STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 8/8/2022 through 8/10/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# BBL611.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 8/8/2022 through 8/10/2022. Event ID #BBL611.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §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. §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. §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. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		9/9/22

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

Electronically Signed | 09/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 1	F 561		

religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, observations, and interviews with residents and staff, the facility failed to honor a resident's preference for showers for 1 of 2 (Resident #15) reviewed for choices.

The findings included:

Resident #15 was admitted on 1/15/2021 with diagnoses that included heart failure and osteoarthritis.

Resident #15's quarterly Minimum Data Set (MDS) dated 6/2/2022, with an assessment reference date of 6/3/2022 indicated the resident was cognitively intact, required extensive assistance with activities of daily living, and was dependent with bathing.

On 8/08/2022 at 10:56 AM an interview was conducted with Resident #15. He stated his scheduled shower days were Monday and Thursday. He had no problem getting shower on Mondays but he did not get his scheduled shower on Thursdays. He stated he got bed baths instead of showers on Thursdays. He stated he has been told it was due to low staffing. He further stated he filed a grievance in July regarding not getting scheduled showers. He was told by the Administrator showers were a safety issue when there was not adequate staff available and that he may need to consider being flexible with his shower days. Resident #15 stated very little had changed since his discussion with the

SAMPLE SET: #15

1. RESIDENT #15 STILL CONTINUES TO PREFER SHOWERS ON MONDAYS AND THURSDAY.
2. RESIDENT #15 GIVEN A SHOWER ON 8/11/2022.
3. RESIDENT INTERVIEWED BY SOCIAL WORKER AND RESIDENT #15 STATED THAT SHOWERS WERE BEING RECEIVED. INTERVIEW WAS ON 9/7/2022.
4. STAFF DEVELOPMENT COORDINATOR WILL INSERVICE ALL (NURSES AND CNAs/MED AIDES) STAFF REGARDING RESIDENT #15□S SHOWER SCHEDULE. 9/9/2022.
5. POINT OF CARE CHARTING HAS BE MODIFIED TO DIFFERIENTATE BETWEEN SHOWERS AND BATHS GIVEN. STAFF WILL BE ABLE TO DISTINQUISH BETWEEN THE TWO MOVING FORWARD. 9/7/2022.
6. AN AUDIT SHEET CREATED TO ASSURE SHOWERS ARE GIVEN TO RESIDENT #15 AS SCHEDULED.
7. CLINICAL MANAGER/DESIGNEE TO REVIEW AUDIT FORM TO ADDRESS ALL SKILLED NURSING RESIDENTS THAT ARE ON A SHOWER SCHEDULE. THESE FORMS WILL BE REVIEWED DAILY X4 WEEKS THEN WEEKLY X8 WEEKS THEN MONTHLY X3 MONTHS.
8. STAFF DEVELOPMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 2 Administrator, he was still not getting 2 showers a week and staffing continued to be a serious problem in the facility. Resident #15's shower/bath log for July 2022 indicated he received a shower on 7/7/, 7/10, and 7/11/2022. On 8/10/2022 at 2:40 PM a phone interview was conducted with Nursing Assistant (NA#9) who documented bath/shower for Resident #15 on 7/11/2022. She stated she did not give Resident #15 a shower on 7/11/2022. She further stated she did his morning care which included a bed bath. NA#9 stated the problem with their documentation system was that it did not allow you to differentiate between bed bath and shower. On 8/10/22 at 2:54 PM a phone interview was conducted with NA#1 who documented bath/shower for Resident #15 on 7/10/2022. She stated she did not recall is she gave the resident a bed bath or a shower on 7/10/2022 and the documentation system did not differentiate between bed bath and shower. She stated the facility was short staffed and there were times she had to give Resident #15 a bed bath instead of his scheduled showers due to lack of staff. Attempts to contact the NA who documented giving Resident #15 a shower on 7/7/2022 were not successful. An interview was conducted with the Director of Nursing (DON) on 8/10/2022 at 4:50 PM. She stated the facility was experiencing staffing challenges. It was her expectation residents received scheduled showers.	F 561	COORDINATOR/ DESIGNEE TO PROVIDE IN-SERVICE TO ALL NURSING STAFF(NURSES AND CNAs/MED AIDES) REGARDING RESIDENT RIGHTS AND ADHERING TO RESIDENTS BATHING SCHEDULE. ALSO, TO ADDRESS UPDATED POINT OF CARE CHANGES TO SHOWER AND BATHING ICONS WHERE STAFF CAN DIFFERIENTATE BETWEEN THE TWO SERVICES RENDERED. SDC WILL ALSO INTRODUCE A NEW SHOWER ASSIGNMENT SHEET FOR ALL NURSING TO COMPLETE UPON EACH SHIFT. INSERVICE TO BE COMPLETED BY 9/9/2022. NURSING STAFF WILL NOT PROVIDE RESIDENT ADL CARE UNTIL INSERVICE IS COMPLETED. 9. CLINICAL MANAGER WILLL AUDIT SHOWER ASSIGNMENT SHEETS OF EACH SKILLED NURSING RESIDENT DAILY X4, WEEKLY X8 AND MONTHLY X3. 10. STAFF DEVELOPMENT COORDINATOR/DON WILL PRESENT AUDIT FINDINGS AND PROCESS IN QAPI MONTHLY FOR 3 MONTHS TO DETERMINE IF PROCESS HAS IMPROVED AND OR MAKE CHANGES AS NECESSARY.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 4 §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview with the Physician Assistant (PA), resident and staff, the facility failed to notify the Physician and or the PA when a resident had a significant weight loss for 2 of 4 sampled residents reviewed for nutrition (Residents #13, #3). Findings included: 1. Resident # 13 was admitted to the facility on 5/13/22 with multiple diagnoses including dysphagia (difficulty swallowing food/liquids) and hemiplegia (partial paralysis on one side of the body) following cerebral infarction affecting the right dominant side. The admission Minimum Data Set (MDS) assessment dated 5/26/22 indicated that Resident #13 had severe cognitive impairment, was independent with eating and was on a mechanically altered diet. The assessment further indicated that the resident's weight was 189 pounds (lbs.). Resident #13's care plan for nutrition dated 5/29/22 was reviewed. The care plan problem	F 580	SAMPLE SET:#13,#3 1. PHYSICIAN ASSISTANT INFORMED OF WEIGHT LOSS OF BOTH RESIDENT #13 AND #3 ON 8/9/2022. 2. WEEKLY RESIDENT AT RISK MEETING ESTABLISHED: ADDRESSED RESIDENT□S #13 AND #3 WITH INTERDISCIPLINARY TEAM. 3. PHYSICIAN GROUP UPDATED AND INFORMED WEEKLY OF WEIGHT LOSS VIA CLINICAL MANAGER/DESIGNEE. 4. CLINICAL MANAGER WILL REVIEW/DISCUSS WEIGHT LOSS ISSUES DAILY VIA CLINICAL MEETINGS. 5. STAFF DEVELOPMENT COORDINATOR WILL INSERVICE NURSING TEAM TO ADDRESS ANY WEIGHT LOSS ISSUES TO THE CLINICAL MANAGER OR NURSING SUPERVISOR. 9/9/2022. 6. AN AUDIT TOOL ESTABLISHED TO MONITOR THAT THE PHYSICIAN IS NOTIFIED OF WEIGHT LOSS AND IT WILL BE AUDITED BY CLINICAL MANAGER DAILY XS 4 WEEKS,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 5 was the resident was at risk for nutritional decline related to dysphagia. The goal was for the resident to tolerate diet as ordered with no complications and to maintain her weight within 5% of 189 lbs. The approaches included staff to monitor resident's weight as ordered and to notify the physician and her family of any concerns. Review of Resident #13's weights revealed that he had lost 42 pounds (lbs.) in 3 months (May 2022 through August 2022). Resident #13 weighed 189 lbs. on 5/13/22 and 147 lbs. on 8/5/22. Review of the Physician/Physician Assistant (PA) progress notes revealed that Resident #13 was seen by the PA on 6/30/22, 7/7/22, 7/14/22, 7/21/22, 7/28/22 and 8/3/22. The notes did not address the resident's weight loss. The Physician Assistant (PA) was interviewed on 8/10/22 at 12:15 PM. The PA stated that he expected to be notified when a resident had a significant weight loss, and he also expected the RD to identify weight loss and to implement interventions to prevent further weight loss. The PA reported that he was never notified that Resident #13 had a significant weight loss, however, if nursing notified him of weight loss, he would normally refer the resident to the RD to assess and to intervene. 2. Resident #3 was admitted to the facility on 4/29/22 with multiple diagnoses including dysphagia (difficulty swallowing food/liquids) and hemiplegia (partial paralysis on one side of the body) following cerebral infarction.	F 580	WEEKLY X8 WEEKS AND MONTHLY X3 MONTHS THEREAFTER. 7. DURING WEEKLY RESIDENT AT RISK MEETINGS THE MEDICAL DIRECTOR/PA WILL BE NOTIFIED BY CLINICAL MANAGER/DESIGNEE OF ANY WEIGHT LOSS ISSUES THAT HAVE BEEN REVIEWED BY THE INTERDISCIPLARY TEAM. 9/9/2022 8. PA WILL VERIFIED VIA SIGNATURE SHEET THAT HE HAS REVIEWED ANY CHANGES IN RESIDENT WEIGHT LOSS. 9. DON/STAFF DEVELOPMENT COORDINATOR OR CLINICAL MANAGER WILL PRESENT FINDINGS TO QAPI COMMITTEE TO REVIEW EFFECTIVENESS OF PROCESS FOR 6MONTHS TO DETERMINE ANY CHANGES ARE NECESSARY.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 6	F 580		

The admission Minimum Data Set (MDS) assessment dated 5/5/22 indicated that Resident #3's cognition was intact, was independent with eating and was on a mechanically altered diet. The assessment further indicated that the resident's weight was 169 pounds (lbs.).

Resident #3's care plan for nutrition dated 5/30/22 was reviewed. The care plan problem was the resident was at risk for nutritional decline related to dysphagia and recent weight loss of 10 lbs. The goal was "I will tolerate diet as ordered with no complications and will maintain my weight within 5% of my admission weight". The approaches included "staff to monitor my weights as ordered and notify the physician and my family of any concerns".

Review of Resident #3's weights revealed that he had lost 13 lbs. in 3 months (April 2022 through July 2022). He weighed 169 lbs. on 4/29/22 and 156 lbs. on 7/5/22.

Review of the Physician/Physician Assistant (PA) progress notes revealed that Resident #3 was seen by the PA on 7/11/22, 7/18/22, 7/22/22, 8/2/22 and 8/8/22. The notes did not address the resident's weight loss.

