Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
701012701	or definition	IDENTIFICATION NO.	A. BUILDING: _		30MI 2212B	
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE			
240.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ON, NC 27589	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPL	ETE
C 000	Initial Comments		C 000			
C 074	County Department of a complaint investigate focused Infection Corvisit's on October 26, and a desk review on October 30, 2020, and a telephone exit on Nocomplaint investigation Warren County Department of the County Depa	ntrol Survey with onsite 2020 and October 29, 2020 October 27-28, 2020, d November 2-4, 2020, and ovember 4, 2020. The on was initiated by the rtment of Social Services on	C 074			
C 074	10A NCAC 13G .0318 Furnishings	5(a)(1) Housekeeping and	C 074			
	10A NCAC 13G .0318 Furnishings (a) Each family care (1) have walls, ceiling coverings kept clean This Rule shall apply	home shall: is, and floors or floor				
	failed to ensure the flo leak in the ceiling in a a wall, the window co	as evidenced by: as and interviews, the facility coring in the dining room, a resident bedroom, a hole in verings, ceiling fans and kept clean and in good				
	room on 10/26/20 at 8 -There was a large te of the chairs at the di	ar in the linoleum under one				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	` '	
			A. BOILDING				
		FCL093012	B. WING		11/04/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPL	ĹETE	
C 074	curled up around the Interview with the me at 9:22am revealed: -The flooring under th been put down within -The foot of the chair was installed. Observation of the ce on 10/26/20 at 9:10ar -There was water dar one of the resident's l -There were two disco brown rings around th approximately 12 to 1 -The corner where the peeling from the ceilin of brown; the peeling about 12 to 14 inches Interview with a resid on 10/26/20 at 9:10ar -The ceiling had beer -Water had ran down Interview with a secon the room on 10/26/20 a recent storm the ce resident's bed had go Interview with a MA or revealed: -The leak in the ceilin monthsShe had told the Adr the Administrator had	B inches wide and was edges. dication aide (MA) 10/26/20 de dining room table had the last year. tore the flooring soon after it diling in a resident bedroom merevealed: mage on the ceiling above bed. bolored areas with dark nem; each area was 4 inches in diameter. de ceiling met the wall was neg and was various shades section of the ceiling was solong. The who resided in the room merevealed: The leaking all summer. The wall when it rained hard. The dresident who resided in the at 9:11am revealed during illing leaked and the otten wet. The modern of the ceiling was solong and the otten wet. The modern of the ceiling was solong.	C 074	DEFICIENCY)			
	had ran down the wal	vet when it leaked but water Il with the last storm.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74457 2744	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 074	Continued From page	2	C 074			
	Observation of a second/26/20 at 2:20pm re-There was a hole the resident's door, where every time the door we-There was a heating baseboard area of the was broken, and the was broken at the months." -The hole behind the since she moved inShe did not think the heat came from "som Observation of a third at 7:43am revealed: -There were two wind the windows did not he windows he window what on the window; he wo covered at nightThe wall had "been I what happened to the Based on observation determined the other interviewable.	ond resident room on evealed: e size of a softball behind the ethe door knob hit the wall was opened. unit mounted to the etwall; the heating unit cover wires were exposed. ent who resident in the room more revealed: facility for "about 10 door had been "that way" wall unit still worked, but ewhere" in the winter. It resident room on 10/26/20 lows facing the road; one of have a mini-blind or curtain It beside the bed had been et length of the bed. ent who resided in the room more revealed: at happened to the mini blind build like for the window to be like that" he did not know et paint. In and interviews, it was resident in the room was not				
	Observation of a third	I resident room on 10/20/20				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _		001111	
		FCL093012	B. WING		11/04	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
	OUR MARY OF		TON, NC 27589			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 074	Continued From page	e 3	C 074			
	at 1:20pm revealed a approximately 6 feet in and dirty.	n area on the wall in length that was scuffed,				
	wall in the den area o	return vent cover on the n 10/26/20 at 9:35am ng of dust on each of the				
	the wall in the hall are	ond air return vent cover on ea on 10/29/20 at 9:52am ng of dust on each of the				
	the resident's dining r	iling fan light fixture above oom table on 10/29/20 at hick coat of dust on each of				
	Nurse (RN) on 10/29/ -The facility was "dete were an ongoing cone -She looked at the fac and the needed repail -She had brought her	cility as the residents' home rs "bothered" her. concerns about the repairs Administrator because she				
	10/29/20 5:46pm reverble table just happed overble incoleum was represented the facility process and the facility process quarterly until the pandemic but canceled reduce the risk of CO-She was usually on the surface of the surface	um under the dining room or the last month. colaced about 4 months ago. corofessionally cleaned at e coronavirus (COVID-19) ed the cleaning service to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE S			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			RANKLIN STREE	,		
PIVOTAL	CARE		NTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
C 074	Continued From page	e 4	C 074			
	facility.					
	11/04/20 at 2:15pm re-She had a daily chec facility and the staff fe-The cleaning list was -She ensured the sta cleaning list showing unannouncedThe staff generally described the star -She walked around the but she may not have everything that was become she was not aware that have blinds or a curtary -She knew about a district inches in size on the because it happened september 2020The ceiling never lead belongings got wetShe called the landled-She had not looked	ck off list for cleaning at the collowed it. s posted in the office. Iff were following the up at the facility lid a good job of cleaning. If to inform her of repairs. Ithe facility when she visited the had time to notice oroken or needed repairs. Ithe resident's room did not the informal a window covering. It is colored area about 12 ceiling in a residents' room during a storm in the laked water and no one's				
C 076	10A NCAC 13G .031 Furnishings	5(a)(3) Housekeeping and	C 076			
		home shall: an and in good repair; to new and existing homes.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
			TON, NC 27589		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 076	Continued From page	e 5	C 076			
		ns and interviews, the facility ident's bed and dresser n good repair.				
	1:20pm revealed: -There was a box spr	dents room on 10/20/20 at ing and mattress sitting on				
		ained and the fabric on the				
	side of the box spring	was torn.				
		of the resident's room on evealed the resident's bed				
	floorThe resident's bed hashe had started working "somewhere around to	evealed: esident's bed was on the ad been on the floor since				
	room on 10/26/20 at 8 -His bed had been on frame broke "about a	the floor because the bed				
	10/26/20 at 7:43am re missing a drawer and	ond resident's room on evealed the dresser was d the resident's clothes were n area where the drawer				
	Interview with a residen	ent who resided in the room				

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on 10/26/20 at 7:36am revealed the missing

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREE ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE	
C 076	what happened to the Based on observation determined the other interviewable. Telephone interview was 11/03/20 at 2:16pm resident and resident's room every her if a drawer was manual to a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She expected the Manual was a soon as she found bed frame replaced. She indicate the she was a soon as she found bed frame replaced. She in she was not aware a soon as she found bed frame replaced. She in she was not aware a soon as she found bed frame replaced.	mates and he did not know a drawer. In and interviews, it was resident in the room was not with the Administrator on evealed: In a resident's drawer was resident's head the facility when she was did not have a check list or	C 076			
C 102	10A NCAC 13G .0317 Equipment	7 (a) Building Service	C 102			
	10A NCAC 13G .0317 Equipment	7 Building Service				
	mechanical, and plum	all fire safety, electrical, nbing equipment in a family aintained in a safe and				

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FOR DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,		(X3) DATE	
J. CONNECTION	DENTIFICATION NOINDER.	A. BUILDING: _		COIVIE	LLILD
	ECI 002042	B. WING		44	/0.4/2020
	FCL093012			11	/04/2020
ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CARE					
	WARREN	ITON, NC 27589			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	e 7	C 102			
Based on observation failed to ensure all elemaintained in a safe of to the light fixture in the bedroom not working sink, and the exhaust working. The findings are:	ns and interviews, the facility ectrical equipment was operating condition related ne kitchen and a resident; the drain in the kitchen fan on the stove not				
revealed: -The overhead ceiling bulb and the socket w -The exhaust fan for t -There was a sign on sink that read "do not sink overflow, dump it	light did not have a light vas exposed. the stove did not work. the cabinet door under the let the red bucket under the				
_	under the sink that was				
two-thirds full of wate	r.				
Observations of the men's bathroom on 10/26/20 at 8:38am and 9:03am revealed the toilet was clogged but was not overflowing.					
10/26/20 at 8:11am re -There was a bucket of because the drain leadShe emptied the bucket of the edge of the yardThe toilet in the men stopped up and was a sometimes would over	evealed: under the sink in the kitchen lked. lket about once a week at s bathroom would get slow to go down and erflow.				
	CARE SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I Continued From page This Rule is not met Based on observation failed to ensure all ele maintained in a safe of to the light fixture in th bedroom not working sink, and the exhaust working. The findings are: Observation of the kit revealed: -The overhead ceiling bulb and the socket w -The exhaust fan for t -There was a sign on sink that read "do not sink overflow, dump if high" -There was a bucket t two-thirds full of wate Observations of the n at 8:38am and 9:03ar clogged but was not of Interview with a media 10/26/20 at 8:11am re -There was a bucket t because the drain lead -She emptied the buck the edge of the yardThe toilet in the men stopped up and was a sometimes would over	FCL093012 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related to the light fixture in the kitchen and a resident bedroom not working; the drain in the kitchen sink, and the exhaust fan on the stove not working. The findings are: Observation of the kitchen on 10/26/20 at 8:10am revealed: -The overhead ceiling light did not have a light bulb and the socket was exposed. -The exhaust fan for the stove did not work. -There was a sign on the cabinet door under the sink that read "do not let the red bucket under the sink overflow, dump it when the water gets too high" -There was a bucket under the sink that was two-thirds full of water. Observations of the men's bathroom on 10/26/20 at 8:38am and 9:03am revealed the toilet was clogged but was not overflowing. Interview with a medication aide (MA) on 10/26/20 at 8:11am revealed: -There was a bucket under the sink in the kitchen because the drain leaked. -She emptied the bucket about once a week at	ROVIDER OR SUPPLIER TOTAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related to the light fixture in the kitchen and a resident bedroom not working; the drain in the kitchen sink, and the exhaust fan on the stove not working. The findings are: Observation of the kitchen on 10/26/20 at 8:10am revealed: -The overhead ceiling light did not have a light bulb and the socket was exposed. -The exhaust fan for the stove did not work. -There was a sign on the cabinet door under the sink that read "do not let the red bucket under the sink toverflow, dump it when the water gets too high" -There was a bucket under the sink that was two-thirds full of water. Observations of the men's bathroom on 10/26/20 at 8:38am and 9:03am revealed the toilet was clogged but was not overflowing. Interview with a medication aide (MA) on 10/26/20 at 8:11am revealed: -There was a bucket under the sink in the kitchen because the drain leaked. -She emptied the bucket about once a week at the edge of the yard. -The toilet in the men's bathroom would get stopped up and was slow to go down and sometimes would overflow.	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 C 102 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related to the light fixture in the kitchen and a resident bedroom not working; the frain in the kitchen sink, and the exhaust fan on the stove not working. The findings are: Observation of the kitchen on 10/26/20 at 8:10am revealed: -The exhaust fan for the stove did not work. -There was a sign on the cabinet door under the sink that read "do not let the red bucket under the sink that read "do not let the red bucket under the sink that read "do not let the was two-thirds full of water. Observations of the men's bathroom on 10/26/20 at 8:38am and 9:03am revealed the toilet was clogged but was not overflowing. Interview with a medication aide (MA) on 10/26/20 at 8:11am revealed: -There was a bucket under the sink in the kitchen because the drain leaked. -She emptied the bucket about once a week at the edge of the yard. -The toilet in the men's bathroom would get stopped up and was slow to go down and sometimes would overflow.	TOUR PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET MARRENTON, NC 27589 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PILL) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 From Page

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	OF DEFICIENCIES		(V2) MULTIPLE	CONSTRUCTION	(X3) DATE S	IDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		COMPLE	
			A. BUILDING: _			
			B. WING			
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DIVOTAL	CADE	303 W FR	ANKLIN STREE	:T		
PIVOTAL	CARE	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 102	Continued From page	e 8	C 102			
	had been working at the working at the facility -The exhaust fan on the at least a month. Interviews with another 8:08am and 8:37am in the overhead light in since she started worder -The exhaust fan ove Observation of a residual 10/26/20 at 9:03am in the reached up and turned ceiling fan with her had not some on 10/26/20 at 9:03am in the reached up and turned ceiling fan with her had not some on 10/26/20 at 9:03am in the reached up and turned ceiling fan with her had not some on 10/26/20 at 9:03am in the light on the ceiling at the light switch on a pull string to turn it on the light, they on and off.	the facility since she started the month before. The stove had not worked for er MA on 10/26/20 at revealed: In the kitchen had not worked king in September 2020. In the stove did not work. It is dent in her bedroom on everaled the resident and on the light bulb on the light bulb on the light swho resided in the 10:10 am revealed: In gran in their room worked the wall but there was not a				
	bulb to turn it on and -The light bulb would sometimes, but she h					
		een like that for a "long				
	the light worked the p	n 10/26/ at 9:22am revealed oull chain for the light was n was missing for about a				
	Nurse (RN) on 10/29/	with the facility's Registered /20 at 1:56pm revealed: n sink was leaking and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
			D. MINO			
		FCL093012	B. WING		11/	04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W FR	ANKLIN STREE	Т		
		WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 102	Continued From page	9	C 102			
	-She knew they overh not working. -She had reported he	nead light in the kitchen was r concerns about the Administrator but she felt				
	10/29/20 at 5:46pm re -The exhaust vent on since the last fire insp -The sink in the kitche was still leaking; she at 10/20/20She was usually on to check everything ever facility.	the stove had not worked bection about a year ago. In had been repaired but attempted to repair it on the stop of things, but she did not try time she was at the could with the distance she				
	11/04/20 at 2:15pm re-She did not know the rooms had to twist the turn the light on and or running. -There should have b to turn it on and off ar-She expected the stathat needed repairs. -She walked around t but she may not have everything that was b-The lights to the residure or off when she got the She thought the over worked; it just needed -She was not aware to not work at the light so not told her the lights.	e residents in one of the e light bulb with their hand to off but leave the ceiling fan een a pull chain on the light and still leave the fan running. It is inform her of things the facility when she visited thad time to notice roken or needed repairs. It is dents' rooms were either on here. Thead light in the kitchen dan ew light bulb. The overhead kitchen light did witch on the wall; staff had				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE FON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
C 102	Continued From page	: 10	C 102			
	in the kitchen because to see to work.	e the staff would not be able				
C 140	10A NCAC 13G .0405 Tuberculosis	5(a)(b) Test For	C 140			
	(a) Upon employment home, the administrate live-in non-residents is tuberculosis disease it measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services. Tuberculosis Mail Service Center, F. (b) There shall be do home that the administrany live-in non-reside	Test For Tuberculosis tor living in a family care for, all other staff and any shall be tested for n compliance with control the Commission for Health in 10A NCAC 41A .0205 amendments and editions. available at no charge by ment of Health and Human s Control Program, 1902 Raleigh, NC 27699-1902. cumentation on file in the strator, all other staff and ints are free of tuberculosis direct threat to the health or				
	This Rule is not met a TYPE B VIOLATION	as evidenced by:				
	facility failed to ensure C, D,) completed a tw	ews and interviews, the e 4 of 4 sampled staff (A, B, ro-step tuberculosis (TB) control measures adopted or Health Services.				
	The findings are:					
	(SIC), personnel reco -Staff A was hired on					

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 140	Continued From page	e 11	C 140			
	test administered on negative on 09/17/20 -There was documen	09/14/20 and read as tation Staff A had a second ered on 10/02/20 and read				
	and 2:00pm revealed -She was not sure ex working at the facilityShe had been provid Administrator and ins September 2020.	actly when she started , but that it was March 2020. led blank forms by the tructed to sign the forms in B skin test since she started				
	prior to June 2020Staff A worked 5:00p -Staff A worked 8:00a	ne sheets revealed: sheets provided for Staff A nm-7:00pm on 06/24/20. nm-5:00pm on 06/25/20. nm-5:00pm on 06/30/20.				
	10/21/2020 at 12:06p	with the Administrator on m revealed a contracted ne TB skin test for Staff A.				
	10/26/20 at 1:14pm re- -Staff TB skin tests w department or comple the facility. -Staff A came from an	with the Administrator on evealed: ere completed at the health eted by a nurse who went to nother facility, and she had ation on a TB skin test from				
	10/27/20 at 8:41am re	ins tests for the facility "a				

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	or periornoire		(VO) MULTIPLE	CONCEDUCTION	(V2) DATE CUDVEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL093012	B. WING		11/04/2020
NAME OF D	DOV/IDED OD OUDDUIED	OTDEET A	DDD500 01TV 0TA	TE 7/D 00DE	•
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	•	
PIVOTAL	CARE		RANKLIN STREE		
		WARREN	NTON, NC 27589		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	NEGOLATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	INATE
C 140	Continued From page	e 12	C 140		
	-She had to stop doin	ig the TB skin test because			
	she could no longer of				
	g				
	Second telephone int	erview with the contracted			
	nurse on 10/27/20 at				
	-She had not adminis	tered any TB skin tests in			
	2020.	•			
	-She did not know ho	w the facility had obtained a			
	form with her signatur	re on it.			
	-She did not administ	er a TB skin test to Staff A.			
	I	with the Administrator on			
	10/27/20 at 3:03pm re				
		g her staff to go out to do			
		of coronavirus (COVID-19)			
		d a named contracted nurse			
		minister staff TB skin tests.			
		ould not drive to the nurse's			
	office, so the nurse w				
		e would send her a copy of			
	the completed employ	yee IB skin tests.			
	2 Povious of Stoff Pla	, Supervisor-in-Charge			
	(SIC), personnel reco				
	-Staff B was hired on				
		tation Staff B had a TB skin			
	test administered on				
	negative on 09/16/20				
		tation Staff B had a second			
		ered on 10/05/20 and read			
	as negative on 10/08/				
	J = = : : 3, 00,				
	Interview with Staff B	on 10/26/20 at 8:08am			
	revealed she had not	had a TB skin test			
	administered in Septe	ember 2020 or October			
	2020.				
		with the Administrator on			
	10/21/2020 at 12:06p	m revealed a contracted			
	nurse administered a	TB skin test for Staff B.			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		FCL093012	B. WING		11/	04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
PIVOTAL	CARE	303 W FF	RANKLIN STREET			
TIVOTAL		WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 140	Continued From page	e 13	C 140			
	10/26/20 at 1:14pm re- The staff TB skin tes health department or went to the facility. She did not recall wh TB skins test but Staf had used Staff B's pre- Staff B had been out back at the facility for Telephone interview w 10/27/20 at 8:41am re- She had done TB sk while back" but did no- She had to stop doin she could no longer of Second telephone int nurse on 10/27/20 at She had not adminis 2020. She did not know hor form with her signatur She did not administ Telephone interview w 10/27/20 at 3:03pm re- She was not requirin TB skin test because pandemic, so she had go to the facility to ad She knew her staff w office, so the nurse w The contracted nurse the completed employ	ts were completed at the completed by a nurse who here Staff B had obtained her if B was a "rehire" and she evious information. I on leave and had been "about one month." with the contracted nurse on evealed: ins tests for the facility "a bit recall the date. If the the test because obtain the serum. erview with the contracted 10:38am revealed: tered any TB skin tests in with the facility had obtained a re on it. er a TB skin test to Staff B. with the Administrator on evealed: g her staff to go out to do of coronavirus (COVID-19) da named contracted nurse minister staff TB skin tests. yould not drive to the nurse's ent to the facility. e would send her a copy of yee TB skin tests.				
	3. Review of Staff C's (SIC), personnel reco	s, Supervisor-in-Charge ord revealed:				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		FCL093012	B. WING		11	1/04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE	303 W F	RANKLIN STREET			
FIVOIAL	OAKE	WARRE	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 140	-Staff C was hired on -There was documer test administered on negative on 09/04/20 -There was documer TB skin test administ as negative on 09/23 Telephone interview 10/21/2020 at 12:06g nurse administered at 10/26/20 at 1:14pm r -The staff TB skin test health department or went to the facilityShe did not know whis TB test; "I do not because he came from the staff C revealed: -He had not had a TE facility because he waserum; he had a chearth and the serum; he had a chearth and the serum of the se	ntation Staff C had a TB skin 09/01/20 and read as 0. Intation Staff C had a second tered on 09/21/20 and read 3/20. with the Administrator on om revealed a contracted a TB skin test for Staff C. In with the Administrator on revealed: It is series were completed at the recompleted by a nurse who of the staff C had completed know much about him own another county. In another county. In a skin test completed at the reas allergic to the TB skin test st x-ray completed. It is a skin test completed at the reas allergic to the TB skin test st x-ray completed. It is a skin test completed at the reas allergic to the TB skin test st x-ray completed. It is a skin test completed at the reas allergic to the TB skin test st x-ray completed. It is a skin test completed at the reas allergic to the TB skin test st x-ray but sopy of the results of the skin test completed. It is a skin test completed at the reas allergic to the TB skin test st x-ray but sopy of the results of the skin test st x-ray but sopy of the results of the skin test st x-ray but sopy of the results of the skin test st x-ray but sopy of the results of the skin test st x-ray but sopy of the results of the skin test st x-ray but sopy of the results of the skin test x-ray but sopy of the results of the skin test x-ray but sopy of the results of the skin test x-ray but so x-ray but so x-ray but x-ray bu	C 140	DEFICIENC		

