br>During an observation of wound care on 07/28/22 at 10:18 AM Unit Coordinator (UC) #2 was observed swatting a gnat away from Resident #71 's sacral wound prior to putting her dressing on the wound. There was no fruit or open food noted in the room.<br><br>An interview on 07/28/22 at 10:40 AM with Unit Coordinator #2 revealed she had swatted a gnat away from Resident #71's wound while providing wound care. She stated there were sometimes issues with gnats in rooms where residents kept food.<br><br>An observation on 07/28/22 at 10:29 AM and | F 925 | Maintenance Director/designee will perform weekly facility audits times 4 weeks then monthly for 3 months to monitor pest control effectiveness. Any issues during monitoring will be reported to the pest control company for addressing during their weekly visits unless it needs to be addressed immediately in which the Maintenance Director/designee will address according to pest control efficiency and safety. The Maintenance Director will report findings of the monitoring process to the facility QAPI Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>The facility alleges compliance on 08/21/2022 | |

| 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 07/29/2022 |

| 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 925 | Continued From page 124 | F 925 | | |

07/29/22 at 11:00 AM of Room 52 revealed a dead roach in the shower in Resident #84's room.

An interview on 07/29/22 at 3:35 PM with the Maintenance Director revealed he was not aware there were flies in the building and stated no one had reported them to him. He stated he was aware of the gnats in the building and said the Pest Control company had been out to the facility today for their monthly maintenance. He further stated they had recommended and added more glue boards (glue traps for flying insects) to the resident hallways to help with gnats and said it would also help with flies. The Maintenance Director explained that currently he worked on issues that were verbally given to him, but they were looking at a better system of written requests for maintenance to allow him to better track jobs to be done and those that were completed.

Review of the Pest Control company's written maintenance performed on 07/29/22 revealed areas of concern identified on the exterior, in resident rooms, behind the dishwasher, in the kitchen and drains in patient rooms with recommendations for repairs to prevent pests entering the building. There were 5 additional glue boards added to the resident care hallway to combat flying insects and sprays and treatments left for the Maintenance Director to use in the interim before the next visit.

An interview with the Administrator revealed she expected the facility to be as free from insects and bugs as possible and stated they were currently working with the Pest Control company to resolve the issue of insects and bugs. Additionally, she stated they were trying to keep

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345415 | A. BUILDING _____ B. WING _____ | C 07/29/2022 |

| 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 925 | Continued From page 125<br>open food out of the resident rooms and throwing away any old food in their rooms. | F 925 | | |