The Physician Assistant (PA) was interviewed on 8/10/22 at 12:15 PM. The PA stated that he expected to be notified when a resident had a significant weight loss, and he also expected the RD to identify weight loss and to implement interventions to prevent further weight loss. The PA reported that he was never notified that Resident #3 had a significant weight loss, however, if nursing notified him of weight loss, he would normally refer the resident to the RD to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 7 assess and to intervene.	F 580		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 623	Continued From page 8	F 623		

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 623	Continued From page 9 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and interview with a resident's responsible party (RP) and staff, the facility failed to notify the resident or the responsible party in writing of the reason for discharge to the hospital for 2 of 2 residents reviewed for hospitalizations (Residents #13 and #36). The findings included: 1. Resident #13 was originally admitted to the facility on 5/13/22. A nurse's note dated 5/16/22 at 4:59 AM revealed that Resident # 13 was transferred to the emergency room (ER) and was admitted. The note was written by Nurse #3.	F 623	SAMPLE SET:#13, #36 1. HEALTHCARE ADMINISTRATOR HAS INCORPORATED THE NOTICE OF TRANSFER FORM AND THE FORM WILL BE GIVEN TO RESIDENT #13 AND SENT CERTIFIED MAIL OR IN-PERSON TO RESPONSIBLE PARTY BY 9/9/2022 VIA SOCIAL WORKER. 2. NOTICE OF TRANSFER FORM WAS NOT GIVEN TO RESIDENT #36 OR RESPONSIBLE PARTY AS THE RESIDENT IS DECEASED. 3. RESIDENT NOTICE OF TRANSFER FORM WILL BE IMPLEMENTED BY STAFF DEVELOPMENT COORDINATOR AND ACCESSIBLE TO ALL LICENSED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 623	Continued From page 10 A nurse's note dated 5/21/22 at 5:20 PM revealed that Resident #13 was readmitted back to the facility. Review of the medical records revealed no documentation that a written notice was provided to the responsible party (RP) regarding the reason for the hospitalization. Nurse #3 was interviewed on 8/9/22 at 4:20 PM. The Nurse reported that when a resident was discharged to the hospital, the responsible party (RP) was called via telephone to inform her/him that the resident was discharged to the hospital. She indicated that she didn't know that the facility has to notify the resident or the responsible party (RP) in writing of the reason for the discharge. The acting Director of Nursing (DON) was interviewed on 8/10/22 at 4:50 PM. The Acting DON stated that she didn't know that the facility has to notify the resident or the RP in writing when a resident was discharged to the hospital. 2. Resident #36 was admitted 11/9/2019 and discharged 6/27/2022. The resident's medical record included a progress note written on 6/27/2022 by the Physician Assistant (PA) indicated Resident #36 needed to be transferred to the hospital for fever and low blood oxygen. Resident #36's Minimum Data Set (MDS) dated 6/27/2022 indicated she was discharged to the hospital with return anticipated. A nursing progress note dated 7/1/2022 revealed	F 623	NURSES TO PROVIDE TO ANY RESIDENTS BEING TRANSFERRED AND DISCHARGED FROM THE FACILITY. ALL RESPONSIBLE PARTIES WILL BE SENT A NOTICE OF TRANSFER FORM VIA CERTIFIED MAIL/EMAIL BY SOCIAL WORKER/DESIGNEE. 9/9/2022. 4. CLINICAL MANAGER/SOCIAL WORKER TO AUDIT ALL COMPLETED TRANSFERS AND DISCHARGES FORMS AND PRESENT FINDINGS DURING DAILY CLINICAL MEETINGS. 9/9/2022 5. STAFF DEVELOPMENT COORDINATOR/DESIGNEE WILL EDUCATE ALL LICENSED NURSES THAT NEW FORM HAS BEEN EXECUTED AND WILL NEED TO BE USED FOR ALL DISCHARGE AND TRANSFERS. ANY NURSES NOT EDUCATED WILL BE TAKEN OFF SCHEDULE UNTIL INSERVICE IS COMPLETED. 9/9/22 6. SOCIAL WORKER WILL PRESENT FINDINGS OF AUDIT TO THE QAPI COMMITTEE TO REVIEW PROCESS FOR ITS EFFECTIVENESS DURING MONTHLY QAPI MEETINGS X3 MONTHS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 623	Continued From page 11 Resident #36 had been admitted to the hospital on 6/27/2022. Her family opted for hospice care, and she was transferred to a Hospice House where she expired. On 8/09/2022 at 3:55 PM an interview was conducted with Nurse #3. She stated when residents were transported to the hospital, the facility sent a face sheet (resident demographic information), medication administration record (MAR), and a copy of the bed hold policy. She further stated the residents' families were notified via phone call, but she did not know of a written notification of discharge. On 8/09/2022 at 4:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated a bed hold policy was sent out with the resident along with the face sheet, MAR and summary as to why the resident was being transported to the hospital. She further stated the family or RP was contacted via phone but there was no written notification of discharge sent to them. On 8/10/2022 at 4:50PM an interview was conducted with the DON. She stated it was her expectation a written notification of reason for discharge be sent to residents and/or resident's responsible party. She was not aware a written notice was required.	F 623		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 12 by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of diagnoses (Resident #13), medications (Resident #15) & urinary devices (Resident #29) for 3 of 16 sampled residents whose MDS were reviewed. Findings included: 1. Resident #13 was admitted to the facility on 5/20/22 with multiple diagnoses including anemia, glaucoma and ulcer. Resident #13 had doctor's orders dated 5/20/22 for Ferrous Sulfate 325 milligrams (mgs) by mouth daily for anemia, Latanoprost (Xalatan) 1 drop (gtt.) to both eyes daily for glaucoma and Lansoprazole (Prevacid) 30 mgs by mouth daily for ulcers. The May 2022 Medication Administration Records (MARs) were reviewed and revealed that Resident #13 had received the Ferrous Sulfate, Xalatan eye drops and Prevacid during the assessment period. The admission MDS assessment dated 5/26/22 was reviewed. The assessment did not indicate that Resident #13 had diagnoses of anemia, glaucoma and ulcer. The MDS Nurse was interviewed on 8/10/22 at 3:08 PM. The MDS Nurse reviewed the resident's doctor's orders, the May 2022 MARs and the MDS dated 5/26/22. She verified that Resident #13 had diagnoses of anemia, glaucoma and ulcer and had received medications including Ferrous Sulfate, Xalatan eye drops and Prevacid during the assessment	F 641	SAMPLE SET: #13, #15, #29 1. MDS COORDINATOR UPDATED AND RESUBMITTED ASSESSMENT ON #13 ON 8/24/2022. THE DIAGNOSIS WAS MODIFIED ON THE ASSESSMENT TO REFLECT THE MEDICATION ADMINISTRATION RECORD FOR ACCURACY. 2. MDS COORDINATOR ALSO UPDATED RESIDENT #15□S MDS ASSESSMENT AND ADDED THE DIURITETIC AND THE OPIOID/ACETAMINOPHEN WHICH REFLECTED THE MEDICATION ADMINISTRATION RECORD ON 8/9/2022. 3. MDS COORDINATOR ALSO MODIFIED RESIDENT #29□S MDS ASSESSMENT TO ONLY ADDRESS AN INDWELLING CATHETER. 4. A COMPUTER GENERATED WORK ORDER WAS SUBMITTED TO CORRECT WHY THE AUTO-POPULATED CROSS WALKED DATA DID TRANSFER TO THE MDS FROM THE ELECTRONIC MEDICATION RECORD. THIS WORK ORDER WAS SUBMITTED THE WEEK OF 8/10/2022 TO MATRIX CARE. IT HAS NOT BEEN RESOLVED AT THIS TIME. 5. THE RN SUPERVISOR HAS AUDITED THE PAST 3 MONTH OF ASSESSMENTS DATING BACK TO 5/2/2022 TO RECONCILE THE MEDICATION ADMINISTRATION RECORDS AND MDS SECTIONS I(ACTIVE DIAGNOSIS) &	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 13 period. She stated that she missed to code the anemia, glaucoma and ulcer under the diagnoses on the admission MDS dated 5/26/22. The acting Director of Nursing (DON) was interviewed on 8/10/22 at 4:50 PM. The acting DON stated that she expected the MDS assessments to be coded accurately. 2. Resident #29 was admitted on 8/10/21 with a diagnosis of urinary retention. Her significant change Minimum Data Set (MDS) dated 6/14/22 indicated Resident #29 was coded for an indwelling urinary catheter and for intermittent catheterization. A review of Resident #29's August 2022 Physician orders indicated the presence of an indwelling urinary catheter ordered on 3/2/22. A review of Resident #29's nursing notes from 6/1/22 to 6/14/22 did not include documented evidence of intermittent catheterization but rather the presence of an indwelling urinary catheter. An observation was conducted on 8/9/22 at 4:30 PM with Nurse #2 of Resident #29's urinary catheter care. She presented with an indwelling urinary catheter. An interview was conducted with Nurse #2 on 8/9/22 at 4:30 PM, she stated Resident #29 has had an indwelling urinary catheter a very long time and she was unable to recall any occasion that intermittent catheterization was completed or required.	F 641	N(MEDICATION). THE MDS COORDINATOR FOUND 6 ERRORS OF 69 ASSESSMENTS REVIEWED. MDS COORDINATOR WAS ABLE TO MAKE THE MODIFICATIONS AS NECESSARY. 6. DON PROVIDED EDUCATION TO MDS COORDINATOR OF THE IMPORTANCE OF ACCURACY OF ASSESSMENTS COMPLETED ON MDS. 9/9/2022. 6. DON/RN SUPERVISOR WILL AUDIT 20% OF ASSESSMENTS WEEKLY X4 FOR 3MTHS TO DETERMINE ACCURACY AND MODIFY ANY ASSESSMENTS WHERE THE INFORMATION HAS NOT AUTO POPULATED FROM THE MEDICATION ADMINISTRATION RECORD. 7. DIRECTOR OF NURSING WILL PRESENT AUDIT FINDINGS TO THE QAPI COMMITTEE TO DETERMINE EFFECTIVENESS OF THE PROCESS DURING THE MONTHLY QAPI MEETINGS EVERY MONTH TIMES X6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 14	F 641		

An interview was completed on 8/10/22 at 3:00 PM with the MDS Nurse. She stated she thought she saw a nursing note during the 7-day MDS look back period where Resident #29 was catharized for urinalysis. She stated she coded the 6/14/22 MDS in error for intermittent catheterization.

An interview was completed on 8/10/22 at 5:04 PM with the interim Director of Nursing. She stated it was her expectation that Resident #29's MDS be coded accurately in the area of bladder appliances.

3. Resident #15 was admitted to the facility 1/15/2021 with diagnoses that included heart failure and osteoarthritis.

The resident's medical record revealed a physician's order for Lasix (a diuretic) 40mg by mouth every other day for edema. The start date was 5/13/2022. There was no end date. The medical record also included a physician's order for Norco 5 milligrams (mg)-325mg by mouth every 6 hours as needed for pain. Norco is a combination pain reliver containing the opioid hydrocodone and a non-opioid pain reliever, acetaminophen. The start date for the Norco was 10/20/2021 and there was no end date.

Resident #15's Medication Administration Record for the May and June 2022 indicated the resident did receive both Lasix and Norco during May and June 2022.