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		NKLIN STREE ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 140	Continued From page	e 15	C 140		
	Second telephone int nurse on 10/27/20 at -She had not adminis 2020She did not know ho form with her signature. She did not administ Telephone interview w 10/27/20 at 3:03pm re-She was not requirin TB skin test because pandemic, so she had go to the facility to ad-She knew her staff w office, so the nurse we-The contracted nurse the completed employ 4. Review of the facility revealed Staff D did not linterview with Staff D revealed: -She worked at the faftrom Friday at 5:00pm -She was a medication-She started working weekend in Septembor Telephone interview w 12:04pm revealed: -She had not had a T she began working at	erview with the contracted 10:38am revealed: tered any TB skin tests in w the facility had obtained a re on it. er a TB skin test to Staff C. with the Administrator on evealed: g her staff to go out to do of coronavirus (COVID-19) d a named contracted nurse minister staff TB skin tests. yould not drive to the nurse's ent to the facility. e would send her a copy of yee TB skin tests. ty's personnel records not have a personnel record. on 10/26/20 at 7:34am or incility every other weekend or until Monday at 8:00am. On aide. at the facility the first er 2020. with Staff D on 11/04/20 at B skin test completed since in the facility. er to provide a copy of any			
	•	vith the Administrator on			

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
DIVOTAL	CADE	303 W FF	RANKLIN STREE	т		
PIVOTAL	CARE	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 140	Continued From page	e 16	C 140			
	Staff D was "just fillin-Staff D was a "fill-in" facility." -Staff D had been a lepeer's facility and had peer's facilityShe was sure the peall state required pap. The facility failed to esting completed up residents at increase tuberculosis disease.	ong-term employee at the da personnel record at the eer's facility had completed between the erwork on Staff D. ensure all staff had TB skin on hire, which placed the drisk for exposure to the facility's failure was alth, safety, and welfare of				
C 145	accordance with G.S this violation. CORRECTION DATE VIOLATION SHALL N 19, 2020. 10A NCAC 13G .040 Qualifications 10A NCAC 13G .040 (a) Each staff person shall: (5) have no substant	6(a)(5) Other Staff 6 Other Staff Qualifications of a family care home tiated findings listed on the Care Personnel Registry 1E-256;	C 145			
	Based on interviews,	as evidenced by: and record reviews, the re 2 of 4 sampled staff (Staff				

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Division (of Health Service Regu	lation			,	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET			
	T		NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 145	Continued From page	e 17	C 145			
		bstantiated findings on the n Care Personnel Registry				
	The findings are:					
	(SIC), personnel reco-Staff A was hired on -There was documen Personnel Registry (H 09/14/20There was no documbeing completed whe June 2020. Interview with a Staff and 2:00pm revealed -She was not sure exworking at the facilityShe had been provid Administrator and ins September 2020.	09/23/20. tation of a Health Care HCPR) check dated nentation of a HCPR check n Staff A began working in A on 10/26/20 at 10:30am				
	prior to June 2020Staff A worked 5:00p -Staff A worked 8:00a -Staff A worked 8:00a Review of the month! September 2020 and	sheets provided for Staff A om-7:00pm on 06/24/20. om-5:00pm on 06/25/20. om-5:00pm on 06/30/20. oy staffing schedule for October 2020 revealed: om-5:00pm on Tuesdays and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
,		15211111107111011152111	A. BUILDING: _		33 2.	
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 145	revealed Staff A work hours per day. Review of Staff A's tir 2020 revealed Staff A to thirteen hours per of the thirteen hours per of the thirteen hours per day. Review of Staff A's tir revealed Staff A work twelve hours per day. Telephone interview work thirteen hours per day. Telephone interview work thirteen hours per day. Telephone interview work thirteen hours and the work of the time, because show the working out. An employee quit in had to bring Staff A on when she completed. Review of the facility revealed Staff D did not the thirteen hours work the paperwork had been began working at the thirteen hours interview work the thirteen hours working at the thirteen hours working at the thirteen hours working at the thirteen hours per day.	ne sheet for August 2020 ed 10 days for six to twelve ne sheet for September a worked 16 days for seven day. ne sheet for October 2020 ed 13 days for seven to with the Administrator on king one day a week when king for the facility." she did a HCPR on Staff A at the was not sure Staff A would September 2020 and she in full time and that was a HCPR check on Staff A. ty's personnel records to thave a personnel record. with Staff D on 11/04/20 at the did not know what completed on her since she facility.	C 145	DEFICIENCY)		
	Staff D was "just filling -Staff D was a "fill-in" facility." -Staff D had been a lo					

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DIVISION	n nealth Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL093012	B. WING		11/04/2020	
	20,4252 02 0422452	0.70-5-1	DDD500 01TV 0T4	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	SIREETA	DDRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W F	RANKLIN STREE	ET		
	57 ti (2	WARREI	NTON, NC 27589			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
C 145	Cantinual Framera	- 10	C 145			
C 143	Continued From page	9 19	0 145			
	-She was sure the pe	er's facility had completed				
	all state required paper	•				
	an state is quite pup					
0.44=			0.44=			
C 147	10A NCAC 13G .0406	S(a)(7) Other Staff	C 147			
	Qualifications					
		6 Other Staff Qualifications				
	(a) Each staff person	of a family care home				
	shall:					
	(7) have a criminal ba	ackground check in				
	accordance with G.S.					
	131D-40;					
	1015 10,					
	This Rule is not met	as avidanced by:				
		ews and interviews, the				
	-	e 2 of 4 sampled staff, (Staff				
		ninal background check				
	completed upon hire.					
	The findings are:					
	 Review of Staff A's 	, Supervisor-in-Charge				
	(SIC), personnel reco	rd revealed:				
	-Staff A was hired on					
	-There was documen	tation of a criminal				
	background check da					
	-There was no docum					
		ing completed when Staff A				
	began working in Jun					
	began working in Jun	e 2020.				
	Interview with a Stoff	A on 10/26/20 at 10:30am				
	and 2:00pm revealed					
		actly when she started				
		, but that it was March 2020.				
		led blank forms by the				
		tructed to sign the forms in				
	September 2020.					
	-She did not know if a	a criminal background check				
	had been completed					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PIVOTAL CARE STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) C 147 C 147 C Ontinued From page 20 Working at the facility. Review of Staff A's time sheets revealed: There were no time sheets revealed:	STATEMENT OF DEFICIE AND PLAN OF CORREC
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROVIDER'S PLAN OF CORRECTION WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 147 Continued From page 20 Working at the facility. Review of Staff A's time sheets revealed:	
PIVOTAL CARE Continued From page 20 Review of Staff A's time sheets revealed: Sum ARRENTO S	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 147 Continued From page 20 C 147 working at the facility. Review of Staff A's time sheets revealed:	NAME OF PROVIDER OF
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE DEFICIENCY) CONFLICTION SHOULD BE COMPLIANCE DEFICIENCY) COMPLIANCE DEFICIENCY COMPLIANCE DEFICIENCY COMPLIANCE DEFICIENCY ACTION SHOULD BE COMPLIANCE DEFICIENCY COMPLIANCE DEFICIENCY ACTION SHOULD BE COMPLIANCE DEFICIENCY COMPLIANCE DEFICIENCY ACTION SHOULD BE COMPLIANCE DEFICIENCY COMPLIANCE DEFICIENCY	PIVOTAL CARE
working at the facility. Review of Staff A's time sheets revealed:	PREFIX (E
-There were no time sheets provided for Staff A prior to June 2020Staff A worked 5:00pm-7:00pm on 06/24/20Staff A worked 8:00am-5:00pm on 06/25/20Staff A worked 8:00am-5:00pm on 06/26/20Staff A worked 8:00am-5:00pm on 06/30/20. Telephone interview with the Administrator on 11/04/20 revealed: -Staff A was only working one day a week when she "first started working for the facility." -She was not sure if she did a background check on Staff A at that time, because she was not sure Staff A would be working outAn employee quit in September 2020 and she had to bring Staff A on full time and that was when she completed a criminal background check on Staff A. 2. Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 11/04/20 at 12:04pm revealed she did not know what had been completed on her since she began working at the facility. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -Staff D did not have a personnel record because Staff D was "just filing it." -Staff D was "gist filing it." -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility, and had a personnel record at the peer's facility and had a personnel record at the peer's facility.	working Review -There was prior to was prior

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		EQ1 000040	B. WING		44/04/0000	
NAME OF P	ROVIDER OR SUPPLIER	FCL093012	RESS, CITY, STA	TE ZIP CODE	11/04/2020	
PIVOTAL			NKLIN STREE	,		
FIVOIAL	Г		ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE
C 176	staff person on the procompleted within the cardio-pulmonary resimanagement, including provided by the American Red Cross, American Safety and First Aid, or by a train certification as a train from one of these orgiperson on site has be incapable of performil licensed physician, the training. This Rule is not met TYPE B VIOLATION Based on observation reviews, the facility fastaff person was on the had completed a cour resuscitation (CPR) a including the Heimlich 24 months for 3 of 4 staff and Staff D). The findings are: 1.Review of Staff A's, personnel record reversity of the staff A was hired on the staff A was hired on the staff A was hired on the staff and the staff A was hired on	Training on suscitation Training on suscitation Training on suscitation Training on suscitation The shall have at least one semises at all times who has last 24 months a course on suscitation and choking ing the Heimlich maneuver, sican Heart Association, National Safety Council, Health Institute and Medic ser with documented er on these procedures anizations. If the only staff sen deemed physically ing these procedures by a lat person is exempt from The service on cardio-pulmonary ind choking management, in maneuver, within the last sampled staff (Staff A, Staff) Supervisor-in-Charge (SIC), saled: 09/23/20. a CPR card dated 09/19/20	C 176			

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DIVISION	n nealth Service Negu	lation	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL093012	B. WING		11/04/2020	1
	20,4252 02 0422452	0.70.57.45	DD500 0171/ 074	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
TIVOTAL	OAKE	WARREN	TON, NC 27589			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X:	5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	,	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DA	TE.
				DEFICIENCY)		
0.470	0 " 15	00	C 176			
C 176	Continued From page	22	C 176			
	Observation on 10/29	0/20 at 9:48am revealed				
		nts were the only individuals				
		nts were the only individuals				
	at the facility.					
		A 40/00/00 1.40.00				
		A on 10/26/20 at 10:30am				
	and 2:00pm revealed					
		actly when she started				
	working at the facility,	, but that it was March 2020.				
	-She had been provid	led blank forms by the				
	Administrator and ins	tructed to sign the forms in				
	September 2020.	ŭ				
	•	cond shift medication aide				
		(she did not recall the date)				
	for a "couple of hours					
	=					
		he was the only staff at the				
	facility.					
	-Her previous employ	ment had been in				
	housekeeping.					
		PR class since she started				
	working at this facility					
	-She had never taken	ı a CPR class.				
	-She had not provided	d a copy of a CPR card to				
	the Administrator.					
	Review of Staff A's tin	ne sheets revealed:				
		sheets provided for Staff A				
	prior to June 2020.	one of the contract of the con				
	•	m-7:00pm on 06/24/20.				
		m-5:00pm on 06/25/20.				
	-Staπ A worked 8:00a	m-5:00pm on 06/30/20.				
		y staffing schedule for				
		October 2020 revealed:				
	-Staff A worked 8:00a	m-5:00pm on Tuesdays and				
	Thursdays.					
	-Staff A worked every	other Sunday from				
	8:00pm-8:00am.	•				
	•	sheduled on the dates Staff				

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A worked.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREET TON, NC 27589	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 176	Continued From page	23	C 176			
	revealed Staff A work hours per day.	ne sheet for August 2020 ed 10 days for six to twelve				
		ne sheet for September worked 16 days for seven day.				
		ne sheet for October 2020 ed 13 days for seven to				
	September 2020, and	e sheets for August 2020, l October 2020, revealed worked on scheduled shifts.				
	10/26/20 at 1:14pm re- -She was responsible -All staff had CPR trai working at the facility CPR cards to her.	with the Administrator on evealed: for personnel records. ining before they began and provided a copy of their ff A's personnel record was				
	the organization listed 10/27/20 at 8:30am re- The CPR card provide Staff A was not register. All valid CPR cards we CPR was completed we CPR cards could only approved course had she did not have any completed CPR training organization.	led by the Administrator on ered with their organization. would be registered when with an approved trainer. y be obtained once an been completed. y information Staff A hading through their				
	Interview with the faci	lity's contracted CPR				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE	303 W F	RANKLIN STREET			
		WARREI	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 176	instructor on 10/29/20 -She had not conduct the Administrator sinc -She did not have a re instruction for Staff AThe certification num issued by the America completion of the coa through the ARC; the name of the card hold numberIf the certification num valid the ARC would re name on the card. 2. Review of Staff B's (SIC), personnel reco -Staff A was hired on -There was a copy of with an expiration dat Observation on 10/26 Staff B and six reside at the facility. Interview with Staff B revealed: -She started to work a	at 11:22am revealed: ded any CPR instruction for de 12/30/19. decord of providing CPR deber on the CPR cards an Red Cross (ARC) upon derse and could be verified ARC could provide the der through the certification der through the certification der through the reference the der through the card was not der	C 176			
	card, and she had no CPR card to the Adm -She had not taken a started working at this	er for a copy of her CPR t provided a copy of her inistrator. CPR class since she s facility.				
		6/20 at 9:34am revealed nts were the only individuals				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
C 176	at the facility. Review of the monthly September 2020 and -Staff B worked 8:00a Wednesdays and Fric -Staff B worked every 8:00am-8:00pmNo other staff was so B worked. Review of Staff B's tir 2020 revealed: -Staff B worked 8:00a-Staff B worked five d Review of Staff B's tir revealed Staff B work twelve hours per day. Review of all staff tim September 2020, and one medication aide with the september 2020, and one medicati	y staffing schedule for October 2020 revealed: am-5:00pm on Mondays, days. y other Sunday from cheduled on the dates Staff me sheet for September am-8:00pm on 09/20/20. lays for nine hours per day. me sheet for October 2020 ded 14 days for three to de sheets for August 2020, ded October 2020, revealed worked on scheduled shifts. with the Administrator on evealed: de for personnel records. ining before they began and provided a copy of their off B's personnel record was with a representative from d on Staff B's CPR card on evealed: ded by the Administrator on dered with their organization.	C 176	DEFICIENCY)	
		would be registered when with an approved trainer.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. 201221110.			
		FCL093012	B. WING		11/04	/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 176	approved course had -She did not have any completed CPR traini organization. Interview with the faci instructor on 10/29/20 -She had not conduct the Administrator sinc -She did not have a reinstruction for Staff BThe certification numissued by the America completion of the coat through the ARC; the name of the card hold numberIf the certification nurvalid the ARC would reame on the card. 3. Review of the facil revealed Staff D did revealed Staff D did revealed Staff D did revealed: -She worked from 5:00 on Monday; she did the weekendShe started working weekend in September 10/26 training the started working weekend in September 10/26 training the started working weekend in September 10/26 training train	y be obtained once an been completed. y information Staff B had ng through their lity's contracted CPR of at 11:22am revealed: ged any CPR instruction for the 12/30/19. gecord of providing CPR of the CPR cards and Red Cross (ARC) upon are and could be verified ARC could provide the der through the certification on the card was not not be able to reference the lity's personnel records to thave a personnel record. In the could provide the lity's personnel records that a personnel record of the lity's personnel record. In the could provide the lity's personnel records that a personnel record of the lity's personnel record. In the could provide the lity's personnel record of the lity's personnel record of the lity's personnel record. In the could provide the lity's personnel record of the lity'	C 176			
		n expired in September				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		FCL093012	B. WING		1	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
C 176	2019She had not renewe not have the money to she had not provide the Administrator. Review of the month! September 2020 and -Staff D worked every 5:00pm on Friday under No other staff was son D worked. Review of Staff D's till 2020 revealed Staff A until 8:00am on 09/28. Review of all staff time September 2020, and one medication aide of the staff D did not have a available to review. Telephone interview of 10/26/20 at 1:14pm results -She was responsible -Staff D did not have Staff D was "just filling-staff D was a "fill-in" facility." -Staff D had been a lepeer's facility and had peer's facility. The facility failed to express the person was on the precompleted a course in resuscitation (CPR) and the person was on the precompleted a course in resuscitation (CPR) and the person was on the precompleted a course in resuscitation (CPR) and the person was on the precompleted a course in resuscitation (CPR) and the precompleted a course in the precompleted a course in the precompleted a course in the precompleted a cours	d her CPR because she did to take a CPR class. d a copy of her CPR card to by staffing schedule for October 2020 revealed: y other weekend from til 8:00am on Monday. The cheduled on the dates Staff by worked 09/25/20 at 5:00pm 3/20. The sheets for August 2020, d October 2020, revealed worked on scheduled shifts. The Administrator on evealed: a personnel records. The apersonnel records a personnel record because g it." The who worked at a "peer's bong-term employee at the da personnel record at the ensure at least one staff remises at all times who had	C 176			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D MINO		
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI		
PIVOTAL	CARE		RANKLIN STREET ITON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICENCY)	ULD BE COMPLETE
C 176	Continued From page	÷ 28	C 176		
	choking management harm and was detrime	CPR certification and placed the residents at ental to the health, safety, sidents and constitutes a			
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 10/28/20 for			
		DATE FOR THE TYPE B IOT EXCEED DECEMBER			
C 185	10A NCAC 13G .060° Staff	1(a) Management and Other	C 185		
	Staff (a) A family care hom responsible for the tothome and shall also be Division of Health Sercounty department of and maintaining the return The co-administrator, share equal responsible for the operation of the	rvice Regulation and the social services for meeting ules of this Subchapter. when there is one, shall bility with the administrator e home and for meeting ules of this Subchapter.			
	This Rule is not met a TYPE A1 VIOLATION				
	Based on observation	ns, interviews, and record			

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DIVISION	n Health Service Negu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING			
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			ANKLIN STREE			
PIVOTAL	CARE					
		WARREN	TON, NC 27589			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE	BATE
			+	,		
C 185	Continued From page	e 29	C 185			
	•	trator failed to assure the				
	-	facility to meet and maintain				
		ion prevention and control				
	program related to Co					
	administration, health	n care, training on				
	cardio-pulmonary res					
	tuberculosis, adult ca	re home medication aide				
	training and compete	ncy evaluation				
	requirements, housel	keeping and furnishing,				
	building service equip	oment, orders for				
	self-administration of	medication, and staff				
	qualifications.					
	•					
	The findings are:					
	J					
	Interview with a resid	ent on 10/26/20 at 2:22pm				
	revealed:					
	-The Administrator wa	as at the facility once a				
	month.	,				
	-She wished the Adm	ninistrator was at the facility				
		ministrator could see what				
	was going on in the fa					
		ninistrator to see "how the				
		se the other residents were				
	always asking for thin					
	g	.9				
	Interview with a medi	ication aide (MA) on				
	10/26/20 at 8:37am re	, ,				
		as at the facility once a				
	month.	as at the facility office a				
		as usually at the facility on				
		and stayed "about 3-hours."				
		e Administrator at the facility				
	in October 2020.	C Administrator at the lability				
	III OCIODEI 2020.					
	Intorvious with another	er resident on 10/29/2020 at				
		ri resident on 10/29/2020 at				
	5:48pm revealed:	Managan (DOM) baabbaan				
		Manager (BOM) had been				
	to the facility a couple					
	- ine BOM was at the	e facility about an hour, every				