Resident #15's quarterly Minimum Data Set (MDS) dated 6/2/2022, with an assessment reference date of 6/3/2022 indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 15 did not receive diuretics or opioids during the assessment period. On 8/09/2022 at 11:36 AM an interview was conducted with the MDS nurse. She reviewed Resident #15's MDS dated 6/2/2022 and stated she thought the system would have pulled those medications, Lasix and Norco, into the MDS. She further stated she had just realized the system did not. The MDS nurse stated both the diuretic and the opioid should have been coded 3 out of 7 days. On 8/10/2022 at 5:00 PM and interview was conducted with the Director of Nursing. She stated it was her expectation that the MDS be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 656	Continued From page 16 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a comprehensive care plan for the use of the indwelling urinary catheter for 1 of 3 sampled residents reviewed for indwelling catheters (Resident #3). Findings included: Resident #3 was admitted to the facility on 4/29/22 with multiple diagnoses including urinary retention. Resident #3 had a doctor's order dated 4/29/22 for indwelling urinary catheter for urinary retention.	F 656	SAMPLE SET: #3 1. MDS COORDINATOR MODIFIED CARE PLAN ON 8/11/2022 TO INDICATE RESIDENT #3 HAD AN INDWELLING CATHETER. 2. MDS COORDINATOR REVIEWED CARE PLAN MODIFICATION WITH INTERDISCIPLINARY TEAM FOR RESIDENT #3. 3. MDS COORDINATOR/RN SUPERVISOR/DON TO REVIEW ALL RESIDENTS WITH FOLEY CATHETERS AND UPDATE CARE PLANS AS NECESSARY.-9/9/2022 4. MDS COORDINATOR WILL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 656	Continued From page 17 The admission Minimum Data Set (MDS) assessment dated 5/5/22 indicated that Resident #3's cognition was intact, and he had an indwelling urinary catheter. Resident #3's care plan dated 5/30/22 was reviewed. There was no care plan developed for the use of the indwelling urinary catheter. Resident #3 was observed on 8/8/22 at 11:37 AM. He was in bed and had an indwelling urinary catheter in place. When interviewed, the resident stated that he had the urinary catheter since admission. The MDS Nurse was interviewed on 8/10/22 at 3:05 PM. The MDS Nurse reviewed the physician's orders and the nurse's notes and verified that Resident #3 had an order for the indwelling urinary catheter and had the urinary catheter during the assessment period. She indicated that she missed to develop a comprehensive care plan for the urinary catheter. The acting Director of Nursing (DON) was interviewed on 8/10/22 at 4:50 PM. The acting DON stated that she expected a comprehensive care plan developed when a resident had an indwelling urinary catheter.	F 656	COMPLETE MDS ASSESSMENT SEC H (BOWEL/BLADDER) AND REVIEW ALL FOLEY CATHETERS TO ASSURE CARE PLANS ARE UP-TO-DATE.-9/9/2022 5. DON/RN SUPERVISOR/CLINICAL MANAGER WILL ADDRESS ANY RESIDENTS THAT HAVE CHANGES WITH RESIDENT FOLEY CATHERERS AND MDS COORDINATOR TO MODIFY CARE PLAN AS NEEDED. 6. IDT TO REVIEW ALL RESIDENTS WITH CATHETERS IN RESIDENT AT RISK MEETING AND ADJUST CARE PLAN AS NECESSARY DURING THESE MEETINGS. 7. DON TO REDUCATE MDS COORDINATOR OF IMPORTANCE OF CARE PLAN ACCURACY AND UPDATE INFORMATION AS NECESSARY. 8. DON/RN SUPERVISOR WILL USE AUDIT TOOL REVIEWING SECTION H ON MDS(BOWEL/BLADDER) AND THOSE RESIDENTS ON FOLEY CATHETERS FOR CARE PLAN ACCURACY DAILY X4 WEEKS, WEEKLY X8 WEEKS AND MONTHLY X□S3. 9. CLINICAL MANAGER/RN SUPERVISOR/DESIGNEE WILL INFORM/UPDATE PHYSICIAN OF RESIDENT AT RISK MEETING FINDINGS EACH WEEK. 10. DON/RN SUPERVISOR TO REVIEW EFFECTIVENESS OF PROCESS IN MONTHLY QAPI MEETINGS MONTHLY X6.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 657	Continued From page 18 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to revise the comprehensive care plan after a Significant Change in Status Assessment for 1 of 3 residents reviewed for accidents (Resident #29). The findings included: Resident #29 was admitted on 8/10/21 with a diagnosis of Multiple Sclerosis.	F 657	SAMPLE SET: #29 1. MDS COORDINATOR REVISED RESIDENT #29□s CARE PLAN ON 8/24/2022 TO INDICATE USE OF A MECHANICAL LIFT. 2. STAFF DEVELOPMENT COORDINATOR TO EDUCATE NURSING STAFF TO IMMEDIATELY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 657	Continued From page 19 Review of the Significant Change in Status Assessment Minimum Data Set (MDS) dated 6/14/22 indicated Resident #29 had no transfers during the 7-day look back period. Review of Resident #29's mobility care plan initiated 9/20/21 indicated she was to be transferred using a sit-to-stand lift (lift designed to assist a resident who lacked the strength or muscle control to rise to the standing position) for all transfers as of 11/19/21. Review of an incident report dated 7/7/22 at 8:45 PM noted Resident #29 had been lowered to the floor during a transfer using a total body lift device (hydraulic lift utilizing a body sling). An interview was completed on 8/9/22 at 4:03 PM with Nursing Assistant (NA) #3. She stated Resident #29 was very stiff and required the use of a total body lift for all transfers and she could not recall a time when she used a sit-to-stand lift. On 8/10/22 at 1:30 PM an observation with the interim Director of Nursing (DON) was conducted. Located on the employee bulletin board was an undated document indicating Resident #29 used a total body lift for transfers. The DON stated the document had been posted on the bulletin board for a least 6 months so staff would know the correct sling size to use when transferring any total body lift resident. Resident #29's name appeared on the list as requiring a medium size sling. The interim DON also stated the electronic care guide was also utilized by the aides identifying the resident's lift status. Review of Resident #29's electronic care guide utilized by the aides read the staff were to take extra time to	F 657	NOTIFY NURSE AND CLINICAL MANAGER OF ANY RESIDENT TRANSFER STATUS CHANGES. 9/9/2022. ALL NURSING STAFF INSERVICED AND THOSE WHO WERE NOT PRESENT WILL BE TAKEN OFF THE RESIDENT CARE SCHEDULE UNTIL EDUCATION IS COMPLETED. 3. CLINICAL MANAGER TO ASSESS AND ADDRESS ANY TRANSFER STATUS ASSESSMENT UPDATES WITH REHAB MANAGER. 4. CLINICAL MANAGER WILL ADDRESS ANY CHANGES OF RESIDENT TRANSFER STATUS DURING MORNING MEETINGS. 5. MDS COORDINATOR WILL UPDATE RESIDENT□S CARE PLAN TO ADDRESS ANY CHANGES IN STATUS DURING MORNING CLINICAL MEETINGS. 6. DON/RN SUPERVISOR WORKED WITH MDS COORDINATOR AUDITED ALL RESIDENTS WITH ASSISTED DEVICES TO ASSURE THAT CORRECTED INFORMATION WAS ON THE CARE PLAN; MDS COORDINATOR TO UPDATE CARE PLAN. 7. DON/RN SUPERVISOR/SDC/DESIGNEE WILL AUDIT TRANSFER STATUS DAILY X8 WEEKS, WEEKLY X4 WEEKS AND MONTHLY X3 MONTHS. 8. DON WILL PRESENT AUDIT FINDINGS TO QAPI COMMITTEE FOR EFFECTIVENESS OF PROCESS IN QAPI MEETINGS MONTHLY X6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 657	Continued From page 20 ensure equipment was ready for a transfer as of 7/7/22. The interim DON stated maybe Resident #29's transfer status needed to be re-evaluated to determine the correct method of transferring her. A telephone interview was completed on 8/10/2 at 2:55 PM with Nurse #4. She stated Resident #29 had required use of a total body lift for transfers since her admission due to her muscle stiffness and inability to actively participate in transfers. An interview was completed on 8/10/22 at 3:00 PM with the MDS Nurse. She stated at the time she added the sit-to-stand lift for transfers to Resident #29's care plan on 11/19/21, it was likely during an Interdisciplinary Team (IDT) Meeting. The MDS Nurse stated at the time she completed the most recent care plan revision on 6/16/22, she asked to floor staff how Resident #29 was transferred and they reported she used a sit-to-stand lift for transfers. An interview was completed on 8/10/22 at 5:04 PM with the interim DON. She stated it was her expectation Resident #29's care plan to be accurate and reflect her accurate transfer status.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with residents and staff, the facility failed to provide nail care for 2 of 2 dependent	F 677	SAMPLE SET: #15,#30 1. RESIDENT #15 RECEIVED NAIL	9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 21 residents (Residents #15, #30) reviewed for activities of daily living. The findings included: 1. Resident #15 was admitted on 1/15/2021 with diagnoses that included heart failure and osteoarthritis. Resident #15's quarterly Minimum Data Set (MDS) dated 6/2/2022, with an assessment reference date of 6/3/2022 indicated the resident was cognitively intact, required extensive assistance with activities of daily living, and was total dependent with bathing. Resident # 15's comprehensive care plan was last updated 6/10/2022 and include a focus for risk of decline with activities of daily living related to osteoarthritis and limited range of motion. Interventions included staff would set up clothing and personal hygiene supplies, bathing supplies, and assist as needed. On 8/10/2022 at 9:30 AM Resident #15's fingernails were observed to be long. When asked about his fingernails, he stated he did not like his nails to be long. He further stated staff would sometimes trim his nails, but it was infrequent. He stated he was not able to trim his nails himself due to his hands being unsteady. Attempts to interview Nurse Assistant (NA) #4 who was assigned to Resident #15 at the time of the observation on 8/10/22 were not successful. An interview was conducted with Nurse #1 on 8/10/2022 at 9:45 AM. She stated there was one NA on the hall for over 30 residents. She further stated nail care was provided during showers.	F 677	CARE ON 8/11/2022 AND TO BE COMPLETED ON MONDAYS AND THURSDAY WHICH ARE HIS SHOWERS DAY OR AS NEEDED. 2. RESIDENT #30 RECEIVED NAIL CARE ON 8/11/2022 AND WILL RECEIVE SERVICES TUESDAYS AND FRIDAYS. 3. STAFF DEVELOPMENT COORDINATOR/CLINICAL MANAGER/DESIGNEE TO PROVIDE IN-SERVICE TO ALL NURSING STAFF REGARDING RESIDENT RIGHTS AND ADHERING TO RESIDENTS NAIL CARE DURING SCHEDULED SHOWER DAYS. 4. ALL LICENSED NURSES TO DO NAIL CARE FOR RESIDENTS WITH DIABETIC HEALTH ISSUES. 5. ALL NURSING STAFF(LICENSED NURSES,MED AIDES/TECHS, AND CNAs) TO BE INSERVICED AT 100%. ANY NURSING STAFF NOT INSERVICED WILL BE TAKEN OFF SCHEDULE UNTIL THEY RECEIVED THEIR EDUCATION.9/9/2022 6. CLINICAL MANAGER/RN SUPERVISOR TO REVIEW RESIDENT SHOWER AND NAIL CARE SCHEDULE FOR EACH RESIDENT. 7. CLINCAL MANAGER/RN SUPERVISOR TO AUDIT ALL NAIL CARE GIVEN TO EACH RESIDENT DAILY X4 WEEKS, WEEKLY X8 WEEKS AND MONTHLYX3 MONTHS TO VERIFY WHO HAS RECEIVED SERVICES AS SCHEDULED. 8. CLINICAL MANAGER/DESIGNEE TO REVIEW AUDIT FORM AND ADDRESS ANY NAIL CARE CONCERNS DURING	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 22 On 8/10/2022 at 9:50 AM an interview was conducted with the Director of Nursing (DON) she stated the NAs were responsible for providing nail care for residents when providing showers. She further stated she was aware of Resident #15 missing his scheduled showers but was not aware he needed nail care. 2. Resident #30 was admitted on 4/8/2022 with diagnoses that included fracture to the sacrum. Resident #30's quarterly Minimum Data Set (MDS) dated 7/14/2022 indicated the resident had moderate cognitive impairment, had highly impaired hearing, and could understand and be understood by others. The resident required extensive assistance with activities of daily living and was dependent with personal hygiene and bathing. On 8/10/2022 at 9:40 AM Resident #30's was observed to have long fingernails on both hands. When asked if he liked his nails long, he stated he did not. Resident #30 stated the NAs trim his nails, but they had not been trimmed in a while. He indicated he probably couldn't trim his own nails. When asked about showers, he stated he got bed baths most days, showers were painful for him. Attempts to interview Nurse Assistant (NA) #4 who was assigned to Resident #30 at the time of the observation on 8/10/22 were not successful. An interview was conducted with Nurse #1 on 8/10/2022 at 9:45 AM. She stated there was one NA on the hall for over 30 residents. She further stated nail care was provided during showers.	F 677	DAILY CLINICAL MEETINGS. 9. IF ANY ISSUES HAVE BEEN IDENTIFIED, THE CLINCAL MANAGER/DESIGNEE WILL ADDRESS WITH NURSING STAFF. 10. SDC WILL INTRODUCE BATHING/NAIL CARE FORM AND INSERVICE STAFF AT 100%. ANY STAFF NOT INSERVICED WILL BE TAKEN OFF THE SCHEDULE UNTIL INSERVICE IS COMPLETED. 9/9/2022 11. CLINICAL MANAGER/RN SUPERVISOR TO PRESENT FINDINGS TO QAPI COMMITTEE TO DETERMINE EFFECTIVENESS OF PROCESS DUKRING THE MONTHLY QAPI MEETINGS FOR 3 MONTHS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 23 On 8/10/2022 at 9:50 AM an interview was conducted with the Director of Nursing (DON) she stated the NAs were responsible for providing nail care for residents when providing showers. She was not aware Resident #30 was not getting nail care.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, Physician Assistant (PA) interview and Responsible Party (RP) interview and record review the facility failed to identify the root cause and implement effective interventions to prevent multiple falls (Resident #32). In addition, the facility failed to identify the root cause for multiple falls (Resident #18) and failed to safely utilize a total body (hydraulic lift utilizing a body sling) lift while attempting to transfer a resident resulting in a fall without injuries (Resident #29). This was for 3 of 3 residents reviewed for accidents. The findings included: 1. Resident #32 was admitted on 6/25/21 with cumulative diagnoses of Dementia, osteoporosis, a history of a femur fracture and a history of falls.	F 689	1.SAMPLE SET: #32,#18,#29 1. RESIDENT #32: RESIDENT HAD MULTIPLE FALLS. 2. STAFF DEVELOPMENT COORDINATOR INSERVICED NURSING STAFF ABOUT LOCKING WHEEL CHAIRS. 3. DON ADDED INTERVENTIONS FOR RESIDENT TO BE PLACED IN COMMON AREAS FOR INCREASED VISUALIZATION. 4. CLINICAL MANAGER TO IMPLEMENT ANTI-ROLLBACKS FOR RESIDENT□S WHEELCHAIR-9.9.2022 5. ADD RESIDENT TO A TOILETING PROGRAM-5/8/2022. 6. USE NEW ROOTCAUSE ANALYSIS	9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 24 Her annual Minimum Data Set (MDS) dated 7/18/22 indicated severe cognitive impairment, extensive assistance with transfers and she was coded as have two falls with minor injuries since the previous MDS assessment. She was also coded for a prognosis of less than six months and hospice services. Resident #32 was care planned for falls initially on 6/30/21 and last revised on 7/30/22. Interventions included in part frequent checks, encourage her to stay in the common area for closer staff supervision, routine toileting and staff were not to lock her wheelchair brakes. Review of Resident #32's electronic care guide utilized by the aides included the same interventions as her comprehensive care plan. Resident #32's fall incident reports read the following: *4/14/22 at 5:15 PM, Resident #32 fell from her wheelchair and on the floor in the hallway. She sustained a laceration to her forehead and sent to the hospital for an evaluation. Her CT Scan was negative for head or spine injuries and she returned to the facility with steri-strips to her forehead laceration. The intervention read to encourage her to stay in the common area for closer staff supervision. There was no documented evidence of the facility completing a root cause analysis. *5/8/22 at 4:00 PM, Resident #32 was on the floor in the Dining Room with her wheelchair behind her. She sustained a skin tear to her left hand. The intervention read to remind staff to provide routine toileting. There was no documented evidence of the facility completing a root cause analysis.	F 689	FORM IF SHE WOULD FALL AGAIN. 7. #29: RESIDENT-HAD AN ASSISTED FALL. 8. CARE PLAN WAS MODIFIED TO USE PROPER LIFT DEVICE. 8/24/2022 BY MDS COORDINATOR 9. STAFF DEVELOPMENT COORDINATOR INSERVICED-PROVIDED INSTRUCTIONAL VIDEOS FOR NURSING TO PROPERLY USE LIFT DEVICES. BY 9/9/2022 10. RN SUPERVISOR TO RANDOMLY AUDIT 2 C.N.A. STAFF TO PROVIDE RETURN DEMONSTRATION OF MECHANICAL DEVICE. DON/SDC TO REVIEW FORMS FOR VERIFICATION. STARTING 9/8/2022. AUDITS BY RN SUPERVISIOR/DESIGNEE WILL OCCUR WEEKLY X8, MONTHLY X3 THERE AFTER. 11. RESIDENT #18: RESIDENT WAS TRANSFERRED TO ASSISTED LIVING ON 8/18/22 12. RESIDENT #18 WAS PLACED IN A TOILETING PROGRAM PRIOR TO DISCHARGE.8/18/2022 13. IN-SERVICED LICENSED NURSING STAFF TO DO ROOT CAUSE ANALYSIS- COMPLETING INCIDENT REPORTS. BY 9/9/2022. 14. THERAPY REHAB MANAGER INFORMED ABOUT NEW FALL PROTOCOLS, LIFT DEVICES AND RESIDENT AT RISK MEETING REVIEW OF ALL FALLS. 9/9/2022 15. AUDIT FALL REPORTS FOR ACCURACY-DAILY REVIEW DURING MORNING CLINICAL MEETING. 9/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 25 *6/6/22 at 8:20 PM, Resident was observed lying on the floor with her back close to the bed. She sustained a skin tear to her left forearm, left wrist, right shin and a raised area to her right forehead with an abrasion. Neurological checks initiated and steri-strips were applied to her skin tears. The intervention read for staff to provide routine rounds for safety. There was no documented evidence of the facility completing a root cause analysis. Review of the nursing notes read the skin tear to her right shin appeared red on 6/14/22 at 8:50 PM and a nursing note dated 6/16/22 at 10:19 PM read the area to her right shin had increased redness, slough with moderate exudate. The Physician was notified and orders were given on 6/17/22 for a wound consult. A nursing note dated 6/20/22 at 11:15 PM read there was edema to her right shin, ankle and foot with foul smelling drainage. A nursing note dated 6/21/22 at 1:42 PM read Resident #32 was seen by the wound consultant and new orders were given for wound care and an antibiotic. A nursing note dated 6/29/22 at 10:22 AM read the wound consultant assessed the area and noted improvement with no evidence of an infection and the wound consult dated 7/5/22 indicated the area to her right shin was healed. *7/30/22 at 4:00 PM, Resident #32 was observed on the floor in front of her wheelchair with her wheelchair brakes locked. Location was not documented and she did not sustain any injuries. Staff were in-serviced not to lock Resident #32's wheelchair brakes while she was up in her wheelchair. There was no documented evidence of the facility completing a root cause analysis. An observation was completed on 8/8/22 at 10:36 AM. Resident #32 was sitting in a high back wheelchair at Nurses Station #1. She was trying	F 689	16. DON/CLINICAL MANAGER/DESIGNEE WILL REVIEW (BRIEF INTERIEW FOR MENTAL STATUS) BIMS ASSESSMENT DURING EACH RESIDENTS FALL REVIEW. 17. ESTABLISHING A WEEKLY RESIDENT AT RISK MEETING AND PROVIDED EXPANDED IDT APPROACH. DON, CLINICAL MANAGER, STAFF DEVELOPMENT COORDINATOR, MDS COORDINATOR, SOCIAL WORKER, MEDICAL RECORDS, CERTIFIED DIETARY MANAGER, LIFE ENRICHMENT COORDINATOR(ACTIVITIES), AND HEALTHCARE ADMINISTRATOR. 18. PROVIDE RESULTS OF RAR MEETING TO MEDICAL DIRECTOR/PHYSICIAN GROUP EACH WEEK. 19. CLINICAL MANAGER WILL CREATE A FALL LOG, WRITE DOWN INTERVENTIONS, AND TREND FALLS FOR MONITORING AND TRACKING. 9/9/2022 20. ACTIVITIES TO LOG- ALL RESIDENT ACTIVITIES FOR FREQUENT FALLS AND ALSO CONNECT THEM WITH PENICK VILLAGES CHAPLAIN FOR ROOM VISITS. 21. IMPLEMENT A FALL SCENE INVESTIGATION FORM (FSI FORM) THAT WILL HELP ASSESS ROOT CAUSE ANALYSIS BY 9/9/22. 22. STAFF DEVELOPMENT COORDINATOR AND DON REVIEWED ALL RESIDENT INCIDENT REPORTS AND INTERVENTIONS FOR FALLS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 26 to propel herself but was not able to make any significant progress. The wheelchair brakes were unlocked and Nurse #4 was standing beside her. Review of another fall incident report dated 8/8/22 read the following: *8/8/22 at 5:30 PM, Resident #32 was sitting in her wheelchair at Nursing Station #1. She was observed leaning forward and Nurse #4 asked her to lean back. Nurse #4 continued charting when she heard a noise. She looked up and did not see Resident #32. She found her lying on the floor on her stomach in front of the wheelchair. Resident #32 had a lump to the left side of her forehead and was sent out to the hospital for an evaluation. The intervention read to place Resident #32 in bed after being up for 2 or more hours unless there was an activity to keep her preoccupied. A nursing note dated 8/8/22 at 10:00 PM read Resident #32 returned to the facility and her CT scan was negative for head or spine injuries. She returned with a large hematoma covering the entire left side of her forehead from above her left eye up to her scalp. There was no documented evidence of the facility completing a root cause analysis. An interview was completed on 8/9/22 at 2:05 PM with Nurse #4, She stated the fall dated 7/30/22 occurred at NS #1 when an agency aide placed her at Nurses Station #1 and locked her wheelchair brakes. She stated the agency aides were not familiar with interventions put in place to prevent Resident #29 from falling. A telephone interview was completed on 8/9/22 at 3:00 PM with agency Nursing Assistant (NA) #5. She stated she did not recall being assigned Resident #32 on 7/30/22 but did recall leaving	F 689	DATING BACK TO 7/7/2022. REVIEW DATE WAS ON 9/9/2022. 23. THERAPY TEAM TO EVALUATE FOR ALL NEW FALLS. 24. AT LEAST 20% OF ALL FALLS FOR EVERY TWO WEEKS WILL BE AUDITED TO DETERMINE IF FSI HAS BEEN COMPLETED. 25. DIRECTOR OF NURSING WILL PRESENT INFORMATION FOR REVIEWED EVERY MONTH DURING QAPI FOR 6 MONTHS TO DETERMINE IF SYSTEM IS WORKING.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 27	F 689		

early at 2:00 PM that day and rolling Resident #32 up to Nurses Station #1 as she was leaving. She stated she did not recall locking her wheelchair brakes but confirmed an in-service about it on 8/1/22.

An interview was completed on 8/10/22 at 8:20 AM with the Administrator. He stated the managers discussed any falls from the day/night before every Monday through Friday and discussed weekend falls on Mondays. He stated at that time, the Director of Nursing (DON) put interventions in place and the MDS Nurse revised the care plan. He stated the facility also reviewed resident falls during the Resident at Risk (RAR) monthly meeting and included the Director of Nursing, Nurse Managers, the MDS Nurse and himself. He stated the RAR meetings were weekly up until recently but offered no explanation as to why the weekly meetings were discontinued. The Administrator stated they were resuming the weekly RAR meetings weekly on 9/5/22. The Administrator was unable to answer how agency staff were educated about how to care for the residents, he stated he was not sure if there was any sort of orientation and deferred the question to the interim DON.

A telephone interview was completed on 8/10/22 at 9:30 AM with the previous DON. She stated her last day at the facility was 7/28/22. She stated all managers met Monday through Friday and discussed all resident falls. She stated the facility could not provide 24 hour/7 days a week supervision but they did the best they could. She stated staffing was a challenge but it was a challenge everywhere in healthcare.

An observation was completed on 8/10/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 28	F 689		

10:00 AM of Resident #32. She was in her room sitting up in a recliner. Observed was a large dark blue and purple discoloration to the entire left side of her forehead and around her left eye.