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	or riealth Service Regu						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		' '	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED	
		FCL093012	B. WING		11/	04/2020	
			L		1 117		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
PIVOTAL (CARE	303 W FR	ANKLIN STREE	ĒΤ			
		WARREN	TON, NC 27589)			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETE DATE	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	KOFKIATE	5/112	
C 185	Continued From page	e 30	C 185				
	other month.						
		as at the facility the 6th of					
	every month and stay						
	every month and stay	ed about an nour.					
	Telephone interview v	vith the facility's nurse (RN)					
	on 10/29/20 at 1:16pr	. ,					
	-	there were not supervision					
		the day to day operations of					
	the facility were comp						
		here was an Administrator					
	and as the RN she co						
	boundaries.	·					
	-She had told the Adn	ninistrator, the Administrator					
	should be at the facili	ty weekly: "I had told her					
	that early on."						
	-She did not get a res	sponse like, "I am going to					
	try or anything."						
	-The Administrator ne	eded to be at the facility					
	once a week.						
		vith the Administrator on					
	10/27/20 at 12:30pm						
		r [Business Office Manager					
	(BOM)] was responsi						
	because the BOM ha						
	-She handled billing,						
	• •	nt to the facility once a					
	month.						
	Telephone intonvious	with the Administrator on					
	10/29/20 at 6:30pm re	with the Administrator on					
		ity one day a month to do					
	business.	ity one day a month to do					
	-She was at the facilit	v on the evening of					
	10/13/20.	., 5.1 alo 5751mig 01					
		to the facility, so she and the					
	BOM shared the resp						
		e facility once a month.					
		go to the facility on the 6th of					

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the month.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 501251110.			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CADE	303 W FRA	NKLIN STREE	т		
FIVOIAL	DAIL	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ξ
C 185	Continued From page 31		C 185			
	-She was based an hour away and it was not the best situationIt would be easier to manage the facility if it was closer.					
	Noncompliance identi included:	ified during the survey				
	1. Based on observations, interviews and record reviews, the facility failed to ensure follow-up for acute and routine healthcare needs for 2 of 3 residents sampled (#1, #3) including a resident who had a referral appointment for an Epileptologist for seizures, notification to the Neurologist for seizures and complaint of toothache (#3); and a resident who experienced increased weakness and slurred speech after being administered another resident's medication, and whose primary care physician (PCP) had referred the resident to a Neurologist due to increased tremors (#1). [Refer to Tag C246 10A NCAC 13G .0902(b) Health Care (Type A1 Violation)].					
	interviews, the facility recommendations and the Centers for Disea North Carolina Depar Services (NC DHHS) maintained to provide during the global coropandemic regarding revention and controlisk of transmission a staff not wearing face a social distance of 6 not wearing facemask and visitors. [Refer to	d guidance established by se Control (CDC) and the tment of Health and Human were implemented and e protection of the residents				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
			, 231251110. <u>_</u>	A. BUILDING: B. WING ESS, CITY, STATE, ZIP CODE KLIN STREET N, NC 27589 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		RANKLIN STREE		
			ITON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE COMPLETE
C 185	Continued From page 32		C 185		
	(Type A2 Violation)].				
	facility failed to ensur A, B, C, and D) who a had completed their r competency validatio medications and com 10-hour medication a the direction of a regipharmacist or success required state examin Tag C935 G.S. § 131 Medication Aides; Tra Evaluation Requirem 4. Based on observatinterviews, the facility medications as order residents (#1 and #3) to treat asthma, an al supplement (#1) and (#3). [Refer to Tag C3	nation (Staff A). [Refer to D-4.5B(b) Adult Care Home aining and Competency ents (Type B Violation)].			
	reviews, the facility fa staff person was on the had completed a cou- resuscitation (CPR) a including the Heimlich 24 months for 3 of 4 s				
		eviews and interviews, the e 4 of 4 sampled staff (A, B,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		FCL093012	B. WING		11/0	4/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
C 185	C, D,) completed a tw skin test according to by the Commission for Tag C140 10A NCAC Tuberculosis (Type B 7. Based on interview facility failed to ensure screening for the pressubstances was computed (Staff A, B, C, and Tag C992 G.S. 131D-Screening for the Prescubstances Required Employment in Adult Violation)]. 8. Based on observating facility failed to ensure room, a leak in the cean hole in a wall, the wiftens and wall air return good repair. [Refer to .0315(a)(1) Housekee (Standard Deficiency) 9. Based on interview facility failed to ensure A, Staff D) had no sull North Carolina Health (HCPR) upon hire. [Refer to .0406(a)(5) Other (Standard Deficiency) 10. Based on record in facility failed to ensure A, Staff D), had a crin completed upon hire.	control measures adopted or Health Services. [Refer to 13G .0405(a) Test for Violation)]. It is and record reviews, the examination and sence of controlled oleted for 4 of 4 sampled and D) prior to hire. [Refer to 45 Examination and sence of Controlled I for Applicants for Care Homes (Type B) ions and interviews, the example the the flooring in the dining in a resident bedroom, window coverings, ceiling the service was the example of the prior to hire. Tag C076 10A NCAC 13G reping and Furnishings of the example of the prior to hire. Tag C076 10A NCAC 13G reping and Furnishings on the example of the prior to Tag C145 10A NCAC are Personnel Registry the example of the prior to Tag C145 10A NCAC are Staff Qualifications	C 185			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL			E SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 185	Continued From page	÷ 34	C 185			
	interviews, the facility implementation of physampled resident (Refinger stick blood sug Tag C249 10A NCAC Care (Standard Deficity). Based on observational facility failed to ensure dresser were kept clesser to Tag C074 10	ysician's orders for 1 of 1 sidents #1) with orders for ar (FSBS) checks. [Refer to 13G .0902(c)(3-4) Health iency)]. ations and interviews, the e a resident's bed and an and in good repair. DA NCAC 13G .0315(a)(3)				
	Housekeeping and Furnishings (Standard Deficiency)]. 13.Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records for 3 of 3 sampled residents (Resident #1, #2 and #3). [Refer to Tag C342 10A NCAC 13G .1004(j) Medication Administration (Standard Deficiency)].					
	interviews, the facility of controlled substand reconciled accurately receipt and administrations substances for 1 of 1 an order for a controll an anti-anxiety medic	ation of controlled sampled resident (#1) with ed sleeping medication and ation. [Refer to Tag C367 B(a) Controlled Substances				
	record reviews, the fa residents sampled (# self-administered med	ations, interviews, and acility failed to ensure 2 of 3 of 3 and #3) who dications had orders to ription medications that were				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		303 W FF	RANKLIN STREET			
PIVOTAL	CARE		ITON, NC 27589			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 185	Continued From page	35	C 185			
	treatment and an inha					
	facility failed to ensur- was maintained in a s related to the light fixt resident bedroom not kitchen sink, and the working. [Refer to Tag	ations and interviews, the e all electrical equipment eafe operating condition cure in the kitchen and a working; the drain in the exhaust fan on the stove not g C102 10A NCAC 13G e Equipment (Standard				
	management, operatifacility were implement medication aides, who the care of the reside medication administrates resident (#1) being accurate, and the MAs were trained physicians, which reshaving multiple seizure the resident's Primary Neurologist and a too the resident's Dentist; implemented for a residented f	ation which resulted in a dministered the wrong is contraindicated for this history of Myasthenia Gravis; to notify the residents ulted in a resident (#3) res that were not reported to or Care Provider and thache was not reported to is FSBS were not sident (#1) with a diagnosis on administration records not completed and re unable to determine if is were administered as in place to screen or COVID-19 per the Center				
	for Disease Control g	uidelines and ensuring staff sks; and there was always				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ΓΕ, ZIP CODE	
PIVOTAL	CARE	303 W F	RANKLIN STREE	т	
TIVOTAL	I		NTON, NC 27589		
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C 185	Continued From page	e 36	C 185		
	Administrator resulted	uscitation. This failure of the d in serious neglect and n of the residents' which			
	, ,	a plan of protection in . 131D-34 on 11/04/20 for			
	CORRECTION DATE VIOLATION SHALL N 4, 2020	FOR THE TYPE A1 NOT EXCEED DECEMBER			
C 246	10A NCAC 13G .090	2(b) Health Care	C 246		
	. ,	2 Health Care assure referral and follow-up nd acute health care needs			
	This Rule is not met TYPE A1 VIOLATION	<u>-</u>			
	reviews, the facility far acute and routine hear residents sampled (# who had a referral ap Epileptologist for seizur toothache (#3); and a increased weakness being administered a and whose primary care	tures, notification to the tres and complaint of a resident who experienced and slurred speech after nother resident's medication, are physician (PCP) had to a Neurologist due to			
	The findings are:				

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
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	WARRENT					
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C 246	Continued From page 37		C 246			
	11/01/19 revealed diadepression and mild in a. Review of Resident plan dated 01/15/20 replan dated 01/15/20 re	t #3's physician assessment revealed: s from a visit with Resident was documentation to follow she had more seizures.				
	and progress notes fr 06/02/20 revealed: -The visit was a follow-Resident #3 told the had gotten worse since. The facility staff reposeizures since her last-Resident #3 had 17:05/30/20Resident #3 had two duration of each seizures. Resident #3 did not to the onset of a seizure. Resident #3's seizur automatisms (the per conscious thought or	Neurologist her seizures ce her last visit. orted Resident #3 had a few st visit. seizures from March 2020 to a seizures per week and the ure was a few minutes. have any warning signs prior ure.				
	Resident #3's Neurol 1:10pm revealed: -Resident #3 had bee	with a representative from ogist office on 10/27/20 at en referred to an Neurologist for her seizures.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
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		FCL093012	B. WING		11/04/2020
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	CLIMMADY CT.		ON, NC 27589		TION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
C 246	Continued From page	38	C 246		
	with the Epileptologis office informed the fac	ice made the appointment t and the Epileptologist's cility of the appointment. htment with the Epileptologist /04/20.			
	Resident #3's Neurold 11:34am revealed Re the Epileptologist offic epileptic episodes and seizures because the	with a representative from ogist office on 11/03/20 at sident #3 was referred to be to see if she was having do to get specific help for her Neurologist did not think he or Resident #3 without the ferral.			
	on 10/28/20 at 12:51p -Staff took residents to their personal carsThere was a folder for had paperwork that the (RN) has placed in the the interpretation of the interpretation of the physician would and paperwork into the bring the folder back to the state of the interpretation of t	or medical appointments in or each resident; the folder he facility Registered Nurse he folder. Itaken to the resident's have any visit information he folder and the staff would not to the facility.			
	resident's information -The physician would visit into the folder an back to the facilityThe facility RN would	evealed: ents to medical uld take a folder with the			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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PIVOTAL	CARE		RANKLIN STREE	Т	
		WARREI	NTON, NC 27589		
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IAG	· ·		IAG	DEFICIENCY)	
0.040			0.040		
C 246	Continued From page	e 39	C 246		
	-Facility staff were res	sponsible for documenting			
	appointments on the				
	· · · · · · · · · · · · · · · · · · ·	with a third MA on 10/29/20			
	at 9:52am revealed:				
		dent #3 to her physicians'			
	appointments.				
		vith information for Resident			
		appointments but had never			
	put the seizure log in				
	-If the physician gave	call the Administrator and let			
	her know.	can the Administrator and let			
		up appointment made for			
		ald put the appointment			
	down on the calendar				
	Telephone interview v	with the facility's RN on			
	10/29/20 at 2:43pm re				
	-The Neurologist wan	ited to send Resident #3 to			
	the Epileptologist in a	nother city for a follow up			
	related to the residen	t's seizures.			
		trator did not want to drive			
		er city during the pandemic			
	,	want to expose Resident #3			
	to the COVID-19 virus				
		ything about a telehealth			
	• •	Epileptologist for Resident			
	#3.				
	Telephone interview v	with the facility's RN on			
	11/03/20 at 2:57pm re				
	· · · · · · · · · · · · · · · · · · ·	referred Resident #3 to a			
		tify the resident's seizures.			
		he specialist [Epileptologist]			
	would have made acc				
		nt for Resident #3 and she			
		ehealth appointment for the			
	resident.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED	
	AN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING:			
		FCL093012	B. WING		11	/04/2020
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DIVOTAL	CARE	303 W FF	RANKLIN STREET			
PIVOTAL	CARE	WARREN	ITON, NC 27589			
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C 246	Continued From page	e 40	C 246			
	the Epileptologist office revealed: -The appointment for for 06/04/20 and was on 06/03/20The appointment wa					
	Telephone interview with a representative from the Epileptologist office on 11/02/20 at 11:43am revealed: -The appointment for 06/04/20 was made in March 2020.					
		ested to cancel the not requested to reschedule				
	the appointmentThe resident could h					
	06/04/20.	ointment scheduled for				
		do telehealth appointments				
		I not come into the office; e to have access to care				
		telehealth or in person				
		estricted in person visits.				
		ald have been rescheduled				
	10/29/20 at 5:06pm re -The Epileptologist's of they were not seeing Family Care Homes in pandemicShe was also told by the first visit with then could not be done via	office had notified her that any patients that lived in n the office during the the Epileptologist's office n had to be in person and telehealth. Resident #3 would be able to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
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		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ITE, ZIP CODE	
		303 W FF	ANKLIN STREE	ET .	
PIVOTAL	PIVOTAL CARE WARRENT)	
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C 246	6 Continued From page 41		C 246		
	-The Epileptologist's	office had called and			
		B's appointment and did not			
	reschedule the appoi				
	resorredule the appoi	nunon.			
	b. Review of Residen	t #3's seizure log dated			
	08/04/20 to 10/09/20	-			
	-There was documen	tation of the date, the time			
		ons, the length, comments			
		e for each time Resident #3			
	had a seizure.				
	-There was documen	tation Resident #3 had 16			
	seizures between 08/				
	-There was documen	tation of a seizure on			
	· ·	20 at 12:00am for 2 minutes.			
	-There was documen				
	08/11/20 at 4:20am fo				
	-There was documen				
	08/19/20 at 12:19am				
	-There was documen				
	08/21/20 at 5:21am fo				
	-There was documen 08/26/20 at 3:00am for				
	-There was documen				
	08/31/20 at 12:21am				
	-There was documen				
	09/01/20 at 12:02am				
	-There was documen				
	09/13/20 at 5:20am fo				
	-There was documen	tation of a seizure on			
	09/20/20 at 3:30am fo				
	-There was documen	tation of a seizure on			
	09/21/20 at 1:26am fo	or 1 minute.			
	-There was documen	tation of a seizure on			
	09/26/20 at 11:30pm	for 1 minute and 53			
	seconds.				
	-There was documen	tation of a seizure on			
	09/27/20 at 4:09am fo	or less than 1 minute.			
	-There was documen	tation of a seizure on			
	10/01/20 at 3:30am fo	or 2 minutes.			

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-There was documentation of a seizure on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BOILDING	A. BUILDING:			
	FCL093012	B. WING	B. WING		04/2020	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
CADE	303 W FR	ANKLIN STREE	т			
PIVOTAL CARE WARRENT						
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE	
Continued From page 42		C 246				
10/03/20 at 2:30am for There was document 10/09/20 at 2:30am for There was no document the Neurologist or a property of the Seizure Telephone interview with 1:21pm revealed: Resident #3 usually kicked her legs; her significant to do the seizure. Resident #3 usually after a seizure. She was trained to do day and time and the sheet. Resident #3's seizur the morning and were	or 1 minute. Itation of a seizure on or 1.5 minutes. Inentation of notification to orimary care provider (PCP) s. With a MA on 10/28/20 at Imade a loud noise and seizures usually lasted 2 to 3 Inventation of notification to orimary care provider (PCP) s. With a MA on 10/28/20 at Imade a loud noise and seizures usually lasted 2 to 3 Inventation of the seizure is a seizure log Inventation of the seizure is a seizure log Inventation of a seizure lo	C 246				
-She was never told t about a seizure. -Resident #3 had a se	o inform or call anyone eizure at 5:00am on					
10/29/20 at 9:52am re-Resident #3 had seiz sleptResident #3 made a Resident #3 would so catch her breathThe noise would aler-She would go into Reuntil the seizure was -Resident #3's seizur	evealed: zures at night while she loud noise like a moan and bund like she was trying to rt her to the seizure. esident #3's room and sit over. es would last 1 to 2 minutes					
	ROVIDER OR SUPPLIER CARE SUMMARY ST (EACH DEFICIENC REGULATORY OR) Continued From page 10/03/20 at 2:30am fo -There was documen 10/09/20 at 2:30am fo -There was no docun the Neurologist or a p for any of the seizure Telephone interview v 1:21pm revealed: -Resident #3 usually kicked her legs; her s minutesResident #3 usually after a seizureShe was trained to d day and time and the sheetResident #3's seizur the morning and were anywhere in the facili -She was never told t about a seizureResident #3 had a si 10/28/20 that lasted a went back to sleep. Telephone interview v 10/29/20 at 9:52am r -Resident #3 had seiz sleptResident #3 made a Resident #3 made a Resident #3 mould se catch her breathThe noise would ale -She would go into R until the seizure was -Resident #3's seizur	FCL093012 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 10/03/20 at 2:30am for 1 minute. -There was documentation of a seizure on 10/09/20 at 2:30am for 1.5 minutes. -There was no documentation of notification to the Neurologist or a primary care provider (PCP) for any of the seizures. Telephone interview with a MA on 10/28/20 at 1:21pm revealed: -Resident #3 usually made a loud noise and kicked her legs; her seizures usually lasted 2 to 3 minutesResident #3 usually went right back to sleep after a seizureShe was trained to document the seizure, what day and time and the length on a seizure log sheetResident #3's seizures were at night or early in the morning and were loud enough to be heard anywhere in the facilityShe was never told to inform or call anyone about a seizureResident #3 had a seizure at 5:00am on 10/28/20 that lasted about 1 minute; Resident #3 went back to sleep. Telephone interview with a second MA on 10/29/20 at 9:52am revealed: -Resident #3 had seizures at night while she sleptResident #3 made a loud noise like a moan and Resident #3 would sound like she was trying to	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 Indicuted From page 42 Indicuted From	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 C 246 10/03/20 at 2:30 am for 1 minuteThere was documentation of a seizure on 10/09/20 at 2:30 am for 1.5 minutesThere was no documentation of notification to the Neurologist or a primary care provider (PCP) for any of the seizures. Telephone interview with a MA on 10/28/20 at 1:21 pm revealed: -Resident #3 usually went right back to sleep after a seizureShe was trained to document the seizure, what day and time and the length on a seizure log sheetResident #3's seizures were at night or early in the morning and were loud enough to be heard anywhere in the facilityShe was never told to inform or call anyone about a seizureResident #3 had a seizure at 5:00 am on 10/28/20 that lasted about 1 minute; Resident #3 went back to sleep. Telephone interview with a second MA on 10/28/20 at 9:52 am revealed: -Resident #3 made a loud noise like a moan and Resident #3 made a loud noise like a moan and Resident #3 made a loud noise like a moan and Resident #3 made a loud noise like a moan and Resident #3 would sound like she was trying to catch her breathThe noise would alert her to the seizureShe would go into Resident #3's room and sit until the seizure was overResident #3's seizures would last 1 to 2 minutes	The correction interview with a MA on 10/28/20 at 1:21 pm revealed:	

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from the waist down move.