An interview was completed on 8/10/22 at 12:10 PM with Nurse #4. She stated Resident #9 was at Nursing Station #1 on 8/8/22 while she was charting. She stated she and other staff had to keep reminding Resident #32 to not lean forward but rather lean back in her wheelchair. Nurse #4 stated she continued charting when she heard a bump and found Resident #32 on the floor in front of her wheelchair. She stated her wheelchair brakes were not locked at the time of the fall and she sustained a bump to her left forehead. Nurse #4 stated she notified the hospice nurse and the Physician and orders were given to send her to the hospital for an evaluation. Nurse #4 stated she left for the day around 7:00 PM and did not receive Resident #32 when she returned from the hospital but was surprised at the bruising the next day.

An interview was completed on 8/10/22 at 12:16 PM with the PA. He stated he would like to know more details involving the circumstances prior to a resident fall for example what medications were administered prior or when was the last time the resident was toileting, etc. to identify a trend or pattern. The PA stated it seemed that the staff were in the resident's rooms too long and if there was only two aides on the floor and the nurse was passing medications, there was a lack of enough staff to oversee residents' safety.

An interview was completed on 8/10/22 at 1:20 PM with the Activity Director (AD). She stated once Resident #29 was up and after lunch, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 29	F 689		

was taken to the afternoon activities but she did not actively participate and would get fidgety and roll herself out of the activity.

A telephone interview was attempted on 8/10/22 at 2:15 PM with Resident #29's hospice nurse. There was no return telephone call.

An interview was completed on 8/10/22 at 2:30 PM with the Rehabilitation Manger (RM). She stated Resident #29 was a hospice resident and in order to evaluate and treat Resident #29, hospice would need to approve it and she stated that seldom if ever happened. The RM stated resident falls were discussed in the morning meeting and she would offer ideas or suggestions but she was not a part of the RAR meetings.

A telephone interview was completed on 8/10/22 at 4:55 PM with Resident #32's RP. She stated she was concerned about her falls and afraid a fall could result in a serious injury or worse for Resident #32. The RP stated she was not sure if the facility was doing all they could to monitor Resident #32 for safety.

An interview was completed on 8/10/22 at 5:04 PM with the interim DON. She stated the facility should resume the weekly RAR meetings to better identify the root cause of a fall and to help identify trends or patterns timely. She also stated it was her expectation that the facility identify the root cause for each fall and implement effective interventions to lessen the number of falls that had occurred with Resident #32.

2. Resident #29 was admitted on 8/10/21 with a diagnosis of Multiple Sclerosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 30	F 689		

Review of the significant change Minimum Data Set (MDS) dated 6/14/22 indicated Resident #29 had severe cognitive impairment was coded for no transfers out of bed during the 7 day look back period. She was coded as having no falls since prior MDS assessment.

Review of Resident #29's care plan for falls initiated 9/20/21 read she had an assisted fall on 7/7/22. The intervention read to remind staff to take extra time to ensure equipment was ready for a transfer.

Review of an incident report dated 7/7/22 at 8:45 PM read the aide was using the total body lift to transfer Resident #29 from her chair to the bed. When the aide attempted to put the lift sling under Resident #29 and secure the lift sling loops on the lift hooks, Resident #29 started to slide to the floor and was lowered to the floor. She did not sustain any injuries.

A telephone interview was completed on 8/10/22 12:10 PM with Nursing Assistant (NA) #2. She stated she was assigned Resident #29 on 7/7/22 at the time of her fall at 8:45 PM. NA #2 stated the evening of 7/7/22, there was only herself and one other aide working. NA #2 stated she was aware that when transferring a total body lift resident, two staff had to be present but because the facility was short staffed, she tried to transfer Resident #29 using the lift alone without any assistance. She stated when only two aides were working, it was impossible to have two staff present for every total body lift. NA #2 stated that since she began working at the facility in June 2022, Resident #29 was transferred using the total body lift. NA #2 stated there was a document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 31	F 689		

posted at Nurses Station (NS) #2 listing all the total body lift residents along with the correct sling size for each resident and Resident #29 was on that list. She stated the lift sling had been removed from underneath Resident #29 and she was attempting to get it under her and hook the sling to the lift but Resident #29 started to slide to so she eased her to the floor. She stated she was in-serviced at the time of the fall to have two staff present for a lift transfer.

A telephone interview was completed on 8/10/22 at 3:30 with Nurse #4. She stated she was working the evening of 7/7/22 when there was one aide for each end of the hall and she was busy in another resident's room. The call light was going off in Resident #29's room and when she entered, she saw Resident #29 on the floor. NA #2 stated she tried to transfer Resident #29 using the total body lift by herself. NA #2 reported Resident #29 slid from her chair while she was attempting to put the sling underneath her and she could not reach the hooks on the lift to fasten the sling loops and eased Resident #29 to the floor. Nurse #4 stated Resident #29 did not sustain any injuries and she had been a total body lift transfer since admission per her family request and due to her stiffness.

An interview was completed on 8/9/22 at 4:03 PM with NA #3. She stated due to Resident #29's muscle stiffness, she was difficult to transfer and required the use of a total body lift. NA #3 stated she thought Resident #29 had been a total body lift transfer since her admission. She further stated that there had to be two staff present when completing a total body lift transfer.

An interview was completed on 8/10/22 at 8:20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 32	F 689		

AM with the Administrator. He stated the managers discussed any falls from the day/night before every Monday through Friday and discussed weekend falls on Mondays. He stated at that time, the Director of Nursing (DON) put interventions in place and the MDS Nurse revised the care plan. He stated the facility also reviewed resident falls during the Resident at Risk (RAR) monthly meeting and included the Director of Nursing, Nurse Managers, the MDS Nurse and himself. He stated the RAR meetings were weekly up until recently but offered no explanation as to why the weekly meetings were discontinued. The Administrator stated they were resuming the weekly RAR meetings weekly on 9/5/22.

A telephone interview was completed on 8/10/22 at 9:30 AM with the previous DON. She stated her last day at the facility was 7/28/22. She stated all managers met Monday through Friday and discussed resident falls. She stated the facility could not provide 24 hour/7 days a week supervision but they did the best they could. She stated staffing was a challenge but it was a challenge everywhere in healthcare.

An interview was completed on 8/10/22 at 12:16 PM with the PA. He stated it seemed that the staff were in the resident's rooms too long and if there was only two aides on the floor and the nurse was passing medications, there was a lack of enough staff to oversee residents' safety.

An observation was completed on 8/10/22 at 1:30 PM with the interim Director of Nursing (DON). Located on the employee bulletin board in the breakroom at NS #2 was an undated document indicating Resident #29 used a total body lift for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 33	F 689		

transfers. The DON stated the document had been posted on the bulletin board for a least 6 months when the new slings came in so staff would know the correct sling size to use when transferring any total body lift resident. Resident #29's name appeared on the list as requiring a medium size sling. The interim DON also stated the electronic care guide was also utilized by the aides identifying the resident's lift status. Review of Resident #29's electronic care guide utilized by the aides read that Resident #29 was a Sit-to Stand lift ((lift designed to assist a resident who lacked the strength or muscle control to rise to the standing position) for all transfers on 11/19/21. The electronic care guide also read for the staff were to take extra time to ensure equipment was ready for a transfer as of 7/7/22.

An interview was completed on 8/10/22 at 5:04 PM with the interim Director of Nursing (DON). She stated it was her expectation that two staff assist with transferring any total body lift resident.

3. Resident #18 was originally admitted to the facility on 3/15/22 with multiple diagnoses including Alzheimer's disease and fracture of the left wrist.

The admission Minimum data Set (MDS) assessment dated 3/22/22 indicated that Resident #18 had severe cognitive impairment, was occasionally incontinent of bladder, and was always continent of bowel. The assessment also indicated that the resident was able to walk in the room with supervision/set up help only, she needed limited assistance with 1-person physical assist with transfers and she was using a wheelchair for mobility. The assessment further indicated that the resident had history of falls and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 34	F 689		

had a fracture related to a fall in the last 6 months prior to admission.

A fall risk assessment dated 4/9/22 was completed for Resident #18, and she scored 12. The assessment indicated that if the score was 10 or greater, the resident should be considered at high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.

Resident #18's incident reports and nurse's notes from 3/15/22 through 8/9/22 were reviewed. The reports/notes revealed that the resident had 5 falls at the facility.

The report/note dated 4/9/22 at 12:00 PM revealed that Resident #18 was observed sitting on the floor in front of a raised recliner with no injury noted. A family member stated that she slid out of the chair. The intervention to prevent further fall was to remind the resident to call for staff assistance for safety. The report did not include the root cause of the fall.

The report/note dated 4/23/22 at 4:45 AM revealed that Resident #18 was observed sitting on her buttocks on the floor near the bathroom with her left leg turned outwards. The resident stated that she needed to go to the bathroom. She was placed in wheelchair and was assisted to the bathroom and back to bed. The physician was notified, and x-ray of the left tibia and fibula was ordered, and the report was negative for fracture. The intervention was to educate the resident on proper footwear when ambulating. The report did not include the root cause of the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 35	F 689		

The report/note dated 4/30/22 at 6:40 AM revealed that Resident #18 was noted on the floor between the foot of the bed and the dresser. Her walker was tipped over on the right side of the bed. The resident stated, "I went to the bathroom and was getting back into bed". There was no injury noted from the fall. The intervention to prevent further falls was to provide frequent check for safety. The report did not include the root cause of the fall.

The report/note dated 6/4/22 at 7:15 AM revealed that Resident #18 was noted on the floor. A few drops of blood were noted on her nose. The intervention to prevent further fall was to continue to provide frequent reminders to use her call bell for staff assistance. The report did not include the root cause of the fall.

Nurse #1 was interviewed on 8/9/22 at 9:37 AM. She stated that she was assigned to Resident #18 when the resident had a fall on 6/4/22. The Nurse reported that when a resident had a fall an incident report was completed, the description of the fall, date, time, the location of the incident and type of injury, if any.

On 6/27/22, Resident #18 was discharged to an assisted living facility and on 7/26/22, she was readmitted to the facility with a diagnosis of intertrochanteric fracture of the right femur.

A fall risk assessment dated 7/29/22 was completed for Resident #18, and she scored 13. The assessment indicated that if the score was 10 or greater, the resident should be considered at high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 36	F 689		

The incident report dated 7/29/22 at 8:20 PM revealed that Resident #18 was observed in the room next door. She was on the floor in front of the bathroom. The resident stated that she was trying to go to the bathroom. The resident stated that her right hip was sore and that she had a "bad hip" and was patting on her right hip. The intervention to prevent further fall was "toileting schedule in place". The report did not include the root cause of the fall.

The admission MDS assessment dated 8/1/22 indicated that Resident #18 had severe cognitive impairment, was occasionally incontinent of bladder and was frequently incontinent of bowel. She needed extensive assist with transfers, ambulation in room occurred only once or twice with 1-person physical assist and she was using a walker and a wheelchair for mobility. She had a fall with no injury since admission, entry, reentry or prior assessment and had a fracture related to a fall in the last 6 months prior to admission.

Resident #18's care plan dated 8/1/22 for falls was reviewed. The care plan problem was "I am at risk for injury related to weakness, balance issues, needs for assistance with mobility and self-care and episodes of incontinence. I have very poor insights and judgment into my own deficits, and I receive medications that can make me dizzy". The goal was "my staff will attempt to reduce risk of falls related injury". The approaches included "staff will complete a fall risk assessment per facility protocol, staff will assist me during transfers from surface to surface as needed, staff will provide physical therapy and occupational therapy as ordered and to be offered toileting during rounds and as needed".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 689	Continued From page 37 Resident #18 was observed on 8/9/22 at 9:10 AM in bed with the door closed and on 8/10/22 at 10:01 AM up in a reclined chair in her room with the door closed. An interview was completed on 8/10/22 at 5:04 PM with the acting DON. She stated the facility should resume the weekly Resident At Risk (RAR) meetings to better identify the root cause of a fall and to help identify trends or patterns timely. She also stated it was her expectation that the facility identifies the root cause for each fall and implement effective interventions to lessen the number of falls. An interview was completed on 8/10/22 at 8:20 AM with the Administrator. He stated the managers discussed any falls from the day/night before every Monday through Friday and discussed weekend falls on Mondays. He stated at that time, the Director of Nursing (DON) put interventions in place and the MDS Nurse revised the care plan. He stated the facility also reviewed resident falls during the Resident at Risk (RAR) monthly meeting and included the Director of Nursing, Nurse Managers, the MDS Nurse and himself. He stated the RAR meetings were weekly up until recently but offered no explanation as to why the weekly meetings were discontinued. The Administrator stated they were resuming the weekly RAR meetings weekly on 9/5/22.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 690	Continued From page 38 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the urinary catheter tubing to prevent accidental removal for 1 of 3 sample residents reviewed for urinary catheters (Resident #5).	F 690	SAMPLE SET: #5 1. CLINICAL MANAGER PLACED ORDER ON 8/31/2022 TO CHECK RESIDENT #5□S STAT-LOCK BID.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 690	Continued From page 39 Findings included: Resident #5 was admitted to the facility on 8/17/20 with multiple diagnoses including obstructive uropathy. The significant Minimum Data Set (MDS) assessment dated 5/6/22 indicated that Resident #5 had severe cognitive impairment and she has an indwelling urinary catheter. Resident #5's care plan dated 5/27/22 was reviewed. The care plan problem was "I require use of indwelling urinary catheter related to history of obstructive uropathy". The goal was "I will remain free of complications related to use of catheter". The approaches included for the staff to monitor for signs/symptoms of complications related to catheter and notify the physician as needed. A nurse's note dated 8/2/22 at 2:55 PM revealed that during care, the nursing assistant (NA) notified the nurse that the resident's catheter was completely out, the resident was assessed, and no bleeding or signs of trauma noted. The note further indicated that a new catheter was inserted. The note was written by Nurse #2. When interviewed on 8/10/22 at 11:01 PM, the nurse stated that she did not remember the name of the NA who reported that Resident #5's urinary catheter was out on 8/2/22. She also reported that she could not remember if the catheter tubing was secured to the resident's thigh the day it was noted to be out. Resident #5 was observed in bed on 8/9/22 at 9:40 AM. The resident had an indwelling urinary	F 690	2. CLINICAL MANAGER PLACED ORDER IN TREATMENT ADMINISTRATOR RECORD FOR ALL LICENSED NURSES TO REVIEW ALL RESIDENTS WITH FOLEY CATHETERS AND ASSESS/CORRECT STAT LOCKS AS NEEDED. 8/31/2022 3. STAFF DEVELOPMENT COORDINATOR/RN SUPERVISOR TO IN-SERVICE ALL LICENSED NURSES OF THE IMPORTANCE TO HAVE A SECURE LOCK FOR ALL RESIDENTS WITH CATHETERS. 9/9/2022 ANY LICENSED NURSES NOT INSERVICED WILL BE TAKEN OFF THE SCHEDULE UNTIL INSERVICE IS COMPLETED. 4. CLINICAL MANAGER/DESIGNEE WILL AUDIT ALL RESIDENTS ON CATHETERS TO MAKE SURE THAT ALL SECURE LOCKS ARE INTACT.9/9/2022 5. CLINICAL MANAGER/DESIGNEE WILL AUDIT SECURE LOCK ON ALL RESIDENTS ON CATHETERS 1X WEEKLY FOR 4WEEKS THEN BIWEEKLY X□S 2 MONTHS THEN MONTHLY THEREAFTER. 6. DIRECTOR OF NURSING WILL REVIEW AUDIT FINDINGS IN WEEKLY RESIDENT AT RISK MEETING X4 WEEKS BY CLINICAL MANAGER/DESIGNEE. 7. CLINICAL MANAGER WILL PRESENT AUDIT FINDINGS TO QAPI COMMITTEE FOR EFFECTIVENESS OF PROCESS DURING MONTHLY QAPI MEETINGS X3 MONTHS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 690	Continued From page 40 catheter, and the catheter tubing was not secured to her thigh. Resident #5 was again observed on 8/10/22 at 10:45 AM with Nurse #1. The resident's catheter tubing was still not secured to her thigh. Nurse #1 was interviewed on 8/10/22 at 10:46 AM. The nurse stated that the NAs were responsible for providing catheter care to residents and to report to the nurse when the catheter tubing did not have a securement device. Nurse #1 indicated that nobody had informed her that Resident #5's urinary catheter did not have a securement device. The acting Director of Nursing (DON) was interviewed on 8/10/22 at 4:50 PM. The acting DON stated that she expected resident's catheter tubing to be secured at all times to prevent accidental removal.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §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- §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;	F 692		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 41 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview with the Registered Dietician (RD), Dietary Manager (DM), Physician Assistant (PA), resident and staff, the facility failed to address and to intervene when a resident was identified to have a weight loss (Residents #13,& #3) which resulted in continued weight loss and failed to provide a nutritional supplement on admission for a resident with history of weight loss and continued to lose weight (Resident #14). This was for 3 of 4 sampled residents reviewed for nutrition (Residents # 13, #3, #14). Findings included: 1. Resident # 13 was admitted to the facility on 5/13/22 with multiple diagnoses including dysphagia (difficulty swallowing food/liquids) and hemiplegia (partial paralysis on one side of the body) following cerebral infarction affecting the right dominant side. The admission Minimum Data Set (MDS) assessment dated 5/26/22 indicated that Resident #13 had severe cognitive impairment, was independent with eating and was on a mechanically altered diet. The assessment further indicated that the resident's weight was 189 pounds (lbs.).	F 692	SAMPLED SET :#3, #13,#14 1. RESIDENT #3 WAS DICHARGED FROM FACILITY ON 8/16/22. DURING THAT TIME PHYSICIAN ASSISTANT ASSESSED RESIDENT□S CONDITION PRIOR TO DISCHARGE. 2. #13 ON 8/18/2022: A SUPPLEMENT WAS ADDED BY THE DIETICIAN FOR RESIDENT #13 REGARDING WEIGHT LOSS AND PA ASSESSED RESIDENT WEIGHT ON 8/24/2022. ALSO, RESIDENT #13 WIEGHTS TO BE CHECKED TWICE WEEKLY ON 9/5/2022. 3. ORDER TO DO WIEGHT CHECKS ON RESIDENT #14 TWICE WEEKLY WAS STARTED ON 9/5/2022. PHYSICIAN ASSISTANT ASSESSED RESIDENT ON 8/8/2022, 8/15/2022, AND 8/22/2022 AND BY REGISTERED DIETCIAN ON 8/24/2022. ALSO PROSTAT WAS ORDERED ON 8/24/2022 FOR RESIDENT #14. 4. ALL RESIDENTS IDENTIFIED IN SAMPLE SET WILL BE WEIGHED TWICE WEEKLY BY NURSING STAFF/THERAPY STAFF. 5. CLINICAL MANAGER/RN SUPERVISOR/DON/SDC WILL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 42 Resident #13's care plan for nutrition dated 5/29/22 was reviewed. The care plan problem was "I am at risk for nutritional decline related to dysphagia from a stroke and on a dysphagia 1, puree consistency and nectar thick liquids". The goal was "I will tolerate diet as ordered with no complications and will maintain my weight within 5% of 189 lbs". The approaches included staff to monitor my weight as ordered and notify the physician and my family of any concerns, Registered Dietician (RD) will assess my weight and nutritional status as needed throughout my stay at the facility. Resident #18's weights were recorded as follows: 5/13/22 - 189 lbs. 6/10/22 - 154 lbs. 7/5/22 - 168 lbs. - 21 lbs. weight loss in 2 months 8/5/22 - 147 lbs. - 42 lbs. weight loss in 3 months (since admission) and 21 lbs. weight loss in 1 month. Review of the RD documentation revealed that Resident #13 was last assessed by the RD on 5/20/22. The RD note indicated that the "resident was on puree diet nectar thick liquids, and feeds self with set up help. His meal intakes were at 75% and has good appetite prior to admission. His current body weight was 188.9 lbs. Continue to monitor nutritional status, skin integrity, meal intakes and laboratory (labs) as available. Interventions/goals were for the resident to maintain current body weight +/- 5%, will maintain meal intake of more than 50% of all meals, will tolerate puree texture, nectar thick liquids, will monitor weights, intakes, labs and skin integrity". Review of the meal intake documentation for June, July and August 2022 revealed that some	F 692	IDENTIFY ALL RESIDENTS WITH WEIGHT LOSS AND HAVE THEM REVIEWED BY DIETICIAN -8/15/2022. 6. CLINCIAL MANAGER/RN SUPERVISOR WILL ADDRESS ANY WEIGHT LOSS TO INHOUSE MEDICAL GROUP WITHIN 72 HOURS WL FINDINGS. 7. NURSING STAFF TO BRING ALL RESIDENTS IDENTIFIED WITH WEIGHT LOSS TO DINING ROOM FOR SOCIALIZATION AND MEALS.- ASSISTANCE IF NECESSARY □ DURING LUNCH AND DINER. 8. CLINICAL MANAGER AND RN SUPERVISOR WILL COMMUNICATE WITH REHAB MANAGER TO EVALUATE FOR SPEECH AND OCCUPATIONAL THERAPY SERVICES TO ALL TRIGGERED FOR WEIGHT LOSS. 9. DIETICIAN TO REQUEST FORTIED MEALS FOR ALL RESIDENTS WITH WEIGHT LOSS. 10. STAFF DEVELOPMENT COORDINATOR/CLINICAL MANAGER/RN SUPERVISOR WILL EDUCATE ALL CNAs AND ON POINT OF CARE/KIOSK DATA ENTRY OF ADLs. MEMO WENT OUT ON 9/9/2022 AND AGAIN ON 9/13/2022. 11. DURING ADMISSION, RESIDENTS WILL BE WEIGHED THEIR FIRST 3 DAYS UPON ADMISSION BY NURSING STAFF/THERAPY TEAM AND THEN 1X WEEKLY UNTIL A PATTERN IS DEVELOPED THEN MONTHLY THERE AFTER. □ THIS WILL BE PLACED AS AN ADMISSION ORDER. 12. DIETICIAN TO PROVIDE ORDERS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 43 days there were no documentation of meal intake. There were no documentation for breakfast, lunch and dinner on 6/1/22, 6/3/22, 6/4/22, 6/5/22, 6/7/22, 6/8/22, 6/11/22, 6/12/22, 6/17/22, 6/18/22, 6/19/22, 6/24/22, 6/26/22, 6/28/22, 7/1/22, 7/2/22, 7/3/22, 7/9/22, 7/10/22, 7/12/22, 7/15/22, 7/16/22, 7/17/22, 7/22/22, 7/26/22, 7/28/22, 8/1/22 and 8/7/22. Resident #13 was observed on 8/8/22 at 12:40 PM with the Speech Therapist and on 8/10/22 at 12:30 PM. He was in his room eating lunch. He was served regular portion of puree diet with nectar thick liquids. He ate almost 100% of his food during each observation. The Dietary Manager was interviewed on 8/10/22 at 11:12AM. The DM stated that the RD has oversight of resident's weights and weight loss. The acting Director of Nursing (DON) was interviewed on 8/10/22 at 10:13 AM. The acting DON stated that residents were weighed monthly by nursing unless it was ordered differently. The weights were recorded electronically on the Medication Administration Records (MARs) and on the weight tracking form. She stated that nobody from nursing was responsible for monitoring/tracking weight loss/gain, however, the RD had access to the resident's weights recorded on the electronic records. The Physician Assistant (PA) was interviewed on 8/10/22 at 12:15 PM. The PA stated that he was never notified that Resident #13 had a significant weight loss. However, if nursing notified him of weight loss, he would normally refer the resident to the RD to assess and to intervene.	F 692	AND THEN HAVE THE NURSES PROCESS ANY UNSIGNED ORDERS VIA MATRIX CARE. A REPORT FOR ANY UNSIGNED ORDERS WILL BE REVIEWED BY THE NURSES TO ADDRESS ANY ORDERS FOR THE DIETICIAN THAT HAS BEEN CREATED. 13. STAFF DEVELOPMENT COORDINATOR/RN SUPERVISOR/CLINICAL MANAGER WILL INSERVICE ALL LICENSED NURSES ON HOW TO RETRIEVE UNSIGN ORDER REPORTS IN MATRIX CARE-ELECTRONIC HEALTH RECORD. NURSES NOT INSERVICED WILL BE TAKEN OFF THE SCHEDULE UNTIL INSERVICE IS COMPLETED. 9/9/2022. 14. STAFF DEVELOPMENT COORDINATOR/RN SUPERVISOR/CLINICAL MANAGER WILL INSERVICE ALL NURSING STAFF OF NEW WEIGHT LOSS PROCESS BY 9/9/2022. THOSE INDIVIDUALS NOT INSERVICED WILL BE TAKEN OFF THE SCHEDULE UNTIL INSERVICE IS COMPLETED. 15. THE UNSIGNED ORDER REPORTS WILL BE REVIEWED BY RN SUPERVISOR/CLINICAL MANAGER TO ASSURE ACCURACY OF ORDER SUBMISSION DURING DAILY CLINICAL MORNING MEETING. 9/9/2022 16. MEAL INTAKE DOCUMENTATION IN MATRIX CARE-EHR: NURSES WILL REVIEW MEAL INTAKE REPORT PRIOR TO END OF SHIFT TO MONITOR DOCUMENTATION IS IN PLACE FOR EACH RESIDENT. 17. NURSES WILL NOTIFY, C.N.As TO	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 44 The Nursing Aide (NA) #4, assigned to Resident #18 was interviewed on 8/10/22 at 3:25 PM. The NA stated that Resident #13 was confused and was able to feed himself. He has good appetite most of the time. She reported that the facility was short of staff, and she tried her best to provide the care and most of the time she did not have the time to document meal intakes. The RD was interviewed on 8/10/22 at 3:49 PM. The RD stated that she started working at the facility in February 2022. She came to the facility 2-3 times per week to see the residents and the rest of the week, she reviewed the residents remotely. She normally assessed residents with weight loss, new admission and quarterly. She reported that from 6/2/22 through 7/11/22, she had not been coming to the facility due to a medical reason, so she reviewed the residents remotely. She had access to the residents' weights electronically and was aware that Resident #13 had a significant weight loss from 189 lbs. in May 2022, 168 lbs. in July 2022 and 147 lbs. in August 2022. The RD reviewed her notes and stated that the last time she assessed Resident #13 was on 5/20/22. The RD did not have an explanation as to why she did not assess and intervene when she identified Resident #13 having a significant weight loss. 2. Resident #3 was admitted to the facility on 4/29/22 with multiple diagnoses including dysphagia (difficulty swallowing food/liquids) and hemiplegia (partial paralysis on one side of the body) following cerebral infarction. The admission Minimum Data Set (MDS) assessment dated 5/5/22 indicated that Resident	F 692	DOCUMENT IF THERE IS A RESIDENT RECORD THAT DOES NOT HAVE MEAL INTAKES. 18. AUDITING TOOL TO REVIEW MEAL INTAKE DOCUMENTATION BY CLINICAL MANAGER DAILY X8 WEEKS THEN WEEKLY FOR 4XS WEEKS THEN MONTHLY FOR 3 MONTHS. 19. ASSIGN CNAs OR DESIGNEES TO PASS SNACKS AND FLUID TO RESIDENTS AT THE HOURS FROM 10A AND 2:30P. 20. HAVE ACTIVITIES TEAM TO DOCUMENT OR LOG RESIDENTS IN THE ACTIVITIES WHO HAVE SNACKS. 21. CLINICAL MANAGER/RN SUPERVISOR/DESIGNEE WILL ASSIGN NURSING /THERAPY STAFF TO WEIGHT RESIDENTS AND TO BE CONSISTENT WITH USING ONE WEIGHT DEVICE. CLINICAL MANAGE DON/RN SUPERVISOR/SDC TO CREATE A WEIGHT LOG FORM AND WEIGHTS LOGGED AND SIGNED OFF BY THOSE DESIGNATED TO WEIGH RESIDENTS. 22. DON, CLINICAL MANAGER AND MDS COORDINATOR TO REVIEW WEIGHT LOG PRIOR TO SUBMISSION ON MATRIX CARE. 23. CLINICAL MANAGER/RN SUPERVISOR TO PRESENT ALL RESIDENTS AT RISK FOR WEIGHT LOSS DURING THE RESIDENT AT RISK MEETING HELD WEEKLY. 24. CLINICAL MANAGER/RN SUPERVISOR/DESIGNEE TO PRESENT AUDIT FINDINGS TO QAPI COMMITTEE TO DETERMINE IF PROCESS IS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 45 #3's cognition was intact, was independent with eating and was on a mechanically altered diet. The assessment further indicated that the resident's weight was 169 pounds (lbs.). Resident #3's care plan for nutrition dated 5/30/22 was reviewed. The care plan problem was "I am at risk for nutritional decline related to dysphagia diet and recent weight loss of 10 lbs.". The goal was "I will tolerate diet as ordered with no complications and will maintain my weight within 5% of my admission weight". The approaches included Registered Dietician (RD) will assess my weight and nutritional status as needed though out my stay at the facility. Resident #3's weights were recorded as follows: 4/29/22 - 169 lbs. 5/13/22 - 169 lbs. 6/5 - no recorded weigh 7/5/22 - 156 lbs. - 13 lbs. weight loss in 3 months (more than 7.5 % in 3 months) Review of the meal intake documentation for June, July and August 2022 revealed that some days there were no documentation of meal intake. There were no documentation for breakfast, lunch and dinner on 6/1/22, 6/2/22, 6/4/22, 6/5/22,6/6/22, 6/7/22, 6/8/22, 6/12/22, 6/17/22, 6/19/22, 6/24/22, 6/25/22, 6/26/22, 6/28/22, 7/1/22, 7/2/22, 7/9/22, 7/10/22, 7/15/22, 7/16/22, 7/17/22, 7/22/22, 7/23/22, 8/2/22, 8/5/22, 8/6/22, and 8/7/22. Review of the RD documentation revealed that Resident #3 was last assessed by the RD on 5/12/22. The note indicated that Resident #3 received mechanically altered diet with thin liquids, feeds self with set up help and his meal	F 692	EFFECTIVE DURING MONTHLY QAPI MEETINGS X6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 46	F 692		