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		DEEC CITY CTA	TE 710 CODE	11/04/2020	
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PIVOTAL CARE		TON, NC 27589			
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C 246 Continued From page 43		C 246			
-She thought Resident #3 was a seizures; the MA would ask the was "okay", but the resident wo her. -After every seizure she documitime and length of the seizure of and nothing else. -Another MA told her how to fill she started working at the facilities. She was not told to notify anyou #3 had a seizure. Telephone interview with a reprocession revealed: -The Neurologist was not notifies seizure. -The last seizure the facility staff Neurologist for was on 01/28/20 resident went to the hospital for resident #3's seizures were "polyneurologist would like to be not happened. -If the facility staff had notified the seizures the Neurologist would aware and he could advise if	resident if she uld not answer ented the date, in the seizure log out the log when y. In after Resident esentative from on 10/28/20 at individual dafter each of notified the when the a seizure. In a seizure enterty bad" and the effice of the eded. It is a seizure log anywhere esentative from on 11/02/20 at eizures (a type of onsciousness and o known as a	C 246			

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-The Neurologist told the facility staff that

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		FCL093012	B. WING		11,	/04/2020
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C 246	Continued From page	e 44	C 246			
	had a seizureThe office was not be so they did not know had increased or declasting longer or shor	the him when Resident #3 eing notified of any seizures, if the number of seizures reased or if they were ter.				
	Interview with Resident #3 on 10/29/2020 at 9:53am revealed: -She knew she recently had a seizure but could not remember when, but it happened at nightWhen Resident #3 had a seizure, she would shake, and the staff would stand at her bed during the seizureShe had about two seizures a week during the night and they lasted about a minute eachAfter her seizures, she normally went back to bedAfter a seizure the staff would ask if she needed them to call 911; she would tell them "no" and then she would go back to bedShe felt better when she laid down after a seizure.					
	seizures happened a	cures were triggered by				
	Nurse (RN) on 10/29, -She took Resident # appointmentsThe Neurologist never facility staff to call hin seizureResident #3's seizur Neurologist had adjust medication about a year.	er told her to instruct the n when Resident #3 had a es were milder since the				

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
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PIVOTAL	CARE		ANKLIN STREE			
		WARREN	TON, NC 27589)		
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PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
C 246	Continued From page	45	C 246			
00	Continued From page	, 40	0 = .0			
	-Resident #3's seizure	es used to be two minutes				
	but were now less that	an two minutes and the				
	frequency decreased	from every night to 2-3				
	times a week.	, ,				
	-The seizure log shee	et was used at an				
	appointment to tell the					
		s while at a scheduled				
	appointment.	3 Wille at a soliculicu				
		anta-d to be metified if				
		wanted to be notified if				
		fferent about Resident #3's				
	seizures.					
	_	traight to Resident #3 when				
	she had a seizure and	d to stay with her until the				
	seizure was over.					
	-Staff were to docume	ent the seizures on the log				
	sheet.					
	Telephone interview v	vith the facility's RN on				
	11/03/20 at 2:57pm re					
		the Neurologist wanted				
	from the facility was the	-				
	-The log was taken to					
	appointments with the					
		•				
		eported to the Neurologist				
		nts that were done via				
	telehealth.					
		not want to be called for				
	each seizure.					
	-	vith the Administrator on				
	10/29/20 at 5:16pm re					
	-The staff did not call	the Neurologist when				
	Resident #3 had a se	izure; they were to				
	document the seizure					
		g the Neurologist too much				
	if they called each tim	-				
	seizure.	io residentino nad d				
		es were very mild and only				
		es were very mild and only				

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little movement.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	ECI 093012					
FCL093012			B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CARE		NKLIN STREE			
			ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	Continued From page	e 46	C 246			
	-Resident #3 did not himinor with shaking.	nave "full" seizures and were				
	facility staff from 10/0 -On 10/16/20 Resider pain to staff and had be adayOn 10/18/20 Resider pain and had been girther mouth with; she then the staff and the staff and had been girther mouth with; she then the staff and t	sident #3 complained of a d finally went to sleep in the sident #3 did not want to get . sident #3 had a toothache dication aide (MA) instructed				
	acetaminophen (a me aches and pains) bed -The MA told Resider acetaminophen becau ordered for herThe MA offered Resi rinse her mouth withResident #3 declined "It did not help the last	the MA and requested edication used to treat minor cause of tooth pain. In #3 she could not have use there was not any dent #3 warm salt water to the salt water rinse stating,				
	Interview with Reside	nt #3 on 10/26/20 at 7:43am				

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-She was congested because she had a

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Division of fleath Service Regulation		1		1	\neg		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		J	
	FCL093012 B. WING			11/04/2020			
			1		11/07/2020	-	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
PIVOTAL CARE 303 W FRA		RANKLIN STREE	:T				
TIVOTAL	VAIL	WARREN	TON, NC 27589				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		<u> </u>	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE		
				22.10.2.10.1		\dashv	
C 246	Continued From page	e 47	C 246				
	toothache.						
		for a while" but she did not					
		of a writte but she did not					
	know how long.	Lan appointment with the					
		an appointment with the					
	dentist today, 10/26/2	:O.					
	Interviews with Resid	ent #3 on 10/29/20 at					
	9:53am and 10:55am						
		use she was hurting due to					
	a toothache.	accome macmaning and to					
		anything for the pain "yet",					
	•	appointment on 11/03/20.					
		rm salt water rinse because					
	it did not help the last						
	•	something for the pain but					
		nave an order for anything					
	for pain.	lave all order for allything					
	•	or about the last two weeks,					
	•	ust rinsing with warm salt					
	water.	ust Illishig with warm sait					
		ven anything for pain during					
	the last two weeks.	ven anything for pain during					
		ne" her mouth was hurting.					
	Sho had told everyt	moder was naturing.					
	Interview with a MA o	n 10/29/20 at 10:51am and					
	10:58am revealed:						
		dent #3 had bad teeth.					
		nplained about tooth pain for					
	about two weeks.						
		t #3's complaint of tooth					
	pain in the communic						
	-The Administrator wo						
		when she came to the					
	facility about twice a						
	•	trator when Resident #3					
	started complaining a						
		dentist appointment for					
	Resident #3.	ασπιοι αρροπιπιστιι ΙΟΙ					
	** *	locident #2 anything for the					
	-one could not give R	esident #3 anything for the				1	

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tooth pain because she did not have an order for

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	o rtogu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
AND I EAR OF CONNECTION		DENTILIOATION NOWDEN.	A. BUILDING: _		CONIFL	
		FCL093012	B. WING		11/0	4/2020
NAME OF PROVIDER OR SUPP	LIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIVOTAL CARE		303 W FR	ANKLIN STREE	:Τ		
PIVOTAL CARE		WARREN ⁻	TON, NC 27589			
PREFIX (EACH DI	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
-She did not of (RN) when Rebecause the fashe usually of was a complation and of the resident #3 of called anyone any of the resident #3 of the physician. Telephone into the physician. Telephone into the physician. Telephone into the physician and the physician and the physician and the physician. Telephone into the physician and	cation. now whall the fesident sacility Ralled that int of an all the pomplair to ask dents. rator was erview	act a standing order was. acility's Registered Nurse #3 complained of tooth pain N had been sick. e Administrator when there my kind of pain. Ohysician or the dentist when med of tooth pain; she never for medication for pain for as the only one that called with a second MA on revealed: m complaining off and on of two weeks prior to bed time. To give Resident #3 because there was not an facility's RN when Resident m to have her rinse her water. #3 needed more for the resident a warm towel to any swelling on Resident mt #3 to brush her teeth to	C 246			
her teeth relie -She would ca when a reside would call the -She never ca call the PCP; Resident #3's -Resident #3 I	ved the fault the faut was PCP. Illed the she was tooth punded	pe bleeding from brushing pressure and the pain". Icility's RN and let her know in pain and the facility's RN PCP unless she was told to so not told to call the PCP for ain. Inplained of tooth pain for eekend she had worked;				

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STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
7.11.2 1 27.11	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		001111	
		FCL093012	B. WING		11/0	04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE		
DIVOTAL	0485	303 W FF	RANKLIN STREE	т		
PIVOTAL	CARE	WARREN	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From page	e 49	C 246			
	"sometimes she did tl	nings for attention".				
	at 2:16pm revealed: -On 10/20/20 she had let her know Resident tooth pain; the facilty' dentist and make an a #3She did not tell the re office about Resident she needed an appoi -The facility's RN told Resident #3's jaw wh was still in painResident #3 had a bi tell the facility's RN be already scheduled to -She had never called for a medication orde RN first; the facility's	her to put a warm towel on en she told her the resident it of swelling but she did not ecause the resident was go to the dentist soon. d a physician for a request r without calling the facility's RN would instruct her to call				
	Interview with the fac 2:09pm revealed: -The facility did not have residentsWhen a resident work or diarrhea they were anything"She was made awar around the middle of -She knew Resident appointment schedule the appointmentShe took Resident # around the middle of oral drops to put on h	e of Resident #3's tooth pain October 2020. #3 had a dentist ed; one of the MAs made 3 to the store on a Saturday October 2020 to purchase				

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them when she needed them.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	IIRVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPL	
			A. BUILDING: _			
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		303 W FR	ANKLIN STREE	T		
PIVOTAL	CARE		TON, NC 27589			
0	CLIMMA DV CT				STION	0.45)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPI	ROPRIATE	DATE
				DEFICIENCY)		
C 246	Continued From page	÷ 50	C 246			
	,					
	1	not contacted her since she				
	_	et the oral drops; she was				
		3 had continued to complain				
	of tooth pain.	rainian and request on order				
		rsician and request an order				
		taminophen for a resident; ough confidence to call.				
	_	he Administrator who could				
		the Administrator would				
	instruct the MA to call					
		called her, and she would				
	have called the physic					
	Thave called the physic	olari.				
	Telephone interview v	vith the Administrator on				
	10/29/20 at 5:06pm re					
	-The MAs could call h	ner, and she would call the				
	physician for an order	r for medication for a pain.				
	-The MAs were not al	llowed to give medication				
	without an order.					
		oad mouth" and had been				
	going to the dentist for	,				
	-She told Resident #3					
	, , ,	ause she did not have an				
		ian for pain medication.				
		ard Resident #3 was having				
	•	22/20 or 10/23/20 when she				
	went to the facility.	the next day that her tooth				
		d she did not complain of				
	pain.	a site did flot complain of				
	-Staff called the denti	st and made the				
	appointment.	or and made the				
		f to have Resident #3 rinse				
	with warm salt water					
		entist when she heard				
		plaining of tooth pain, but				
	the dentist said they					
	medication.	•				
		out calling Resident #3's				
		n (PCP) to ask for pain				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DOILDING		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL (CARE		ANKLIN STREE		
			TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 246	Continued From page	e 51	C 246		
	medication. -The MAs could call the PCP or the dentist themselves to get an order for medication for Resident #3 or any resident; she considered that resident "care". Telephone interview with Resident #3's dentist on 11/02/20 at 10:33am revealed: -Resident #3 had a scheduled appointment at her office for 11/03/20; the appointment was made on 10/19/20There was no reporting of Resident #3's				
	complaint of pain who	en the facility staff called to			
	she would have tried same day and would	to see the resident that have called in medication			
		called the dentist office and cation on 10/30/20 due to			
	-She did not instruct t Resident #3 rinse with	esident #3 a year ago. he facility staff to have h warm salt water or to			
	out to the PCP to req	the facility failed to reach uest pain medication.			
	she wondered how lo pain.	Resident #3 was in pain and ng the resident had been in			
	-One of Resident #3's teeth could have been infected and a cause for the pain; if the facility had requested medication sooner, she would have ordered it for Resident #3.				
	12/30/19 revealed dia mellitus, major depres	t #1's current FL-2 dated agnoses included diabetes ssive disorder, myasthenia nd rapid fatigue of muscles			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
VIAD LEVIA	O CONNECTION	DENTIFICATION NOWIDER.	A. BUILDING: _		COIVIPL	L160
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE FON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 246	weakness in the arm vision, and difficulties hypertension, hypothy dyspnea on exertion. Review of the facility! Administration Errors -If a medication error person, wrong medication error person, wrong medication effects and significant and recommendation scheduled medication -Contact emergency immediately if error put difficulty breathing or -Notify the Administration log darkesident #1 was obstant #1 was obstant #1 was obstant #1 reported the wrong medication -Resident #1 was have bedside. -It was documented "on the table," and "whee each resident #1's medication the table," and "whee each resident #1's medication because Resident #1 last night, 09/21/20. -There was no documented "on the table," and "whee each resident #1 last night, 09/21/20.	ol. Symptoms include and leg muscles, double with speech and chewing), yroidism, diaphoresis, and s policy titled Medication revealed: was made including wrong ation, wrong dosage, or ving action should be taken. pharmacist immediately n to be taken, possible t symptoms that may occur, s for adjusting the next n dosage. medical assistance osed a dangerous situation, unconsciousness. ttor. t report as soon as possible. ication aide's (MA) ated 09/22/20 revealed: served having slurred ed of feeling dizzy. d she had been administered a last night, 09/21/20. ving a hard time walking so a as placed by Resident #1's no more sitting medications nen giving medications, call one to the office." ations were off again did not get her medication	C 246			
		(PCP), Neurologist or rovider had been notified of				

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Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED
		FCL093012	B. WING		11/04/2020
			•		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DIVOTAL.	0485	303 W FR	ANKLIN STREE	T	
PIVOTAL	CARE	WARREN1	ON, NC 27589		
	CUMMADY CT				1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
17.00		,		DEFICIENCY)	
C 246	Continued From page	e 53	C 246		
	the medication admin	istration error.			
	Interview with Reside	nt #1 on 10/29/20 at			
	10:47am revealed:				
	-The evening MA place	ced medication cups on the			
	table at the dinner pla				
		e was on a medication cup.			
		bedtime medications at the			
	dinner meal.	bedune medications at the			
		ning medication "lust			
		ning medication, "just			
	bedtime medication."				
	_	ne to take their medication;			
		and took the medication in			
	the cup.				
	-Someone said, "som	ebody had not taken their			
	medicine." (She did n	ot know who said this)			
	-She realized the cup	of medication remaining on			
		dications so that meant she			
	had taken another res				
	-A named resident sa				
		vas the resident who was			
		vas tile resident who was			
	sitting beside her.				
	-The MA said, "I am s	,			
	-She took a named re				
	-The MA did not ment	tion the incident again to			
	her.				
	-She felt really "out of	f it" the next morning.			
	-She felt "bad all over	r."			
	-She told the facility's	nurse (RN) the next			
		l "nothing he takes will hurt			
	you."	o			
	-	edication was no longer			
	administered at the ta	•			
	aummistered at the ta	IDIC.			
	01 " "				
	•	amed resident's medications			
	on hand on 10/26/20				
		pack labeled evening that			
	contained 2 tablets of	f Magnesium 400mg.			

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contained 7 tablets.

-There was a bubble pack labeled bedtime that

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING.		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE	303 W FF	RANKLIN STREE	ïΤ	
TIVOTAL		WARREN	ITON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 246	Continued From page		C 246		
	Sodium (used to treat	lentified as Divalproex : seizures) ER 500mg,			
	,	to treat seizures) 1000mg,			
		chotic medication) 4mg, (antipsychotic medication)			
	300mg, Melatonin (sle				
	Review of Resident #				
	summary dated 03/26	6/20 revealed: rgic to Magnesium with a			
	reason as myasthenia	-			
		story of myasthenia gravis			
	with vocal cord paraly				
		d precipitate myasthenia			
	gravis, such as magn	esium.			
	Interview with a MA o	n 10/29/20 at 11:03am			
	revealed:	al mandinations in arms			
	-She put the residents	ents' names and placed			
	them at the dining roo				
		e should not administer			
	-	until an incident where a			
	resident took another				
		re told to only administer le in the medication room.			
	modication one by on	o in the medication reem.			
	Telephone interview v	vith the facility's contracted			
	RN on 10/29/20 at 1:1	= -			
		de a complaint to her about			
	taking another resider	nt's medication. oof that it had happened.			
	-The medication coun				
	-She would have expe				
	notified the Administra	ator the night the incident			
	occurred.				
		s had been administering			
		ning room table and she told minister medication in the			
	medication room.	mmoter meuroalion in the			

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			1	_		
		FCL093012	B. WING		11/0	4/2020
			1		1 11/0	7,2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CARE		ANKLIN STREE			
		WARREN	TON, NC 27589			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
0.040			0.040			
C 246	Continued From page	÷ 55	C 246			
	-She also talked to all	the residents after the				
	incident to let them kr	now medications should only				
	be administered from	the medication room.				
		vith Resident #1 on 11/02/20				
	at 11:05am revealed:	b a dii a a maa di a di a a a midb				
	her dinner meal.	bedtime medications with				
		ut bedtime medications at				
	the dinner meal setting					
		r sure how many pills were				
		ne took another resident's				
		e was a lot, more than 5 or				
	6."	,				
	Telephone interview v at 11:10am revealed:	vith another MA on 11/02/20				
	-She had heard about resident's medication.	t Resident #1 taking another				
		ne bedtime medications				
	Resident #1 had take					
		vith an evening MA on				
	11/02/20 at 4:52pm re					
	•	were administered at				
	7:00pm and evening administered at 5:00p					
		ions were put in medication				
	cups at the dinner tab					
	•	dtime medications in cups at				
	the table.	·				
	-Resident #1 never to	ok another resident's				
	medications.					
	-Resident #1 picked u					
		esk one evening in the office				
		ke the medication (he did				
	not recall the date wh	en this incident happened).				
	Tolophono intonvious	vith a second evening MΔ on				

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11/03/20 at 1:08pm revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
PIVOTAL	CARE	303 W FR	RANKLIN STREET		
FIVOIAL	CAIL	WARREN	ITON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
C 246	Continued From page	2 56	C 246		
	5:00pm and bedtime administered at 7:00p -She had "heard" abo administered another errorShe thought the med have been the bedtim Resident #1 did not to Telephone interview volume Neurologist on 11/02/-Magnesium was a madministered to patien myasthenia gravis an problemsResident #1's myastle the last time she had did not think it would be have experienced sluweakness, but she cobecause she had not 18-months due to an appointment schedule -The other medication been administered we because of the diagnobut because there we medications listedOne of Resident #1's been notified of the action. Telephone interview volume.	om. Jut Resident #1 being resident's medication in Jication administered would be medications because ake evening medications. Juth Resident #1's 20 at 11:32am revealed: edication that should not be nots with a diagnosis of d could have caused July and the seen Resident #1, so she have caused Resident #1 to seen Resident #1 in July and the seen Resident #1 Ju			
	another resident's me -He would have expe- the medication admin	cted to have been notified of			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	11/04/2020	
NAIVIL OI 11	NOVIDEN ON 3011 EIEN		NKLIN STREE			
PIVOTAL	CARE		ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 246	Continued From page	= 57	C 246			
0 2.0	-Had he been notified of the symptoms Res	I he would have a better idea ident #1 was experiencing were the possible effects of	02.0			
	provider on 11/03/20 -She was not aware F administered another -She would have expe of the medication error -Had she known of th would have instructed effects and how to ad -She was familiar with medication Resident -It was very concerning been administered the because the named r anti-psychotic medical sedatingResident #1 was ver doses of medications	Resident #1 had been resident's medication. ected to have been notified or. e medication error she distaff of possible side dress the side effects. In the resident whose #1 took in error. In the resident #1 may have the resident's medications				
	impairments, tardive or risk of fallsResident #1 would he taking the wrong med -Resident #1 would need per the effects had cleared upside effects that would relephone interview with 11/04/20 at 2:16pm resident was not aware readministered at the tar-She was concerned	ave been sedated from lication. eed to follow-up with her nough the overnight side p, there could be long-term d need to be addressed. with the Administrator on evealed: medication was being able at meals. because there was no tion, anyone could pick the				

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STATE FORM 6899 70N011 If continuation sheet 58 of 172

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPI	
		FCL093012	B. WING		11/0	04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
		WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 246	Continued From page	e 58	C 246			
	the residents; prepou never fly with me" and -She felt the residents were given the wrong knew what medication	s would have noticed if they medications because they n they took.				
	 b. Review of Resident #1's physician's visit summary dated 09/10/20 revealed: -Resident #1 was concerned about tremors. -Resident #1 had missed her neurology appointment due to lack of transportation. -Resident #1 was advised to reschedule the 					
	missed appointment	with the Neurologist. t Resident #1 advise the				
	Neurologist about the					
	Interview with Resident #1 on 10/29/20 at 3:38pm revealed: -She had always seen a Neurologist once a yearShe had not seen her Neurologist this year (2020) because her appointment was canceled when she did not have transportation to the appointmentHer tremors had gotten worse in September 2020, so the facility's RN took her to see her PCP					
	wanted her to see he -Someone (she did no see a local Neurologi her NeurologistIf she could not see have agreed to see shad made her an app	do anything for her" and r neurologist. ot recall who) wanted her to st, but she wanted to see ther Neurologist, she would omeone locally, but no one sointment.				
	Telephone interview v	vith the facility's contracted				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		F01 000040	B. WING		44/0	4/0000
		FCL093012			11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		303 W FR	ANKLIN STREE	:T		
PIVOTAL	CARE		TON, NC 27589			
	CLIMMADY CT				.1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF		DATE
				DEFICIENCY)		
C 246	Continued From page		C 246			
C 240	Continued From page		0 240			
	RN on 10/29/20 at 1:	•				ı
		(MA) was responsible for				ı
		narge papers and scheduling				ı
	follow-up appointmen	ts ordered.				ı
	-She took Resident #	1 to see the resident's PCP				ı
	because Resident #1	was having an increase in				
	her tremors and she	did not want her to become				ı
	"catatonic like Reside	ent #1 had been before."				ı
	(Catatonic is defined	as lack of movement and				ı !
	communication).					ı .
	-She was trying to "ge	et ahead" of the problem.				ı .
		vanted Resident #1 to				ı .
	follow-up with Reside	nt #1's Neurologist for the				ı .
	tremors.	Ç				ı .
	-There was an order f	from Resident #1's PCP to				ı .
		nt #1's neurologist on the				ı .
	discharge papers.	<u> </u>				ı
		to see her Neurologist at a				ı .
	named hospital clinic.					ı
	-She called the office					ı .
		voice mail about scheduling				ı .
	an appointment.	Č				ı .
		en Resident #1's neurology				ı
	office staff called bacl					ı
	appointment was offe	•				ı
	-She had not followed					ı
	neurology appointme					
						ı
		with the Administrator on				ı
	10/29/20 at 4:39pm re	evealed:				ı
	-She knew Resident #	#1's PCP had recommended				ı
	Resident #1 have a fo	ollow-up appointment with				ı
	her Neurologist.					ı
	-Resident #1 wanted	to see her Neurologist at the				ı
	named hospital.					ı
	-Resident #1's family	member did not want				ı
	Resident #1 transport	ted to the named				ı
	Neurologist because	of the coronavirus				ı
	(Covid-19) pandemic.					ı
		o had spoken to Resident				1

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
DIVOTAL	0.4.0.5	303 W FR	ANKLIN STREE	т		
PIVOTAL	CARE	WARRENT	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 246	Continued From page	e 60	C 246			
	one to follow-up. Telephone interview v					
	Neurologist on 11/02/20 at 11:32am revealed: -Resident #1 had called her on 09/11/20 and complained of being "jittery" and had been evaluated by the resident's PCPShe did not think Resident #1's complaints of being "jittery" were related to the diagnosis of myasthenia gravis and was possibly related to psychiatric medicationsShe reached out to Resident #1's family member but had not received a return callShe did not know Resident #1 was in a family care home setting.					
	-Resident #1 should be evaluate "tremors" ve	oe seen by a Neurologist to ersus "jittery" and it would clinic setting to evaluate the				
	tremorsNo one had called her about an appointment for Resident #1 except Resident #1. Telephone interview with Resident #1's PCP on 11/02/20 at 12:31pm revealed: -He had seen Resident #1 on 09/10/20 due to					
	neurology to see if Re	#1 to be evaluated by esident #1's tremors were				
		ing of Resident #1's maybe Parkinson's disease. esident #1 had not seen the				
		er for Resident #1 to see a een completed.				
	member on 11/03/20	with Resident #1's family at 4:48pm revealed:				

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Resident #1's tremors getting worse (he did not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			D. WING			
		FCL093012	B. WING		11	1/04/2020
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DIVOTAL	CADE	303 W F	RANKLIN STREET			
PIVOTAL	CARE	WARREI	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 246	recall the date). -He did not know the -Someone from the name of the facility sappointment with Redid not ask him to ta appointment. -The facility staff wh COVID-19, and he from COVID-19 as an excresident #1 to see he distance." -The facility always an appointment out facility should be resulted to her appointment were because she wand be cared for. -He would have take	e results of the PCP's visit. facility (he did not recall the staff) called him about an esident #1's Neurologist but like Resident #1 to the o called talked about left the facility staff were using cuse to "get out of taking her Neurologist because of called him if Resident #1 had of the county and he felt the sponsible for taking Resident ents no matter where they was paying to live at the facility en Resident #1 to see the known Resident #1's PCP	C 246			
	were notified when the and mental health is resident (#3) having fifteen days with not experienced multiple Neurologist was not and had an appoint that was canceled a resident (#1) who we neurology appointmincrease in tremors evaluated by her primary was ordered to see thave an appointment Neurologist, and who					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
C 246	mediation that was compasthenia gravis and condition. This failure and physical harm and Violation. The facility provided a accordance with G.S. this violation. CORRECTION DATE	in the resident taking a contraindicated due to deperiencing a change in experiencing a change in experience and constitutes a Type A1 a plan of protection in 131D-34 on 11/04/20 for EFOR THE TYPE A1	C 246			
0 240	10A NCAC 13G .090: (c) The facility shall a following in the reside (3) written procedure a physician or other li and (4) implementation o orders specified in St. Rule. This Rule is not met Based on observation interviews, the facility implementation of physampled resident (Refinger stick blood sug.) The findings are:	2 Health Care assure documentation of the ent's record: es, treatments or orders from idensed health professional; if procedures, treatments or ubparagraph (c)(3) of this as evidenced by: as, record reviews, and if ailed to ensure the essident #1) with orders for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMI			
		FCL093012	B. WING	B. WING		
						/04/2020
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
C 249	Continued From page	e 63	C 249			
	depressive disorder, in hypertension, hypothy dyspnea on exertion.	diabetes mellitus, major myasthenia gravis, yroidism, diaphoresis, and for finger stick blood sugar				
		1's December 2019 ation record (MAR) revealed r checking FSBS daily.				
	Review of Resident #1's August 2020 and September 2020 MAR revealed there was no entry for checking FSBS daily.					
	revealed: -There was an entry tweeklyThere was a hand-drates of 10/05/20, 10/10/26/20There was documents square dated 10/19/20/214.	1's October 2020 MAR o check fasting FSBS rawn square around the /12/20, 10/19/20, and tation in the hand-drawn 0 Resident #1's FSBS was FSBS documented on				
	dated 09/10/20 revea -Resident #1 reported glucose monitoring su -There was documen daily.	I she was out of her FSBS upplies. tation accu-checks were orm weekly blood sugar SBS log. cation aide (MA) on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING			/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
		TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED TO TO DEFICIENCED TO TO TO THE PROVIDER OF THE PROVIDER	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	e 64	C 249			
	a while." -She did not think she FSBS since last winte	ked Resident #1's FSBS "in had checked Resident #1's er when Resident #1 moved esident #1's FSBS were mes a week."				
	Interview with a second MA on 11/02/20 at 2:35pm revealed: -She checked Resident #1's FSBS on 10/19/20The order dated 09/10/20 had been misplaced and when the order was found on 10/19/20, Resident #1's FSBS was checkedShe did not know why Resident #1's FSBS was not checked on 10/26/20She worked on 10/26/20, but the weekend MA administered the morning medications before she came in.					
	care provider (PCP) of revealed: -He first saw Resident -Resident #1 had a conference of FSBS weeklyHe did now know if Fidaily FSBS had been visit on 09/10/20, but FSBS because Resid from 6.4 in December 2020. (An A1C test is your average blood gomonths. An A1C leve considered normal)He expected the ord be checked weekly at	er for Resident #1's FSBS to nd documented so he could es was being controlled.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.12510.			
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DIVOTAL	CADE	303 W FR	ANKLIN STREE	т		
PIVOTAL	WARRENT					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	Έ
C 249	Continued From page	e 65	C 249			
	facility; no one had do she moved to the fac	BS at home daily. er FSBS to be done at the one daily FSBS checks since ility in December 2019. nce a week just to keep it in				
	10/26/20 at 10:51am -A FSBS of 214 was or time stampA FSBS of 170 was or time stamp.	ent #1's glucometer on revealed: recorded; there was no date recorded; there was no date FSBS recorded in the				
	on 10/29/20 at 1:16pr -She took Resident # was aware of the ord -She thought FSBS w while because she re on Resident #1 at the -Whoever saw the ore FSBS would have be transcribing the order -She was aware the ore dated 09/10/20, had in -She saw the weekly when she saw Reside drew blocks around the completed as a re -She did not know wh for weekly FSBS on to the one who took Resi appointmentShe was concerned	1 to the PCP herself and er to check FSBS weekly. Were being done daily for a called seeing a FSBS sheet a facility. der on the FL-2 for daily en responsible for to the MAR. Order for the weekly FSBS and been followed through. FSBS were not being done ent #1 on 10/12/20 and sheen the dates the FSBS should minder for the MAS. By she did not write the order the MAR because she was				

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FSBS were.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
PIVOTAL	CARE		RANKLIN STREE [.] NTON, NC 27589	Γ	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 249	Continued From page	66	C 249		
	facility's contracted ph 3:52pm revealed the of #1's FSBS glucose so when an order was re PCP; 50-strips were of Telephone interview w 10/29/20 at 4:39pm re -She was not aware F to check FSBS weekl -She was concerned in not be monitored if the as ordered.	vith the Administrator on			
C 330	10A NCAC 13G .1004 Administration	ł(a) Medication	C 330		
	(a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a license which are maintained	Medication Administration the shall assure that the inistration of medications, prescription and treatments ance with: ed prescribing practitioner in the resident's record; and in and the facility's policies			
	This Rule is not met a	as evidenced by:			
	interviews, the facility medications as ordered				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL093012	B. WING		1.	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER	303 W F	ADDRESS, CITY, STATE RANKLIN STREET NTON, NC 27589	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	to treat asthma, an al supplement (#1) and (#3). The findings are: 1. Review of Residen 12/30/19 revealed diamellitus, major depregravis, hypertension, diaphoresis, and dyspana. Review of Residen 12/30/19 revealed the for Symbicort 160-4.5 treat asthma) take two day. Review of Resident # administration record -There was an entry for two puffs twice daily administration time of -There was an entry for two puffs twice daily administration time of -There was an entry for two puffs twice daily administration time of -There was an entry for two puffs twice daily administration time of -There were 3 days Sonot documented as a -There were 8 days Sonot documented as a -There were no exceptions are supplied to the	lergy nasal spray and a an oral tooth medication It #1's current FL-2 dated agnoses included diabetes asive disorder, myasthenia hypothyroidism, onea on exertion. It #1's current FL-2 dated are was a medication order among (bronchodilator used to be inhalations two times a I's August 2020 medication (MAR) revealed: Ior Symbicort 160-4.5mcg with a scheduled Is 8:00 am and 8:00 pm. tation Symbicort inistered at 8:00am and 0-08/30/20. I's September 2020 MAR Ior Symbicort 160-4.5mcg	C 330			

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SUMMAC OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 (Act) ID PROVIDERS PLANGE CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 330 C 330 Continued From page 68 revealed: -There was an entry for Symbicort 160-4.5mcg two puffs by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pmThere were 9 days Symbicort 160-4.5mcg was not documented as administered at 8:00pmThere were no exceptions documented for the doses left blank. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed: -Medications that were scheduled to be administered on a regular basis were automatically refilledMedication that was pm (as needed), inhalers, eye drops, and ointments, were not refilled automatically and would need to be requested for a refillThere was an order for Symbicort 160-4.5mcg two puffs twice daily for Resident #1.			FCL093012	B. WING		11/04/2020	
PIVOTAL CARE SUMMARY STATEMENT OF DEFICIENCIES WARRENTON, NC 27589	NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET			TE ZIP CODE	1 11/04	72020
(X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTION SHOULD BE (EACH CORRECTION MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE ON THE APPROPRIATE DATE DATE OF THE APPROPRIATE DATE DATE DATE OF THE APPROPRIATE DATE DATE OF THE APPROPRIATE DATE DATE OF THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D		303 W FR.					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 330 Continued From page 68 revealed: -There was an entry for Symbicort 160-4.5mcg two puffs by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There were 9 days Symbicort 160-4.5mcg was not documented as administered at 8:00pm. -There were no exceptions documented for the doses left blank. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed there was no Symbicort inhaler available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Medications that were scheduled to be administered on a regular basis were automatically refilled. -Medication that was prn (as needed), inhalers, eye drops, and ointments, were not refilled automatically and would need to be requested for a refill. -There was an order for Symbicort 160-4.5mcg two puffs twice daily for Resident #1.	PIVOTAL CARE WARRENT			NTON, NC 27589			
revealed: -There was an entry for Symbicort 160-4.5mcg two puffs by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pmThere were 9 days Symbicort 160-4.5mcg was not documented as administered at 8:00amThere were 7 days Symbicort 160-4.5mcg was not documented as administered at 8:00pmThere were 7 days Symbicort 160-4.5mcg was not documented as administered at 8:00pmThere were no exceptions documented for the doses left blank. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed there was no Symbicort inhaler available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Medications that were scheduled to be administered on a regular basis were automatically refilledMedications that was prn (as needed), inhalers, eye drops, and ointments, were not refilled automatically and would need to be requested for a refillThere was an order for Symbicort 160-4.5mcg two puffs twice daily for Resident #1.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
-Symbicort was not automatically dispensed to the facility; it would need to be requested for refillSymbicort was dispensed on 12/27/19, 04/27/20, 05/19/20, and 08/03/20The Symbicort inhaler would last for 30-days based on the order for 2 puffs twice daily. Observation of Resident #1 on 10/26/20 at 7:53am revealed she had an audible wheeze that could be heard approximately 8 feet away.	C 330	revealed: -There was an entry f two puffs by mouth tw administration time of -There were 9 days S not documented as a -There were 7 days S not documented as a -There were no except doses left blank. Observation of Resid on 10/26/20 at 9:00ar Symbicort inhaler ava Telephone interview v facility's contracted pl 3:52pm revealed: -Medications that wer administered on a reg automatically refilledMedication that was eye drops, and ointm automatically and wo a refillThere was an order two puffs twice daily f -Symbicort was not a the facility; it would ne -Symbicort was dispe 05/19/20, and 08/03/2 -The Symbicort inhale based on the order for Observation of Resid 7:53am revealed she	for Symbicort 160-4.5mcg vice daily with a scheduled f 8:00 am and 8:00 pm. Symbicort 160-4.5mcg was dministered at 8:00am. Symbicort 160-4.5mcg was dministered at 8:00pm. Symbicort 160-4.5mcg was dministered at 8:00pm. Symbicort of the vicions documented for the ent #1's medication on hand m revealed there was no allable for administration. With the pharmacist at the harmacy on 10/29/20 at re scheduled to be gular basis were prn (as needed), inhalers, ents, were not refilled uld need to be requested for for Symbicort 160-4.5mcg for Resident #1. Symbicort	C 330			

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL093012	B. WING		1	/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE		
PIVOTAL	CARE	303 W FF	RANKLIN STREET			
TIVOTAL	UAILE .	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 69	C 330			
	and 10:47am reveale -She used a Symbico helped her breathingShe had used a Sym -She did not recall wh Symbicort inhaler.	ort inhaler for her asthma; "it " nbicort inhaler at the facility.				
	care provider (PCP) of revealed: -Resident #1 was prefor maintenance of Resident #1 should I Symbicort inhaler as -Resident #1 was profond it was important medicationIf Resident #1 did not medication as ordere	nave been using the				
	2020, and October 20 -There was an entry for 0.02% solution four times daily shortness or breath.	e1's August 2020, September 2020 MARs revealed: for Ipratropium Bromide mes daily as needed for for Pro-Air 90MCG Inhaler 2 as needed for cough or tation Resident #1 was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING	B. WING		4/2020
	NAME OF PROVIDER OR SUPPLIER STREET AD 303 W FR WARREN				•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	treatments 32 times at times in August. -There was documen administered Ipratrop treatments 24 times at times in September. -There was documen administered Ipratrop treatments 28 times at times in October. Interview with a medi 10/29/20 at 3:44pm re-She administered and when she worked. -She thought the inhal Resident #1's Symbication of the inhaler on hand "pro-air" and there we available for Resident Interview with a second 6:30pm revealed she medication cabinet (p Symbicort; she had juta Telephone interview with a second 6:30pm revealed she medication cabinet (p Symbicort; she had juta Telephone interview with a second 6:30pm revealed she medication cabinet (p Symbicort; she had juta Telephone interview with a second available to so the Symbicort available to she expected Residual administered as order Telephone interview with a second administered as order Telephone interview with a second available so the Symbolicort available to she symbolicort avai	ium Bromide nebulizer and her Proair inhaler 25 tation Resident #1 was ium Bromide nebulizer and her Proair inhaler 34 tation Resident #1 was ium Bromide nebulizer and her Proair inhaler 36 cation aide (MA) on evealed: inhaler to Resident #1 alter she administered was cort. for Resident #1 was ere no other inhalers to #1 and MA on 10/29/20 at thought the inhaler in the pro-air) was Resident #1's last "overlooked it." with the facility's Registered (20 at 1:16pm revealed: Resident #1 did not have to be administered. ent #1's Symbicort to be officer could have been red. with the Administrator on evealed: esident #1's Symbicort was evealed: esident #1's Symbicort was evealed: esident #1's Symbicort was	C 330			

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-She expected Resident #1's Symbicort to have

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL CARE		ANKLIN STREE TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE COMPLETE	
	12/30/19 revealed the for Vitamin D3 1000IL treat a vitamin D defice Review of Resident # administration record -There was an entry f with a scheduled adm -There was documen administered on 08/0 Review of Resident # revealed: -There was an entry f with a scheduled adm -There were 10 days documented as administered as administered on 08/0	t #1's current FL-2 dated ere was a medication order U (a supplement used to ciency) take one tablet daily. It's August 2020 medication (MAR) revealed: For Vitamin D3 1000IU daily ninistration time of 8:00am. It's September 2020 MAR For Vitamin D3 1000IU daily ninistration time of 8:00am. It's September 2020 MAR For Vitamin D3 1000IU daily ninistration time of 8:00am. Vitamin D3 1000IU was not				
	doses left blank. Review of Resident # revealed: -There was an entry f with a scheduled adm-There were 6 days V documented as admir-There were no except doses left blank. Observation of Resident #1's medical bubble packAll of Resident #1's repackaged in one bubble medications listed.	or Vitamin D3 1000IU daily ninistration time of 8:00am. Vitamin D3 1000IU was not nistered. Only of the lent #1's medication on hand on revealed: ation was in a pre-packaged morning medication was ble pack with the name of				

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Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL093012	B. WING		11/04/2020
		FGE093012			11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
DD/0741		303 W FF	RANKLIN STREE	т	
PIVOTAL (CARE	WARREN	ITON, NC 27589		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE
				DEFICIENCY)	
C 330	Continued From page	e 72	C 330		
	bubble pack and was	not available for			
	administration.				
	-	with the pharmacist at the			
	-	harmacy on 10/29/20 at			
	3:52pm revealed:				
		active order for Vitamin D3.			
		in D3 should have been in			
	Resident #1's bubble				
	-Resident #3's Vitami				
	dispensed since 02/1				
	_	/ Resident #3's Vitamin D3			
	did not get carried for				
	· ·	cted the MAs to notify the			
	pharmacist the medic	cation was not in the bubble			
	pack.				
		ent #1 on 10/29/20 at 9:51am			
	and 10:47am reveale				
		/itamin D3 but did not know			
	if it was in her pill pad				
		en stopped, she did not			
	know why it was stop	ped or when it was stopped.			
		with Resident #1's primary			
		on 11/02/20 at 12:31pm			
	revealed:	" 17" : DO			
	-Resident #1 was pre				
	secondary to a low V				
		have been taking Vitamin D3			
		Resident #1's Vitamin D was			
	"deficient."	ated Decident #41- Vitaria			
	-	cted Resident #1's Vitamin			
	D3 to have been adm	imistered as ordered.			
	Intensionalities !	ection aids (MAN) ==			
	Interview with a medi	, ,			
	10/26/20 at 9:53am re				
		edication from the bubble			
	pack into Resident #1	I's cup at the time she			