intakes were 25-100%. Prostat (a protein supplement) 30 milliliter was added to provide additional 100 kilo calories, 15 grams of protein for wound healing. His admission weight was 169 lbs. Interventions/goals were for the resident to maintain current body weight of +/- 5%, will maintain meal intake of more than 50% of all meals, will tolerate mechanically altered diet with thin liquids. Will monitor weights, meal intakes, laboratory and skin integrity.

Resident #3 was observed on 8/8/22 at 12:37 PM and on 8/10/22 at 12:25 PM. He was in his room eating lunch. He was served regular portion of soft diet with thin liquids. He did not eat much of the food in his tray. When interviewed, he stated that he ate what he wants, and he had no appetite.

The Dietary Manager was interviewed on 8/10/22 at 11:12AM. The DM stated that the RD has oversight of resident's weights and weight loss.

The acting Director of Nursing (DON) was interviewed on 8/10/22 at 10:13 AM. The acting DON stated that residents were weighed monthly by nursing unless it was ordered differently. The weights were recorded electronically on the Medication Administration Records (MARs) and on the weight tracking form. She stated that nobody from nursing was responsible for monitoring/tracking weight loss/gain, however, the RD had access to the resident's weights recorded on the electronic records.
The DON stated that she was aware that Resident #3 had a missing weight in June 2022.

The Physician Assistant (PA) was interviewed on 8/10/22 at 12:15 PM. The PA stated that he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 47	F 692		

never notified that Resident #3 had a significant weight loss. However, if nursing notified him of weight loss, he would normally refer the resident to the RD to assess and to intervene.

The Nursing Aide (NA) assigned to Resident #3 was interviewed on 8/10/22 at 3:25 PM. The NA stated that Resident #3 was able to feed himself. He had poor appetite most of the time. She reported that the facility was short of staff, and she tried her best to provide the care and most of the time she did not have the time to document meal intakes.

The RD was interviewed on 8/10/22 at 3:49 PM. The RD stated that she started working at the facility in February 2022. She came to the facility 2-3 times per week to see the residents and the rest of the week, she reviewed the residents remotely. She normally assessed residents with weight loss, new admission and quarterly. She reported that from June 2 through July 11, 2022, she had not been coming to the facility due to a medical reason, so she reviewed the residents remotely. She had access to the residents' weights electronically and was aware that Resident #3 had a significant weight loss from 169 lbs. in April 2022 to 156 lbs. in July 2022. She reviewed her notes and stated that the last time she assessed Resident #3 was on 5/12/22. The RD did not have an explanation as to why she did not assess and intervene when she identified Resident #3 having a significant weight loss.

3. Resident #14 was admitted with palliative care on 5/24/22 with cumulative diagnosis of a pressure ulcer to her left heel and protein malnutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 48	F 692		

Her admission Minimum Data Set (MDS) dated 5/30/22 indicated Resident #14 had severe cognitive impairment, required extensive assistance with eating, a pressure ulcer and her height of 63 inches with her weight recorded as 120 pounds (lbs.). The MDS was coded as unknown for any weight loss or weight gain.

Resident #14 was care planned on 5/31/22 for a risk of a nutritional decline due to her poor appetite. Interventions included discussing her likes and dislikes, monitoring her weight and to notifying the Physician for any concerns. Interventions also included the Registered Dietitian (RD) would assess her weight and nutritional status as needed.

Review of Resident #14's August 2022 Physician orders included an order dated 5/24/22 for a nutritional drink three times daily due to weight loss but the order read it was not started until 6/29/22. Another order dated 7/20/22 was for a frozen nutritional supplement twice daily due to poor nutrition and the ordered read it was started on 7/20/22. She was also ordered a regular diet and not prescribed a diuretic.

Review of Resident #14's oral intake from 5/25/22 to 8/9/22 ranged from 0 to 100%. There was not any documented evidence of patterns for her meal refusals or zero consumption.

Review of Resident #14's most recent lab work dated 5/27/22 indicated her Albumin was low at 3.1.

Review of Resident #14's electronic medical record read her admission weight on 5/25/22 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 49	F 692		

116.4 lbs. Her following weights were as follows:
* 5/31/22 weight recorded at 109.8 lbs.
* 6/5/22 and 6/7/22 weight recorded at 110 lbs.
*7/5/22 weight recorded at 106.5 lbs.
* 8/5/22 weight recorded at 103.6 lbs.
This data revealed an 11% weight loss in the past 74 days (5/24/22 to 8/5/22).