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administered the medication.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.			
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIVOTAL	CADE	303 W FR	ANKLIN STREE	:Τ		
PIVOTAL	CARE	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	÷ 73	C 330			
	-She did not compare bubble pack to the Ma-Resident medication packs; she "assumed bubble matched the Market and compacks; she bubble matched the Market and compacks; she "assumed to bubble pack and compact and	the medication in the ARs. was prepackaged in bubble the medications in the MARs." she should look at the pare the medication in the k to the resident's MARs. with the same MA on evealed: e Vitamin D3 tablet was in pack and had documented stered on the MAR. Resident #1's Vitamin D3 e1's bubble pack prior to				
	10/29/20 at 1:16pm re-She was not aware F was not in the prepare -"That was why the M bubble pack to the re-Telephone interview of 10/29/20 at 4:39pm re-She was not aware F her Vitamin D3 as ore-She did not understanot packaged in Residuen administered as c. Review of Residen 12/30/19 revealed the	Resident #1's Vitamin D3 kaged bubble pack. lAs should compare the sident's MARs." with the Administrator on evealed: Resident #1 had not received dered. and why the Vitamin D3 was dent #1's bubble pack. ent #1's Vitamin D3 to have a ordered. t #1's current FL-2 dated ere was a medication order				
	for Flonase 50mcg (a allergy symptoms) da	nasal spray used to relieve ily.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL093012	B. WING		1.	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE	303 W F	RANKLIN STREET			
TIVOTAL	OAKE	WARREI	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From pag	ge 74	C 330			
	administration record -There was no entry -There was no document was administered or Review of Resident revealed: -There was no entry -There was no document record.	for Flonase 50mcg daily. mentation Flonase 50mcg n 08/01/20-08/30/20. #1's September 2020 MAR for Flonase 50mcg daily. mentation Flonase 50mcg				
	was administered on 09/01/20-09/30/20. Review of Resident #1's October 2020 MAR revealed: -There was no entry for Flonase 50mcg dailyThere was no documentation Flonase 50mcg was administered on 10/01/20-10/26/20.					
	on 10/26/20 at 9:00a	dent #1's medication on hand am revealed there was no lable to be administered.				
	revealed: -She was using Flon recall if she had eve -She thought using t	ent #1 on 10/29/20 at 9:51am hase at home daily but did not rused Flonase at the facility. he Flonase nasal spray better but she had not asked edication.				
	facility's contracted p 3:52pm revealed: -Medication that was eye drops, and ointn automatically and wo a refill.	with the pharmacist at the charmacy on 10/29/20 at s prn (as needed), inhalers, nents, were not refilled could need to be requested for active order for Flonase				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. 501251110.				
		FCL093012	B. WING		11/04/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
PIVOTAL	CARE		RANKLIN STREET				
	T		NTON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPL THE APPROPRIATE DAT	LETE	
C 330	Continued From page	e 75	C 330				
	filled for Resident #1Flonase 50mcg was #1Flonase 50mcg was	not been requested to be not dispensed for Resident not automatically dispensed I need to be requested for a					
	care provider (PCP) of revealed: -Resident #1 was predicted: -He would have expet to have been administedIf Resident #1's issum would have disconting. Interview with a medical	ected Resident #1's Flonase stered as ordered. e had been resolved he ued the medication. cation aide on 10/26/20 at was not aware Resident #1					
	Telephone interview of 10/29/20 at 1:16pm re-She was not aware In FlonaseIf there was an order	with the facility's RN on					
	10/29/20 at 4:39pm r-She was not aware I Flonase as orderedShe expected Resid been administered as d. Review of Reside 12/30/19 revealed:	Resident #1 had not received ent #1's Flonase to have s ordered. nt #1's current FL-2 dated diabetes mellitus, major					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.11.27 27.11	or definition	IDEITH IO/HIOH HOMBER.	A. BUILDING:		00111112	
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO)N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
C 330	Continued From page	e 76	C 330			
	dyspnea on exertionThere was no order to	one used to regulate sleep)				
	on 10/29/20 at 10:58a	ent #1's medication on hand am revealed there was an C) bottle of Melatonin 10mg ration.				
	Review of Resident # revealed there was no	1's physician's orders o order for Melatonin.				
	Review of Resident #1's August 2020, September 2020, and October 2020 medication administration record (MAR) revealed there was no entry for the administration of Melatonin 10mg at bedtime.					
	revealed:	nt #1 on 10/29/20 at 4:00pm				
	sleep.	(MA) who was working				
		with Resident #1's primary on 11/02/20 at 12:31pm				
	administered Melaton -Even though Melator	nin as a sleep aid. n order for Resident #1 to be nin. nin could be purchased be notified Resident #1				
		with a pharmacist with the harmacy on 10/29/20 at				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DIVOTAL	0455	303 W FF	RANKLIN STREE	т		
PIVOTAL	CARE	WARREN	ITON, NC 27589			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
C 330	Continued From pag	e 77	C 330			
C 330	3:52pm revealed: -There was no order administered MelatorIf Resident #1 had a would have been ent MARsOTC medication prowould have required -There had been no Resident #1 through Interview with a MA orevealed: -She administered M whenever Resident #She assumed there MelatoninShe administered the directions on the OTC -There should have to when Melatonin was -She knew she was shack of the MAR when medication was administering MelatorMedication should in cabinet if there was readministered Melator -All medication should administered, "even a-The MAs knew how	on file for Resident #1 to be nin. In order for Melatonin, it dered on Resident #1's evided through the pharmacy an order. OTC Melatonin provided for the pharmacy. On 10/29/20 at 6:30pm elatonin to Resident #1 #1 asked for the Melatonin. It was an order for the de Melatonin based on the C bottle. Deen a place to document administered. Supposed to write on the en prn (as needed) inistered. In y she had not documented with to Resident #1. In to be in the medication no order on file. with the Administrator on revealed: Resident #1 was being nin without an order. In the discreption of the contact Resident #1's	C 530			
	PCP to obtain an ord 2. Review of Resider	ler for the Melatonin. nt #3's current FL-2 dated				

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11/01/19 revealed diagnoses included seizures,

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREE			
			ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
C 330	Continued From page	e 78	C 330			
	depression and mild i	ntellectual disability.				
	Review of Resident # was no order for an o	3's record revealed there ral tooth medication.				
	Review of Resident #3's medication administration record (MAR) for October 2020 and November 2020 revealed there was no order for an oral tooth medication.					
	Nurse (RN) on 10/29/ -She was made awar complaint of tooth paid October 2020She knew Resident appointment schedule aides (MA) made the -She took Resident # around the middle of medicated oral tooth painResident #3 did not I medicated oral tooth gotten an order for Remedicated oral tooth -She did not think abomedicated oral tooth -Resident #3 kept the	#3 had a dentist ed; one of the medication appointment. 3 to the store on a Saturday October 2020 to purchase drops to put on her tooth for have an order for the drops; she should have esident #3 to have the drops. but getting an order for the				
	2:48pm revealed: -The facility's RN tool oral tooth medicationThe oral tooth medic and she never documanywhere.	with a MA on 11/02/20 at Resident #3 to purchase ation was not on the MAR nented the administration ything about an order for the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/0	04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	E, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREET TON, NC 27589	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 330	Continued From page	e 79	C 330			
	oral tooth medication	l.				
	tooth dropsResident #3 had bot medication herself ar roomResident #3 got the sometime in October -She helped Residen medication two times help with the resident -She did not docume the oral tooth drops a on the MAR.	revealed: and named] medicated oral ught the oral tooth and kept them with her in her oral tooth medication 2020. at #3 use the oral tooth at; the medication seemed to at's pain. ant helping Resident #3 with and the medication was not ew Resident #3 had the oral the facility's RN took				
	1	with Resident #3's dentist on revealed she never ordered desident #3.				
	at 1:47pm revealed: -The facility's RN too medication for her too -She kept the oral too but did not know whe -The staff would help	oth medication in her room				
	10/29/20 at 4:42pm r -An order for medicat	tion was needed before edication, even over the				

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-The staff should call the primary care provider

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 330	(PCP) for an order for should be added to the should be added to a should be added to the should	or a medication and then it he MAR. Soout an oral tooth medication as the first she had heard of eded to be an order administer medications as edications used to treat #1 had not been refilled and at #1 was using her prn nebulizer treatments and an and an oral tooth medication stered by a resident (#3) for order. This failure was alth and safety of the tutes a Type B Violation. a plan of protection in 5. 131D-34 on 11/04/20 for	C 330			
C 342	(j) The resident's me record (MAR) shall b following: (1) resident's name; (2) name of the medi (3) strength and dos medication administer	4 Medication Administration edication administration e accurate and include the ication or treatment order; age or quantity of	C 342			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL093012	B. WING		11/04	1/2020
NAME OF PROVIDER OR SUPPLIER PIVOTAL CARE	303 W FRA	RESS, CITY, STAN NKLIN STREE ON, NC 27589	Т		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
medications or treatmen documenting the resultin (6) date and time of adm (7) documentation of any medications or treatmen omission, including refus (8) name or initials of the the medication or treatm signature equivalent to the documented and maintal administration record (Matter Matter). This Rule is not met as Based on observations, interviews, the facility fair accuracy of the Medication Records for 3 of 3 samp #1, #2 and #3). The findings are: 1. Review of Resident #12/30/19 revealed diagn mellitus, major depressing gravis, hypertension, hyperitension, hyperitension, hyperitension, and dyspined as Review of Resident #12/30/19 revealed an ord 160-4.5mcg (a bronchood asthma) take two inhalations.	in for the administration of ints as needed (PRN) and ing effect on the resident; ininistration; by omission of ints and the reason for the sals; and in e person administering inent. If initials are used, a those initials is to be ained with the medication MAR). Evidenced by: record reviews, and initial to assure the initial t	C 342			

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scheduled administration time of 8:00am and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				_	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIVOTAL	CARE	303 W FR	ANKLIN STREE	:T	
PIVOTAL CARE WARREN			TON, NC 27589	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 342	Continued From page	e 82	C 342		
	8:00pmThere was documentation Symbicort 160-4.5mcg was administered 27 out of 30 opportunities at 8:00am.				
	Review of Resident # revealed:	1's October 2020 MARs			
	inhale 2 puffs by mou scheduled administra	for Symbicort 160-4.5mcg ith twice daily with a ition time of 8:00am and			
	8:00pm.				
	-There was documen				
		ninistered 17 out of 26			
	opportunities at 8:00a				
	-There was documen	-			
		ninistered 19 out of 26			
	opportunities at 8:00p	om. documented.			
	Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was no Symbicort inhaler available to be administered.				
		with the pharmacist at the harmacy on 10/29/20 at			
		Symbicort 160-4.5mcg two			
		daily for Resident #1.			
		utomatically dispensed to			
	1	eed to be requested for refill.			
		ensed on 12/27/19, 04/27/20,			
	05/19/20, and 08/03/2	20.			
	-The Symbicort inhale	er would last for 30-days			
	based on the order fo	or 2 puffs twice daily.			
	Interview with a medi 10/29/20 at 3:44pm re	evealed:			
	-She had documented for Resident #1.	d Symbicort as administered			
		inhaler to Resident #1			

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when she worked.

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OTATEMENT OF DEFICIENCIES (AV.) PROVIDED/OURD/USER/OUR			CONCERNATION	1000	115, (5),	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
VIAD LEWIN (O GONNEGION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPL	,
		FCL093012	B. WING		11/0	04/2020
NAME OF S	DOVIDED OD OUDDI IED	OTDEET :-	DDEEC 0171 071	TE ZID CODE	•	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
PIVOTAL (CARE		ANKLIN STREE			
		WARREN	TON, NC 27589	9		,
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
1/10		,	IAG	DEFICIENCY)		
0.040			0.040			
C 342	Continued From page	e 83	C 342			
	-She thought the inha	aler she administered was]
	Resident #1's Symbio					
	-The inhaler on hand	for Resident #1 was				
	"pro-air" and there wa	as no other inhaler available				
	for Resident #1					
	Interview with a secon	nd MA on 10/29/20 at				
	6:30pm revealed:					
		d Symbicort as administered				
	for Resident #1.					
		aler in the medication cabinet				
	was Resident #1's Sy	mbicort; she had just				
	"overlooked it."					
	D-f4-4-1-4					
		with a medication aide (MA)				
	on 10/26/20 at 9:53ar	п.				
	Pefer to the telephone	e interview with a second				
	MA on 10/27/20 at 9:3					
	WA 011 10/21/20 at 3.0	odam.				
	Refer to the second in	nterview with a MA on				
	10/29/20 at 3:44pm.					
						
	Refer to the telephone	e interview with a third MA				
	on 11/02/20 at 4:52pr					
	·					
	Refer to the telephone	e interview with the facility's				
	Registered Nurse (RN	N) on 10/29/20 at 1:31pm				
	and 2:53pm.	·]]
	Refer to the telephone					
	Administrator on 10/2	27/20 at 12:30pm.]]
	Refer to the telephone					
	Administrator on 10/2	9/20 at 5:23pm.				
	h Badan (B. 11	-t #41 FL O L t				
		nt #1's current FL-2 dated				
	12/30/19 revealed an					
	TUUUIU (a Vitamin sup	oplement) take 1 tablet daily.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE		
	Т		ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
C 342	Continued From page	e 84	C 342		
	-There was an entry the tablet daily with a schoof 8:00amThere was documen	et1's September 2020 ation record (MAR) revealed: for Vitamin D3 1000IU take 1 neduled administration time tation Vitamin D3 1000IU out of 30 opportunities.			
	revealed: -There was an entry f tablet daily with a sch of 8:00amThere was documen	for Vitamin D3 1000IU take 1 needuled administration time tation Vitamin D3 1000IU out of 26 opportunities.			
	revealed: -There was an entry f with a scheduled adn -There was documen administered on 10/0	for Vitamin D3 1000IU daily ninistration time of 8:00am. tation Vitamin D3 was 1/20-10/05/20, 10/07/20, 0/16/20-10/19/20, 10/21/20, 8:00am.			
	on 10/26/20 at 9:00al -All of Resident #1's r packaged in one bub the medications listed	morning medication was ble pack with the name of d on the bubble pack. listed on Resident #1's			
	facility's contracted pl 3:52pm revealed: -Resident #1 had an	with the pharmacist at the harmacy on 10/29/20 at active order for Vitamin D3. in D3 should have been in pack.			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	IRVFY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
			7 20.250.			
		FCL093012	B. WING		11/04/2020	
NAME OF D			DESS CITY STA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
PIVOTAL (CARE		ANKLIN STREE ON, NC 27589			
	OUR MAN DV OT	ATEMENT OF DEFICIENCIES	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 85	C 342			
	-Resident #3's Vitamin D3 had not been dispensed since 02/18/20He did not know why Resident #3's Vitamin D3 did not get carried forward. Telephone interview with a MA on 10/30/20 at 9:23am revealed: -She had assumed the Vitamin D3 tablet was in Resident #1's bubble pack and had documented Vitamin D3 as administered on the MARShe had not noticed Resident #1's Vitamin D3 was not in Resident #1's bubble pack prior to 10/26/20She did not initial administering Resident #1's Vitamin D3 on 10/28/20 because she had compared the bubble pack to the MAR and saw the Vitamin D3 tablet was not in the packShe had not told anyone about the missing Vitamin D3 tablet, "I forgot."					
	Refer to the telephone MA on 10/27/20 at 9:3 Refer to the second ir 10/29/20 at 3:44pm.					
	Refer to the telephone on 11/02/20 at 4:52pn	e interview with a third MA n e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					

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Refer to the telephone interview with the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	TON (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
C 342	Continued From page 86		C 342			
	Administrator on 10/2	9/20 at 5:23pm.				
	c. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Ferrous Sulfate 325mg (an iron supplement) take 1 tablet daily.					
		ation record (MAR) revealed: or Ferrous Sulfate 325mg / with a scheduled 8:00am. tation Ferrous Sulfate				
	Review of Resident #1's October 2020 MARs revealed: -There was an entry for Ferrous Sulfate 325mg take 1 tablet one daily with a scheduled administration time of 8:00amThere was documentation Ferrous Sulfate 325mg was administered 20 out of 26 opportunities.					
	hand on 10/26/20 at 9 bubble pack labeled is	ent #1's medications on 0:00am revealed there was a Resident #1's morning ained Ferrous Sulfate				
	Refer to the interview on 10/26/20 at 9:53ar	with a medication aide (MA) n.				
	Refer to the telephon MA on 10/27/20 at 9:	e interview with a second 30am.				
	Refer to the second in 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephon	e interview with a third MA				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			
		FCL093012	B. WING		11/04	4/2020
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page 87		C 342			
	on 11/02/20 at 4:52pm					
	Refer to the telephone Registered Nurse (RN and 2:53pm. Refer to the telephone Administrator on 10/2 Refer to the telephone Administrator on 10/2 d. Review of Resider 12/30/19 revealed an (used to treat heartbureflux disease) take 1	e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the 17/20 at 12:30pm. e interview with the 19/20 at 5:23pm. at #1's current FL-2 dated order for Omeprazole 40mg arn and gastroesophageal tablet daily.				
	-There was an entry f with a scheduled adm -There was documen	ation record (MAR) revealed: for Omeprazole 40mg daily ninistration time of 8:00am. tation Omeprazole 40mg out of 30 opportunities.				
	revealed: -There was an entry f with a scheduled adm -There was documen	or Omeprazole 40mg daily ninistration time of 8:00am. tation Omeprazole 40mg out of 26 opportunities.				
	hand on 10/26/20 at 9 bubble pack labeled F medications that cont	ent #1's medications on 9:00am revealed there was a Resident #1's morning ained Omeprazole 40mg.				
	on 10/26/20 at 9:53ar	with a medication aide (MA) n.				

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Refer to the telephone interview with a second

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1, ,	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	e 88	C 342			
	MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm					
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephon Administrator on 10/2					
	Refer to the telephon Administrator on 10/2					
	dated 03/16/20 revea	nt #1's physician's orders led there was an order for (used to treat high blood et daily.				
	-There was an entry f 1 tablet daily with a so of 8:00am. -There was documen	c1's September 2020 ation record (MAR) revealed: for Lisinopril 20-12.5mg take cheduled administration time tation Lisinopril 20-12.5mg out of 30 opportunities.				
	revealed: -There was an entry f 1 tablet daily with a so of 8:00amThere was documen was administered 20	for Lisinopril 20-12.5mg take cheduled administration time tation Lisinopril 20-12.5mg out of 26 opportunities.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STAT	E ZIP CODE	,
			ANKLIN STREET	•	
PIVOTAL	CARE	WARREN	TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 342	2 Continued From page 89		C 342		
	hand on 10/26/20 at 9 bubble pack labeled F medications that cont	9:00am revealed there was a Resident #1's morning ained Lisinopril 20-12.5mg.			
	on 10/26/20 at 9:53ar	with a medication aide (MA) n.			
	Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm.				
	Refer to the telephone on 11/02/20 at 4:52pr	e interview with a third MA n			
	-	e interview with the facility's N) on 10/29/20 at 1:31pm			
	Refer to the telephone Administrator on 10/2				
	Refer to the telephone Administrator on 10/2				
	dated 03/26/20 revea	t #1's physician's order led there was an order for anti-anxiety medication) take aily.			
	Review of Resident # 09/10/20 revealed the Lorazepam 1mg take				
	-There was an entry f	ation record (MAR) revealed: or Lorazepam 1mg tablets a scheduled administration			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W FRA	NKLIN STREE	т		
		WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page 90		C 342			
C 342	-There was document administered 8 out of state of the was document administered 4 out of state of the was a hand-with the was an entry for the was document administered 15 out of 8:00am. -There was document administered 10 out of 8:00pm. Review of Resident # revealed: -There was an entry for the was an entry for the was document administered 15 out of 8:00am. -There was an entry for the was document administered 15 out of 8:00am. -There was document administered 15 out of 8:00am. -There was document administered 13 out of 8:00am. -There was document administered 13 out of 8:00am. Observation of Resident of Resident of 10/26/20 at 9-10 at 9	tation Lorazepam 1mg was 10 opportunities at 8:00am. tation Lorazepam 1mg was 10 opportunities at 2:00pm. tation Lorazepam 1mg was 10 opportunities at 8:00pm. ritten entry for Lorazepam that was discontinued on for Lorazepam 1mg tablets teduled administration time of with a start date of 09/10/20 tation Lorazepam 1mg was of 20 opportunities at tation Lorazepam 1mg was of 21 opportunities at 1's October 2020 MARs for Lorazepam 1mg tablets teduled administration time of tation Lorazepam 1mg was of 26 opportunities at	C 342			
	1mgThere was a second	bubble pack labeled				

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Lorazepam 1mg.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page 91 Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.		C 342			
	Refer to the telephone MA on 10/27/20 at 9:3	e interview with a second 30am.				
	Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm					
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					
	Refer to the telephone Administrator on 10/2					
	dated 03/26/20 revea	t #1's physician's order led there was an order for (an anti-depressant) take 1				
	-There was an entry f take 1 tablet daily with time of 8:00am. -There was documen	ation record (MAR) revealed: for Bupropion XL 300mg the a scheduled administration tation Bupropion XL 300mg out of 30 opportunities.				
	revealed: -There was an entry f	1's October 2020 MARs or Bupropion XL 300mg h a scheduled administration				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04	4/2020
NAME OF P	ROVIDER OR SUPPLIER	303 W FRA	DRESS, CITY, STA ANKLIN STREE FON, NC 27589	т		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
C 342	time of 8:00am. -There was documen was administered 20 Observation of Resid hand on 10/26/20 at 9 bubble pack labeled I medications that conton Refer to the interview on 10/26/20 at 9:53ar Refer to the telephon MA on 10/27/20 at 9:33 Refer to the second in 10/29/20 at 3:44pm. Refer to the telephon on 11/02/20 at 4:52pr Refer to the telephon Registered Nurse (Ri and 2:53pm. Refer to the telephon Registered Nurse (Ri and 2:53pm. Refer to the telephon Administrator on 10/2 Refer to the telephon Administrator on 10/2 h. Review of Resider dated 03/26/20 revea Zolpidem Tartrate 5m take 1 tablet at bedtin Review of Resident # medication administrator	tation Bupropion XL 300mg out of 26 opportunities. ent #1's medications on 3:00am revealed there was a Resident #1's morning ained Bupropion XL 300mg. with a medication aide (MA) m. e interview with a second 30am. hterview with a MA on e interview with a third MA m e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the 17/20 at 12:30pm. e interview with the 19/20 at 5:23pm. ht #1's physician's order led there was an order for g (used to treat insomnia) ne.	C 342			

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take 1 tablet at bedtime with a scheduled

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	
		FCL093012	B. WING		11/04	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CADE	303 W FRA	ANKLIN STREE	т		
FIVOIAL	CARE	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	93	C 342			
	administration time of 8:00pmThere was documentation Zolpidem Tartrate 5mg was administered 25 out of 30 opportunities.					
	revealed:	1's October 2020 MARs or Zolpidem Tartrate 5mg				
	take 1 tablet at bedtin administration time of	ne with a scheduled 8:00pm.				
		tation Zolpidem Tartrate d 21 out of 26 opportunities.				
	hand on 10/26/20 at 9 bubble pack labeled F	ent #1's medications on 0:00am revealed there was a Resident #1's bedtime ained Zolpidem Tartrate				
	Refer to the interview on 10/26/20 at 9:53ar	with a medication aide (MA) n.				
	Refer to the telephone MA on 10/27/20 at 9:3	e interview with a second 30am.				
	Refer to the second ir 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephone on 11/02/20 at 4:52pm	e interview with a third MA n				
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					
	Refer to the telephone					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 11/4	
PIVOTAL (CARE		NKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 342	03/26/20 revealed the Memantine 10mg (comedication) take 1 talk Review of Resident # medication administration administration time of tablet by mouth twice administration time of there was document administered 26 out of 8:00am. There was document administered 23 out of 8:00pm. Review of Resident # revealed: There was an entry for tablet by mouth twice administration time of tablet by mouth twice administration time of there was document administered 20 out of 8:00am. There was document administered 19 out of 8:00pm. Observation of Resident # 100pm. Observation of Resident # 100pm. There was a bubble morning medications HCL 10mg. There was a second Resident #1's bedtime Memantine HCL 10m	#1's physician's order dated ere was an order for gnition enhancing olet twice daily. 1's September 2020 ation record (MAR) revealed: or Memantine 10mg take 1 daily with a scheduled 8:00am and 8:00pm. tation Memantine 10mg was of 30 opportunities at tation Memantine 10mg was of 30 opportunities at 1's October 2020 MARs or Memantine 10mg take 1 daily with a scheduled 8:00am and 8:00pm. tation Memantine 10mg was of 26 opportunities at the station Memantine 10mg was opportunities at the station Memantine 10mg was of 26 opportunities at the station Memantine 1	C 342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF D	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	7IP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUFFLIER		RANKLIN STREET	, ZIF GODE		
PIVOTAL	CARE	****	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 342	C 342 Continued From page 95		C 342			
	Refer to the telephone MA on 10/27/20 at 9:3	e interview with a second 30am.				
	Refer to the second in 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephone on 11/02/20 at 4:52pr	e interview with a third MA n				
	Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.					
	Refer to the telephone Administrator on 10/2					
	Refer to the telephone Administrator on 10/2					
	dated 03/26/20 revea	t #1's physician's order led there was an order for vitamin supplement) take 1				
	-There was an entry f tablet daily with a sch of 8:00am. -There was documen	1's September 2020 ation record (MAR) revealed: for Vitamin B1 100mg take 1 eduled administration time tation Vitamin B1 100mg out of 30 opportunities.				
	revealed: -There was an entry f tablet daily with a sch of 8:00am.	1's October 2020 MARs or Vitamin B1 100mg take 1 eduled administration time tation Vitamin 1000mg was of 26 opportunities.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	ZIP CODE	·	
PIVOTAL	CARE		RANKLIN STREET ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	96	C 342			
	hand on 10/26/20 at 9 bubble pack labeled F medications that cont					
	on 10/26/20 at 9:53ar	with a medication aide (MA) n.				
	Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.					
	Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm					
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					
	Refer to the telephone Administrator on 10/2					
	dated 03/26/20 revea	nt #1's physician's order led there was an order for a nin supplement) take 1 tablet				
	-There was an entry f tablet daily with a sch of 8:00am.	ation record (MAR) revealed: or a Multi-Vitamin take 1 eduled administration time tation a Multi-Vitamin was				

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PIVOTAL CARE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) TAG Regulatory or Lsc identifying information) C 342 C 342 C Ontinued From page 97 Review of Resident #1's October 2020 MARs revealed: - There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am There was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 Continued From page 97 C 342 Review of Resident #1's October 2020 MARs revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on	ANDIEANOI	CONTRACTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		OOM! EL	
PIVOTAL CARE 303 W FRANKLIN STREET WARRENTON, NC 27589 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 Continued From page 97 C 342 Review of Resident #1's October 2020 MARs revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on			FCL093012	B. WING		11/0	4/2020
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 Continued From page 97 Review of Resident #1's October 2020 MARs revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE COMPLETE DATE OF THE APPROPRIATE DATE OF THE APPROPRI	PIVOTAL CA	ARE					
Review of Resident #1's October 2020 MARs revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on	C 342	Continued From page	97	C 342			
hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Multi-Vitamin. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/27/20 at 5:23pm. I. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Levothyroxine 75mcg (used to treat	r - tt cc - a c c c c c c c c c c c c c c c c	revealed: -There was an entry for tablet daily with a schoof 8:00amThere was document administered 20 out of the control of	or a Multi-Vitamin take 1 eduled administration time tation a Multi-Vitamin was if 26 opportunities. ent #1's medications on 0:00am revealed there was a Resident #1's morning ained Multi-Vitamin. with a medication aide (MA) in. e interview with a second 30am. heterview with a MA on e interview with a third MA in e interview with the facility's in) on 10/29/20 at 1:31pm e interview with the 7/20 at 12:30pm. e interview with the 9/20 at 5:23pm. t #1's physician's order led there was an order for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SU	
7.11.27 27.11	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _		JOHN EE	
		FCL093012	B. WING		11/04	/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE FON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 342	Continued From page	98	C 342			
	-There was an entry fidally with a scheduled 8:00amThere was document was administered 21 Review of Resident # revealed: -There was an entry fidally with a scheduled 8:00amThere was document was administered 20 Observation of Residehand on 10/26/20 at 9:50 bubble pack labeled fimedications that continuous Refer to the interview on 10/26/20 at 9:53 are Refer to the telephone MA on 10/27/20 at 9:50 Refer to the telephone on 11/02/20 at 4:52 processor Refer to the telephone on 11/02/20 at 4:52 processor Refer to the telephone on 11/02/20 at 4:53 pm.	ation record (MAR) revealed: for Levothyroxine 75mcg d administration time of tation Levothyroxine 75mcg out of 30 opportunities. This October 2020 MARs for Levothyroxine 75mcg d administration time of tation Levothyroxine 75mcg out of 26 opportunities. ent #1's medications on 0:00am revealed there was a Resident #1's morning rained Levothyroxine 75mcg. with a medication aide (MA) m. e interview with a second 30am. heterview with a MA on e interview with a third MA m e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1170-172020
PIVOTAL	CARE	303 W FRA	NKLIN STREE	T	
			ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 342	Continued From page	99	C 342		
	Refer to the telephone Administrator on 10/2				
	dated 03/26/20 reveal	nt #1's physician's order led there was an order for n immunosuppressive blets daily.			
	-There was an entry for tablets daily with a sol of 8:00am.	ation record (MAR) revealed: or Azathioprine 50mg take 3 heduled administration time			
		ation Azathioprine 50mg out of 30 opportunities.			
	Review of Resident #1's October 2020 MARs revealed: -There was an entry for Azathioprine 50mg take 3				
	tablets daily with a sci of 8:00am.	heduled administration time			
		cation Azathioprine 50mg out of 26 opportunities.			
	hand on 10/26/20 at 9 bubble pack labeled F	ent #1's medications on 0:00am revealed there was a Resident #1's morning ained three Azathioprine			
	Refer to the interview on 10/26/20 at 9:53an	with a medication aide (MA) n.			
	Refer to the telephone MA on 10/27/20 at 9:3	e interview with a second 30am.			
	Refer to the second ir 10/29/20 at 3:44pm.	nterview with a MA on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	E, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Refer to the telephonon 11/02/20 at 4:52pr Refer to the telephonon Registered Nurse (Rivand 2:53pm. Refer to the telephonon Administrator on 10/2 Refer to the telephonon Administrator on 10/2 n. Review of Resider 12/30/19 revealed an take two tablets daily. Review of Resident # medication administrator on 10/2 review of Resident # medication administrator on 10/2 n. Review of Resident # medication administrator on 10/2 review of Resident # revealed solution administered 26 out of 8:00am. There was an entry for tablets daily with a solution of Resident # revealed: There was an entry for tablets daily with a solution of Resident # revealed: There was document administered 21 out of 8:00am. There was document administered 21 out of 8:00am.	e interview with a third MA n e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the 17/20 at 12:30pm. e interview with the 19/20 at 5:23pm. Int #1's current FL-2 dated order for Sertraline 100mg Int September 2020 ation record (MAR) revealed: for Sertraline 100mg take 2 sheduled administration time tation Sertraline 100mg was of 30 opportunities. Int's October 2020 MARs for Sertraline 100mg take 2 sheduled administration time tation Sertraline 100mg was of 26 opportunities. ent #1's medications on 0:00am revealed there was a Resident #1's morning ained two Sertraline 100mg	C 342			
	Refer to the interview	with a medication aide (MA)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			
		FCL093012	B. WING		11	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	e 101	C 342			
	on 10/26/20 at 9:53ar	m.				
	Refer to the telephone MA on 10/27/20 at 9:	e interview with a second 30am.				
	Refer to the second interview with a MA on 10/29/20 at 3:44pm.					
	Refer to the telephone on 11/02/20 at 4:52pr	e interview with a third MA n				
	Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.					
	Refer to the telephone Administrator on 10/2					
	11/01/19 revealed dia	t #2's current FL-2 dated agnoses included unspecified matic brain injury chronic, and epilepsy.				
	11/01/19 revealed the	t #2's current FL-2 dated ere was an order for a nin supplement) take 1 tablet				
	revealed: -There was an entry f tablet daily with a sch of 8:00am.	2's September 2020 MAR for a Multi-Vitamin take 1 reduled administration time tation a Multi-Vitamin was				
		2's October 2020 MARs				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL093012	B. WING		11	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	revealed: -There was an entry tablet daily with a sc of 8:00amThere was documed administered 17 out Observation of Reside hand on 10/26/20 at bubble pack labeled medications that consumed to the interview on 10/26/20 at 9:53as. Refer to the interview on 10/26/20 at 9:53as. Refer to the telephore MA on 10/27/20 at 9:83as. Refer to the telephore on 11/02/20 at 3:44pm. Refer to the telephore on 11/02/20 at 4:52ps. Refer to the telephore Registered Nurse (Rand 2:53pm. Refer to the telephore Administrator on 10/25. Refer to the telephore Administrator on 10/25. Refer to the telephore Administrator on 10/25. Review of Resided 11/01/19 revealed the D3 1000IU (a vitaminal daily.	for a Multi-Vitamin take 1 heduled administration time ntation a Multi-Vitamin was of 26 opportunities. dent #2's medications on 9:30am revealed there was a Resident #2's morning ntained a Multi-Vitamin. w with a medication aide (MA) nm. he interview with a second :30am. interview with a MA on he interview with a third MA nm he interview with the facility's (N) on 10/29/20 at 1:31pm he interview with the 27/20 at 12:30pm. he interview with the	C 342			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27589 [(A4)] (PAPID THAN INTERPRET WARRENTON OF DEFICIENCIES WARRENTON, NC 27589 [(EACH CORRECTION WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C Continued From page 103 revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am. -There was an entry for Vitamin D3 1000IU was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was documentation Vitamin D3 1000IU was administered 17 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained a Vitamin D3 1000IU. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
PIVOTAL CARE 303 W FRANKLIN STREET WARRENTON, NC 27589 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C Ontinued From page 103 revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 6:00amThere was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 6:00amThere was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 6:00amThere was administered 17 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained a Vitamin D3 1000IU. Refer to the interview with a medication aide (MA)			FCL093012	B. WING		11/04/2020)
PNOTAL CARE WARRENTON, NC 27589 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C ontinued From page 103 revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation Vitamin D3 1000IU was administered 17 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained a Vitamin D3 1000IU. Refer to the interview with a medication aide (MA)	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	,	
C 342 Continued From page 103 C 342 Continued From page 103 revealed: -There was an entry for Vitamin D3 1000IU was administered 20 out of 30 opportunities. There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am. -There was an entry for Vitamin D3 1000IU was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am. -There was an entry for Vitamin D3 1000IU was administered 17 out of 26 opportunities.	PIVOTAL	CARE					
revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation Vitamin D3 1000IU was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00amThere was documentation Vitamin D3 1000IU was administered 17 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained a Vitamin D3 1000IU. Refer to the interview with a medication aide (MA)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMP	PLETE
Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.	C 342	revealed: -There was an entry tablet daily with a schof 8:00amThere was documen was administered 20 Review of Resident # revealed: -There was an entry tablet daily with a schof 8:00amThere was documen was administered 17 Observation of Resid hand on 10/26/20 at 9:There was a bubble morning medications 1000IU. Refer to the interview on 10/26/20 at 9:53al Refer to the telephon MA on 10/27/20 at 9: Refer to the telephon on 11/02/20 at 3:44pm. Refer to the telephon on 11/02/20 at 4:52pt Refer to the telephon Registered Nurse (RI and 2:53pm. Refer to the telephon.	for Vitamin D3 1000IU take 1 needuled administration time station Vitamin D3 1000IU out of 30 opportunities. #2's October 2020 MARs for Vitamin D3 1000IU take 1 needuled administration time station Vitamin D3 1000IU out of 26 opportunities. #2's medications on 9:30am revealed: pack labeled Resident #2's that contained a Vitamin D3 ## with a medication aide (MA) m. ## with a medication aide (MA) m. ## interview with a second 30am. ## interview with a third MA m. ## interview with the facility's N) on 10/29/20 at 1:31pm ## interview with the	C 342	DELICITIENCI)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		FCL093012	B. WING		11	/04/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL C	CARE		RANKLIN STREE ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	11/01/19 revealed the Magnesium Oxide 40 maintain adequate m. 2 tablets three times a Review of Resident # revealed: -There was an entry f take 2 tablets by moust addinistration and 6:00pmThere was document was administered 17 8:00amThere was document was administered 24 2:00pmThere was document was administered 20 6:00pm. Review of Resident # revealed -There was an entry for take 2 tablets by moust administration and 6:00pmThere was document was administered 17 8:00amThere was document was administered 17 8:00amThere was document was administered 24 2:00pmThere was document was administered 24 2:00pm.	e interview with the 19/20 at 5:23pm. In #2's current FL-2 dated are was an order for 0mg (a supplement to agnesium in the body) take	C 342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D. WING			
		FCL093012			11/	04/2020
NAME OF PROVIDER	R OR SUPPLIER		DDRESS, CITY, STA CANKLIN STREE	,		
PIVOTAL CARE			TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 342 Conti	nued From page	105	C 342			
hand -There morni Oxide -There Resid Magn -There #2's e Magn Refer on 10 Refer MA or Refer 10/29 Refer con 11 Refer Regis and 2 Refer Admin Refer Admin Refer Admin	on 10/26/20 at 9 e was a bubble programmedications a 400mg (2 table e was a second lent #2's noon musium Oxide 40 e was a third bubble eight was a to the telephone eight was a total eight was	bubble pack labeled redications that contained omg (2 tablets). bble pack labeled Resident ons that contained omg (2 tablets). with a medication aide (MA) m. e interview with a second 30 am. hterview with a MA on e interview with a third MA m. e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the 7/20 at 12:30pm.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
			TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 106	C 342			
	revealed: -There was an entry f take 1 tablet by moutl scheduled administra 8:00pmThere was documen was administered 20 8:00amThere was documen was administered 18 8:00pm. Review of Resident # revealed: -There was an entry f take 1 tablet by moutl scheduled administra 8:00pmThere was documen was administered 16 8:00pmThere was documen was administered 16 8:00amThere was documen was administered 14 8:00pm. Observation of Reside hand on 10/26/20 at 9 -There was a bubble morning medications Sodium 500mgThere was a second Resident #2's bedtime Divalproex Sodium E	tation time of 8:00am and tation Divalproex ER 500mg out of 30 opportunities at tation Divalproex ER 500mg out of 30 opportunities at 2's October 2020 MARs or Divalproex ER 500mg on twice daily with a tion time of 8:00am and tation Divalproex ER 500mg out of 26 opportunities at tation Divalproex ER 500mg out of 26 opportunities at ent #2's medications on 0:30am revealed: pack labeled Resident #2's that contained Divalproex bubble pack labeled e medications that contained R 500mg (2 tablets). with a medication aide (MA)				

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Refer to the telephone interview with a second