Review of Resident #14's Physician/Physician Assistant (PA) notes revealed the following:
*6/21/22 Initial encounter-noted was a pressure ulcer to her left heel with no mention of her appetite or weight loss
*6/28/22 routine encounter-eating well
*7/5/22 routine encounter-eating well
*7/12/22 routine follow up encounter-resident was in the dining room eating well and feeding herself Cheerios
*7/18/22 routine follow up encounter-eating well and noted weight loss
*7/25/22 routine follow up encounter-eating well
*8/1/22 routine follow up encounter-eating well and noted weight loss.
*8/8/22 routine follow up encounter-in room drinking a protein drink. Eating well

Review of the comprehensive nutrition assessment completed by the RD and dated 5/31/22 read as follows:
*Resident #14 receives a consistent carbohydrate diet with regular textures and thin liquids. Poor appetite reported, noted intakes of 0 -50% for all meals per her seven day look back. Resident #14 received a nutritional drink three times daily to aid in meeting nutritional needs. She required assistance with most meals. Recent weight loss reported. Current body weight 116.4 lbs., body mass index 20.6 is low for her age.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 50	F 692		

Continues weekly weights. Unstageable pressure wound to her left heel. Will continue to monitor weights, labs, oral intake and nutritional status. The interventions goals read to maintain her current body weight +/- 5%, maintain oral intake of >50% at all meals and to continue to tolerate regular textures. Will continue to monitor weights, oral intakes, lab work, skin integrity through next review.

Review of the only other documented RD note dated 7/18/22 read as follow:

*RD visited Resident #14 due to weight loss. Current body weight was 106.5. Resident #14 on a consistent carbohydrate regular diet and a nutritional drink was ordered three times daily for weight loss. The Nurse in the room reported that Resident #14 did not eat well. Noted her oral intakes over 7 days varied from 0-100%. Recommend liberalizing diet to regular to provide more options and encourage oral intakes. Will continue to monitor oral intakes, weights and labs through the next review. There were no recommendations or evidence that the Physician or PA were notified of continued weight loss.

An observation and interview was completed on 8/8/22 at 12:25 PM. Resident #14 was in the dining room with Nursing Assistant (NA) #3 prompting her with lunch. NA #3 stated her appetite was poor and she was losing weight. She stated the staff try to get her up for all meals. She stated Resident #14 needed more staff assistance if she was eating in bed. NA #3 stated she normally ate 0 to 50% of all her meals but drink her nutritional drink if it was chocolate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 51	F 692		

An observation and interview was completed on 8/10/22 at 8:00 AM. Nurse #2 stated Resident #14's appetite was poor and she had lost weight since her admission but she ate 100% of her breakfast. Nurse #4 stated ate better when up in the dining room but Resident #14 was still in bed to allow for the observation of her wound care. Nurse #4 stated Resident #14 liked the chocolate nutritional drink and she ate better when she was served items that she could pick up to eat rather than eating with a fork or spoon. She stated Resident #14 liked to snack on Cheerios.

A review of Resident #14's electronic wound care provider notes also indicated healing to her left heel pressure ulcer.

An interview was completed on 8/10/22 at 8:20 AM with the Administrator. He stated previously the facility employed a full-time RD but the current RD started in February 2022 and only worked part-time. He stated the facility reviewed resident's with weight loss during the monthly Resident at Risk (RAR) meeting and included the Director of Nursing, Nurse Managers, the MDS Nurse and himself. He stated the RAR meetings were weekly up until recently but offered no explanation as to why the weekly meetings were discontinued.

An interview was completed on 8/10/22 at 12:16 PM with the PA. He stated any time a resident was admitted on palliative care, it was understood that the resident was expected to recover. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 52	F 692		

stated when a resident was admitted to hospice, the resident was not expected to recover. The PA stated since Resident #14 was on palliative care, it was expected that she would recover and return to her baseline. The PA stated the delay in implementing the nutritional drink may have impacted her weight loss. He stated he had not been notified on Resident #14's weight loss and he expected the RD to have identified her weight loss, notified him and implement interventions timely but apparently that did not happen.

A telephone interview was completed on 8/10/22 at 3:45 PM with the RD. She stated she started working part-time at the facility 2/28/22 and she was at the facility 2-3 times weekly. The RD stated she was out for surgery 6/2/22 through 7/11/22 but she worked remotely during that time. She stated she last saw Resident #14 on 7/18/22 and she was aware of her weight loss. The RD stated she did not notify the Physician or the PA about Resident #14's weight loss. The RD stated Resident #14 was prescribed a nutritional drink on admission 5/24/22 but she was not aware that the order was not implemented until 6/29/22. The RD stated she received a list of residents with MDS assessment due so she could complete her quarterly nutritional assessments. She stated she also completed a nutritional assessment for all new admissions and she reviewed all the residents weights monthly to see which residents were having weight loss.

An interview was completed on 8/10/22 at 5:04 PM with the interim Director of Nursing (DON). She stated apparently when Resident #14 was admitted on 5/24/22 with orders for a nutritional drink three times a day, the dietary department was not made aware or given a copy of the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 692	Continued From page 53 She stated it appeared as if someone realized this on 6/29/22 and notified the dietary department. The DON stated the RD was not able to write her own orders unless they were approved by the Physician or the PA. She stated the current RD was not involved in the IDT process and apparently did not communicate effectively with the facility regarding the residents with identified with undesired weight loss.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 725	Continued From page 54 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to provide sufficient nurse staff to ensure a resident got scheduled showers (Resident #15) and provide activities of daily living for dependent residents (Resident #15 and Resident #30). This affected 3 of 11 sampled residents. The findings included: This tag is cross-referenced to: 1. F561 Based on record reviews, observations, and interviews with residents and staff, the facility failed to provide scheduled showers for 1 of 2 (Resident #15) reviewed for choices. 2. F677 Based on record reviews, observations, and interviews with residents and staff, the facility failed to provide nail care for 2 of 2 (Residents #15, #30) reviewed for activities of daily living. On 8/10/2022 at 10:48 AM an interview was conducted with the scheduler. She stated she was covering scheduling since the previous scheduler had been out for several weeks. She further stated the facility had staffing challenges. The morning of 8/10/2022 several staff called out. She stated they sent out a message to all staff via email, text message, voicemail asking for assistance. They also pulled staff from other areas to assist with patient care. When asked about staffing on 8/10/2022 at 10:48 AM, she stated there were 2 nurses and 1 NA for 34 residents, but she was also a Nursing Assistant (NA) and was assisting on the hall. She felt the	F 725	1. FACILITY HIRED A RECRUITMENT AND RETENTION SPECIALIST EFFECTIVE 4/2022. 2. FACILITY HAS CONTRACTED WITH SEVERAL CONTRACT AGENCIES-A.A, E.S AND M.M. 3. FACILITY HAS INCREASED BY RATES ON MULTIPLE OCCASIONS SUCH AS 10/1, 1/31 AND 8/14. FACILITY IS PROVIDING COMPETIVE WAGES FOR NURSING STAFF COMPARED TO THOSE FACILITY IN THE COUNTY. 4. QUALITY INCENTIVES WILL BE PROVIDED TO DIRECT CARE STAFF $1 AN HOUR MORE AN HOUR BASED ON ATTENDANCE, PUNCTUALITY, AND PERFORMANCE EFFECTIVE SEPTEMBER 11TH. INCENTIVES WILL BE PROVIDED EACH PAY PERIOD. 5. SCHEDULER WILL PRESENT STAFFING SCHEDULE DURING CLINICAL MEETING AND ADDRESS ANY CALL OUTS. 6. SCHEDULER/CHARGE NURSE WILL NOTIFY DON AND ADMINISTRATOR WHEN CNAs ARE LOWER THEN 2 IN SKILLED NURSING. DEPARTMENTAL STAFF WILL ASSIST IN CARE WHEN CALL OUTS ARE MADE TO HELP ASSIST RESIDENTS. IF THERE ARE TWO STAFF THEN MEDICATION TECHNICIANS IN ALF WITH ASSIST WITH 30 MIN ROTATING ROUNDING UNTIL STAFFING PATTERN IS INCREASED TO 3. 7A. DON/SDC/RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 725	Continued From page 55 staffing challenges made it difficult but not impossible for staff to complete scheduled showers, nail care, and safely transfer residents. The Director of Nursing (DON) was interviewed 8/10/2022 at 8:39 AM she stated they have had staffing challenges. She stated today there was one NA on the floor so other nurses were called from other areas to assist. She did not believe current staffing challenges were contributing to accidents or preventing residents from getting showers and nail care.	F 725	SUPERVISOR/CLINICAL MANAGER TO EDUCATE STAFF OF STAFFING PROTOCOLS WHEN STAFFING NUMBERS DEVIATE FROM THE BUDGETED AMOUNT. 7B. SCHEDULES ARE GIVEN A MONTH IN ADVANCE TO ALL STAFF ALLOWING THEM TIME TO CHANGE THEIR TIMES IF NEEDED. 8. DON/RN SUPERVISOR/SCHEDULER TO AUDIT SCHEDULED AND RECONCILE TOTAL AMOUNT OF CNA's/NURSES ACTUALLY WORKED PER SHIFT. DAILY X4 WEEKS, WEEKLY X8 WEEKS, AND MONTHLY X3 9. DON/RN SUPERVISOR/SCHEDULER WILL PRESENT FINDINGS IN TOTHE QAPI COMMITTEE MONTHLY FOR EFFECTIVENESS WILL REVIEW MONTHLY X6.	
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 947	Continued From page 56	F 947		

and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure Nursing Assistants (NA) completed annual dementia care training and failed to ensure completions of annual abuse prevention training for 4 of 5 NAs (NAs #2, #6, #7, #9) reviewed for required annual in-service training.

The findings included:

NA #2 had a hire date of 6/10/2022. NA#2 did not have evidence of abuse prevention training or dementia care training.

NA#6 had a hire date of 9/14/2012. The NA's most recent dementia training was dated 3/21/2022 and there was no evidence of abuse prevention training in the last year.

NA #7 had a hire date of 7/29/2021. She completed abuse prevention training on 2/20/2022 but there was no evidence she completed abuse prevention training in the last year.

NA#9 had a hire date of 6/23/2022. There was no evidence she completed abuse prevention training or dementia care training.

08/10/22 08:39 AM an interview was conducted

1. HUMAN RESOURCE DIRECTOR TO ASSIGN ALL HEALTHCARE STAFF TO TAKE DEMENTIA AND ABUSE TRAINING VIA HEALTHCARE ACADEMY- WHICH IS AN ONLINE TRAINING SERVICE FOR OUR EMPLOYEES. TRAINING TO BE COMPLETED BY 9-9-2022.
2. EMPLOYEES THAT DID NOT COMPLETE THE TRAINING BY 9-9-2022 WILL NOT BE SCHEDULED TO WORK UNTIL TRAINING IS COMPLETED.
3. STAFF DEVELOPMENT COORDINATOR WILL AUDIT EMPLOYEE LIST AND RECONCILE THOSE EMPLOYEES WHO COMPLETED HEALTHCARE ACADEMY TRAINING VIA PRINTED VERFICATION FORM. 9/9/2022
4. STAFF DEVELOPMENT COORDINATOR WILL AUDIT ALL NEW EMPLOYEES WHO WILL BE REQUIRED TO COMPLETE THE ABUSE AND DEMENTIA TRAINING UPON HIRE AND PRIOR TO WORKING WITH HEALTHCARE RESIDENTS.
5. STAFF DEVELOPMENT COORDINATOR WILL AUDIT DAILY X8 WEEKS, WEEKLY X4 WEEKS AND MONTHLY 3 MONTHS. STARTING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 947	Continued From page 57 with the DON who was also the Staff Development Coordinator. She stated the facility was experiencing staffing challenges and the previous DON left in June. She accepted the position as Interim DON and was filling many roles. This took her focus away from staff development. She stated it was her expectation that staff complete annual training on dementia care and abuse prevention.	F 947	9/9/2022. 6. STAFF DEVELOPMENT COORDINATOR WILL PRESENT FINDINGS OF AUDITS TO QAPI COMMITTEE FOR EFFECTIVENESS OF PROCESS MONTHLY QAPI MEETINGS X6 MONTHS.	