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		FCL093012	B. WING		1.	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
PIVOTAL	CARE	303 W F	RANKLIN STREET			
		WARRE	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	e 107	C 342			
	MA on 10/27/20 at 9:	30am.				
	Refer to the second in 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm					
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.					
	11/01/19 revealed the	ng (used to treat seizures)				
	Review of Resident #	2's September 2020 MAR				
	take 1 tablet by mout	or Levetiracetam 1000mg h twice daily with a tion time of 8:00am and				
	-There was documen 1000mg was adminis opportunities at 8:00a	tered 18 out of 30 am.				
	-There was documen 1000mg was adminis opportunities at 8:00p	tered 16 out of 30				
	revealed:	2's October 2020 MARs for Levetiracetam 1000mg				
	take 1 tablet by mout					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL093012	B. WING		11	/04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	scheduled administra 8:00pmThere was documen 1000mg was adminis opportunities at 8:00a -There was documen 1000mg was adminis opportunities at 8:00p Observation of Resid hand on 10/26/20 at 9 -There was a bubble morning medications Levetiracetam 1000m -There was a second Resident #2's bedtim Levetiracetam 1000m f. Review of Resident 11/01/19 revealed the Melatonin fast dissolv tablets at bedtime. Review of Resident # revealed: -There was an entry f 3mg take 2 tablets da administration time of -There was an entry f smg take 2 tablets da administration time of -There was an entry f smg take 2 tablets da administration time of -There was an entry f smg take 2 tablets da administration time of -There was an entry f smg take 2 tablets da administration time of -There was an entry f smg take 2 tablets da administration time of -There was documen	tation time of 8:00am and tation Levetiracetam tered 16 out of 26 am. tation Levetiracetam tered 14 out of 26 om. ent #2's medications on 9:30am revealed: pack labeled Resident #2's that contained ag. bubble pack labeled e medications that contained ag. t #2's current FL-2 dated ere was an order for re 3mg (sleep aid) take 2 E2's September 2020 MAR for Melatonin Fast Dissolve aily with a scheduled f 8:00pm. tation Melatonin Fast ministered 20 out of 30 E2's October 2020 MARs for Melatonin Fast Dissolve will with a scheduled	C 342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	ובט
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE			
			ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	C 342 Continued From page 109		C 342			
	hand on 10/26/20 at 9 bubble pack labeled F	ent #2's medications on 9:30am revealed there was a Resident #2's bedtime ained Melatonin 3mg (2				
	Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.					
	Refer to the second in 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephone on 11/02/20 at 4:52pr	e interview with a third MA n				
		e interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephone Administrator on 10/2					
	Refer to the telephone Administrator on 10/2					
	11/01/19 revealed the	t #2's current FL-2 dated ere was an order for g (an antipsychotic) take 2				
	revealed: -There was an entry f 300mg take 1 tablet a administration time of	2's September 2020 MAR or Quetiapine Fumarate at bedtime with a scheduled 8:00pm. tation Quetiapine Fumarate				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING	B. WING		1/2020
	NAME OF PROVIDER OR SUPPLIER STREET ADD 303 W FRA WARRENT					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	revealed: -There was an entry f 300mg take 1 tablet a administration time of -There was documen 300mg was administe opportunities. Observation of Resid hand on 10/26/20 at 9 bubble pack labeled f medications that cont 300mg. Refer to the interview on 10/26/20 at 9:53ar Refer to the telephon MA on 10/27/20 at 9:3 Refer to the second in 10/29/20 at 3:44pm. Refer to the telephon on 11/02/20 at 4:52pr	2's October 2020 MARs for Quetiapine Fumarate at bedtime with a scheduled f 8:00pm. tation Quetiapine Fumarate ered 15 out of 26 ent #2's medications on 0:30am revealed there was a Resident #2's bedtime ained Quetiapine Fumarate with a medication aide (MA) m. e interview with a second 30am. hterview with a MA on e interview with a third MA m. e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the interview with the 17/20 at 12:30pm. e interview with the	C 342			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04	/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1110-	72020
PIVOTAL	CARE		ANKLIN STREE ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 342	11/01/19 revealed the Risperidone 4mg (an at bedtime. Review of Resident # revealed: -There was an entry f tablet at bedtime with time of 8:00pmThere was documen administered 18 out of the revealed: -There was an entry f tablet at bedtime with time of 8:00pmThere was an entry f tablet at bedtime with time of 8:00pmThere was documen administered 15 out of the revealed in	ant #2's current FL-2 dated are was an order for antipsychotic) take 1 tablet 2's September 2020 MAR or Risperidone 4mg take 1 a scheduled administration attation Risperidone 4mg was of 30 opportunities. 2's October 2020 MARs or Risperidone 4mg take 1 a scheduled administration attation Risperidone 4mg was of 26 opportunities. ent #2's medications on 2:30am revealed here was a Resident #2's bedtime ained Risperidone 4mg 1 with a medication aide (MA) m. e interview with a second 30am. hterview with a MA on	C 342			
	Refer to the telephone	e interview with the facility's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
PIVOTAL CARE 303 W FRA			RESS, CITY, STA NKLIN STREE ON, NC 27589	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Registered Nurse (RN and 2:53pm. Refer to the telephone Administrator on 10/2 Refer to the telephone Administrator on 10/2 3. Review of Residen 11/01/19 revealed dia depression and mild i a. Review of Residen 11/01/19 revealed the levetiracetam (a medi seizures) 750mg take Review of a signed pl #3 dated 06/02/20 revealed the levetiracetam 750mg taked 07/23/20 revealevetiracetam 750mg and in the evening. Review of a physician dated 07/23/20 revealevetiracetam 750mg and in the evening. Review of Resident # administration record revealed: -There was an entry for take three tables twice administration time of the tables twice administration time of the tables twice administered 37 times and the tables twice and tables twice and tables the tables twice administered 37 times and tables the tables twice and tables twice and tables the tables twice and tables twice and tables the tables twice and tables twice and tables the tables twice and tables the tables twice and	e interview with the 7/20 at 12:30pm. e interview with the 9/20 at 5:23pm. t #3's current FL-2 dated gnoses included seizures, ntellectual disability. t #3's current FL-2 dated ere was an order for ication used to control four tablets at bedtime. hysician's order for Resident eraled there was an order mg take 3 tablets twice a's order for Resident #3 led an order for take three tablets at noon 3's medication (MAR) for September 2020 for levetiracetam 750mg eraling and 8:00pm. tation levetiracetam was	C 342			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREE ITON, NC 27589			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 342	Continued From page	e 113	C 342			
C 342	Review of Resident # revealed: -There was an entry for take three tables twice administration time of the entry for the entry for take three tables twice administration time of the entry for table table to the entry for the en	for levetiracetam 750mg e daily with a scheduled f 8:00am and 8:00pm. tation levetiracetam was s out of 62. nentation or explanation for of levetiracetam on the ent #3's medication on hand m revealed: acetam 750mg was bubble packs with three ated on the back of the ge and scheduled time as ubble for administering was rening. with a medication aide (MA) m. e interview with a second 30am. hterview with a MA on e interview with the facility's N) on 10/29/20 at 1:31pm	C 342			

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Administrator on 10/27/20 at 12:30pm and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	11/04/2020	
PIVOTAL (303 W FR	ANKLIN STREE	т		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	PLETE
C 342	2 Continued From page 114		C 342			
	b. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for cyclafem (a contraceptive) 1-35-28 take 1 tablet once daily. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for cyclafem 1/35 (28) 1mg-35mcg take one tablet once daily. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for cyclafem 1/35 (28) 1mg-35mcg take one tablet once daily scheduled administration time of 8:00am. -There was documentation cyclafem was administered 22 times out of 30. -There was no documentation or explanation for the 8 missed doses of cyclafem on the MAR.					
	revealed: -There was an entry f 1mg-35mcg take one scheduled administra -There was documen administered 24 times -There was no docum	tablet once daily with a tion time of 8:00am. tation cyclafem was				
	on 10/26/20 at 2:05pr package of 28 tablets 1mg-35mcg; there we administration.	ent #3's medication on hand m revealed there was one for cyclafem 1/35 (28) ere 26 tablets available for with a medication aide (MA)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE ON, NC 27589			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	<u> </u>
C 342	Continued From page	: 115	C 342			
	on 10/26/20 at 9:53am.					
	Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.					
	Refer to the telephone Administrator on 10/2 10/29/20 at 5:23pm.					
	c. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for methylphenidate (a medication used to treat Attention-deficit/hyperactivity disorder) 10mg take 1 tablet once daily.					
	#3 dated 06/02/20 rev	nysician's order for Resident /ealed there was on order 0mg take 1 tablet once				
		n's order for Resident #3 led there was an order to enidate 10mg.				
	Review of Resident # administration record revealed:	3's medication (MAR) for September 2020				
	-There was on order f take 1 tablet once dai administration time of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
	FCL093012		B. WING		11/04/2020	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CARE		ANKLIN STREE			
	WARREN		TON, NC 27589			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
C 342	Continued From page	: 116	C 342			
	-There was documentation methylphenidate was administered 7 times after the discontinued date of 09/17/20; there was no documentation of a discontinued date on the MAR.					
	revealed: -There was on order f take 1 tablet once dai administration time of -There was document administered 20 times discontinued on 09/17 -There was no docum date for methylphenid Observation of Reside on 10/26/20 at 2:05pr methylphenidate avai	8:00am. ration methylphenidate was ry/20 rentation of a discontinued rate on the MAR. rent #3's medication on hand revealed there was no rable. with a medication aide (MA)				
	Refer to the telephone MA on 10/27/20 at 9:3 Refer to the second in 10/29/20 at 3:44pm.					
	Refer to the telephone on 11/02/20 at 4:52pm	e interview with a third MA n				
	Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.					
	Refer to the telephone Administrator on 10/2 10/29/20 at 5:23pm.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
PIVOTAL	CARE	303 W FRA	ANKLIN STREE	:T		
TIVOTAL	OAIL	WARRENT	ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	ILD BE COMPLI	ETE
C 342	d. Review of Residen 11/01/19 revealed the zonisamide (a medica seizures) 100mg take Review of a signed pl #3 dated 06/02/20 rev for zonisamide 100mg the morning. Review of Resident # administration record revealed: -There was an entry f tablet once daily in the administration time of -There was document administered 22 times -There was no docum the 8 missed doses of Review of Resident # revealed: -There was an entry f tablets once daily in the administration time of -There was an entry f tablets once daily in the administration time of -There was document administered 24 times -There was no docum the 7 missed doses of Observation of Residen 10/26/20 at 2:05pr	t #3's current FL-2 dated re was an order for ation used to treat partial 6 tablets once daily. Inysician's order for Resident realed there was an order grake 1 tablet once daily in 3's medication (MAR) for September 2020 for zonisamide 100mg take 1 to morning with a scheduled 8:00am. Itation zonisamide was sout of 30. Itation or explanation for fractions amide on the MAR. 3's MAR for October 2020 for zonisamide 100mg take 6 for morning with a scheduled 8:00am. Itation zonisamide was sout of 31. Itation zonisamide was sout of 31. Itation zonisamide on the MAR. Itation zonisamide was sout of 31. Itation zonisamide was sout of 31. Itation zonisamide on the MAR. Itation zonisamide on the MAR. Itation zonisamide on the MAR. Itation zonisamide on the MAR.	C 342			
	bubble with the dosag	ited on the back of the ge and scheduled time as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL093012	B. WING		1	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	dated for 10/27/20 mo Refer to the interview on 10/26/20 at 9:53ar Refer to the telephon MA on 10/27/20 at 9:3 Refer to the second in 10/29/20 at 3:44pm. Refer to the telephon on 11/02/20 at 4:52pr Refer to the telephon Registered Nurse (Ri and 2:53pm. Refer to the telephon Administrator on 10/2 10/29/20 at 5:23pm. e. Review of Resider 11/01/19 revealed the trazodone (a medicat 100mg take 0.5 table needed. Review of a signed pl #3 dated 06/02/20 rev for trazodone 100mg tablet as needed at b	with a medication aide (MA) m. e interview with a second 30am. hterview with a MA on e interview with a third MA m e interview with the facility's N) on 10/29/20 at 1:31pm e interview with the 7/20 at 12:30pm and ht #3's current FL-2 dated ere was an order for ion used to treat depression) t to one tablet at bedtime as hysician's order for Resident yealed there was an order tablet take 0.5 tablet to 1 edtime.	C 342			
	-There was an entry f					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE FON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 342	of the trazodone on the Review of Resident # revealed: -There was an entry fitake 0.5 tablet to 1 tail. There was document administered 17 times documentation of the of the trazodone on the of the trazodone on the Observation of Reside on 10/26/20 at 2:05 probottle of trazodone with administration. Refer to the interview on 10/26/20 at 9:53 and Refer to the telephone MA on 10/27/20 at 9:53 and Refer to the telephone on 11/02/20 at 3:44 pm. Refer to the telephone on 11/02/20 at 4:52 pm. Refer to the telephone Registered Nurse (RN and 2:53 pm. Refer to the telephone Administrator on 10/2 10/29/20 at 5:23 pm. f. Review of a signed	explanation or effectiveness ne MAR. 3's MAR for October 2020 for trazodone 100mg tablet blet as needed at bedtime. Itation trazodone was some seplanation or effectiveness ne MAR. ent #3's medication on hand more revealed there was a thin six tablets available for with a medication aide (MA) m. e interview with a second 30am. Interview with a MA on the interview with the facility's N) on 10/29/20 at 1:31pm e interview with the facility's N) on 10/29/20 at 12:30pm and physician's order for	C 342			
		/02/20 revealed there was x ER 500mg (a medication				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE		
			TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 342	Continued From page 120		C 342		
	used to treat seizures bedtime.	s) take three tablets at			
	revealed:	(MAR) for September 2020			
	-There was an entry for divalproex ER 500mg take three tablets at bedtime with a scheduled administration time of 8:00pmThere was documentation divalproex was administered 20 times out of 30There was no documentation or explanation for the 10 missed doses of divalproex on the MAR.				
	Review of Resident # revealed:	3's MAR for October 2020			
		or divalproex ER 500mg pedtime with a scheduled f 8:00pm.			
	-There was documen administered 22 times	•			
		nentation or explanation for f divalproex on the MAR.			
	Observation of Residon 10/26/20 at 2:05pr -Resident #3's divalpr				
	packaged alone into l tablets per bubble.	oubble packs with three			
		ated on the back of the ge and scheduled time as			
	-The next available by dated for 10/26/20 be	ubble for administering was edtime.			
	Refer to the interview on 10/26/20 at 9:53ar	with a medication aide (MA) m.			
	Refer to the telephon MA on 10/27/20 at 9:3	e interview with a second 30am.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
PIVOTAL	CAPE	303 W F	RANKLIN STREET			
FIVOIAL	CARL	WARRE	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From page	e 121	C 342			
	Refer to the second i 10/29/20 at 3:44pm.	nterview with a MA on				
	Refer to the telephon on 11/02/20 at 4:52pt	ne interview with a third MA m				
		ne interview with the facility's N) on 10/29/20 at 1:31pm				
	Refer to the telephon Administrator on 10/2					
	Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.					
	-The blanks were bed always initial the MAI medication. -She had told the fac the MARs. -She had also "menti knew was not initialin	, ,				
	revealed she docume she popped the bubb so she would not forg Second interview with 3:44pm revealed if he MAR a day she work	and 10/29/20 at 3:44pm ented on the MAR every time ble pack into a resident's cup get. h a MA on 10/29/20 at er initials were not on the ed, it was because another inistered the medications				

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STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ECI 002042	B. WING		44/0	4/0000
		FCL093012	<u> </u>		11/04	4/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
PIVOTAL CARE		NKLIN STREE ON, NC 27589				
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	T .	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page 122		C 342			
	at 4:52pm revealed: -The Administrator tal MARs when he first s -He had administered not have to write it do -He thought he had "I "lately"He signed the MARs always." -He "forgot" to sign th Telephone interview w Nurse (RN) on 10/29/ revealed: -She looked over the facilityShe knew there were where staff had not in medicationShe called the Admin because she had told and three days later, MARs for the days he -She did not feel med administered, becaus up if they did not rece -She was concerned because "if it is not si -She saw the "holes" was a concernShe told the staff to I MAR because "if it wa not done"She believed the res	I medications before, but did bwn, so he forgot. Deen signing" the MARs I "sometimes, but not the MARs. With the facility's Registered (20 at 1:31pm and 2:53pm MARs when she was at the the "holes" on the MARs witialed administering the MARs witialed administering the MARs when significant the MARs with the MARs with the MARs with the MARs with the MARs worked. It is the residents would speak				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII LL	ILD
		FCL093012	B. WING		11/04	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W FR	ANKLIN STREE	т		
TIVOTAL	OAKE .	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 342	Continued From page 123		C 342			
	Telephone interview of 10/27/20 at 12:30pm -The facility's RN and the facility's RN had reverse ago." -She had "worked" week ago." -She had "worked" week ago." -She had instructed the MARs if they were not the medication; "if your medication, then you medication, then you the medication, then you not be a the same have been working of the working of	with the Administrator on revealed: lited the MARs; she thought reviewed the MARs "about a with one MA the week before signing the MAR. The MAS not to sign the state of the one that administered and do not sign off". With the Administrator on revealed: The MAS strong point; "I make in the MARs she would calcally be see if the medication red. The open the sign off" when they reation; the signature calcally with initials, and "signed off" with initials,				
C 350	10A NCAC 13G .1009 Medications	5 (a) Self-Administration Of	C 350			
	Medications (a) The facility shall properties and physical to self-administer the following requirements (1) the self-administra physician or other perprescribe medications documented in the results.	ts are met: ation is ordered by a rson legally authorized to s in North Carolina and				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,
PIVOTAL	CARE		ANKLIN STREE ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
C 350	prescription medication medication label. (b) When there is a comental or physical aboresident non-complian orders or the facility's procedures, the facility	change in the resident's ility to self-administer or nee with the physician's medication policies and y shall notify the physician.	C 350		
	reviews, the facility fa residents sampled (#' self-administered med self-administer prescr kept in the residents'	ns, interviews, and record iled to ensure 2 of 3 1 and #3) who dications had orders to ription medications that were rooms including a nebulizer aler (#1); and oral dental			
	12/30/19 revealed diamellitus, major depres gravis, hypertension, diaphoresis, and dyspa. Review of a physic dated 12/30/19 reveated -There was an order for 0.02% solution use or times daily as needed.	onea on exertion. ian's order for Resident #1			

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012 B. WING		11/0	4/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
PIVOTAL (CARE		ANKLIN STREE				
			TON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 350	Continued From page	e 125	C 350				
	-There was no order t lpratropium nebulizer						
	9:27am revealed Res machine on her bedsi machine that turns liq mist to treat asthma o	ent #1's room on 10/26/20 at ident #1 had a nebulizer ide table (a nebulizer is a uid medication into a fine often called a breathing					
	revealed: -She did "breathing tr dayThe medication aide medication to use in hobserved her using here."						
	when Resident #1 ne -She gave Resident # use on her ownShe did not check to for Resident #1 to sel treatmentShe knew there was residents to self-admi not think to look to se because it was being started working at the	sk for the nebulizer solution eded it. If the nebulizer solution to see if there was an order f-administer her nebulizer supposed to be an order for nister medications but "did e if there was an order" done that way when she facility.					
	10:30am revealed:	nd (MA) on 10/26/20 at own nebulizer treatments ohysician's order was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
PIVOTAL	CAPE	303 W FF	RANKLIN STREET			
PIVOTAL	CARE	WARREN	ITON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 350			C 350			
	medication.	to self-administer their own				
	Telephone interview v at 9:23am revealed:	vith a third MA on 10/30/20				
	-She gave Resident #1 a vial of medication for her nebulizer and Resident #1 would do the					
	nebulizer treatment h -She did not know Re self-administer order nebulizer treatments.					
	Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed: -The MAs were supposed to put the Ipratropium Bromide 0.02% solution into Resident #1's nebulizer, but Resident #1 knew how to use the nebulizer herself.					
		self-administer order was #1 to self-administer the				
	Telephone interview v 10/29/20 revealed: -She was not aware t	vith the Administrator on he MAs were giving				
	Resident #1 vials of to administer on her classifications.					
		lent #1's nebulizer and ne was doing her breathing				
		with Resident #1's primary s nurse on 11/02/20 at				
		vare Resident #1 was r nebulizer treatments. ed an order for Resident #1				
	to administer her own	n nebulizer treatments. sident #1 would be "okay" to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		FCL093012	B. WING		11	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE	303 W FI	RANKLIN STREET			
TIVOTAL	OAKE	WARREI	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 350	Continued From page	e 127	C 350			
	administer her own ne	ebulizer treatments.				
	dated 03/16/20 revea -There was an order t treat wheezing and st asthma) per actuation as needed.	for ProAir 90 mcg (used to				
	Observation of Resident #1's room on 10/26/20 at 9:27am revealed Resident #1 had an Albuterol inhaler on her bedside table.					
	administration record: -There was an entry f puffs four times daily breath with a schedul 8:00am, 12:00pm, 6:0 -There was documen administered 21 times 12:00pm, 1 time at 5: 10:00pm.	or a ProAir inhaler inhale 2 as needed for shortness of ed administration time of 00pm and 10:00pm. tation ProAir was as at 8:00am, 2 times at 00pm and 1 time at				
	revealed: -There was an entry f puffs four times daily breath with a schedul 8:00am, 12:00pm, 6:0 -There was documen administered 24 times 12:00pm, 1 time at 5: 10:00pm.	tation ProAir was s at 8:00am, 4 times at 00pm and 3 times at nentation the medication				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		303 W FR	ANKLIN STREE	:T		
PIVOTAL	CARE		ON, NC 27589			
()(4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 350	Continued From page	e 128	C 350			
	revealed: -There was an entry for puffs four times daily breath with a schedul 8:00am, 12:00pm, 6:0-There was documen administered 17 times 12:00pm, 1 time at 5:10:00pmThere was no docum was self-administered Interview with Resides 10:47am revealed: -She kept her ProAir -She used the inhalest times per day" but so -She had used her in because she was when one told her she her roomShe did not tell anyo inhaler, "I just did it."	tation ProAir was s at 8:00am, 3 times at 00pm and 15 times at nentation the medication d. ent #1 on 10/29/20 at inhaler in her room. revery day, "maybe 2-3 metimes "just once a day." haler earlier today, 10/29/20 eezing. could not keep her inhaler in one when she had used her cation aide (MA) on				
	10/26/20 at 8:37am re -Resident #1 had an	inhaler in her room.				
		see if there was an order				
		If-administer her inhaler.				
		supposed to be an order for				
		inister medications but "did				
		ee if there was an order"				
	started working at the	done that way when she e facility.				
	Telephone interview v 10/30/20 at 9:23am rd -She was aware Resi					

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Division of	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL093012	B. WING		11/04/2020
		FGE093012			11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIVOTAL A	CARE	303 W FR	ANKLIN STREE	Т	
PIVOTAL	CARE	WARREN [*]	TON, NC 27589		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
			1	DEI IOIENCI)	
C 350	Continued From page 129		C 350		
	her room.				
	-She did not know Re				
		for the inhaler in Resident			
	#1's room.	6 D : 1 / 1/4			
		w often Resident #1 used			
	the inhaler Resident	#1 Kept in her room.			
	Talambana intancia	with the facility is revised (DNI)			
		with the facility's nurse (RN)			
	on 10/29/20 at 1:16pr	ident #1 had an inhaler she			
		ident#1 nad an innaler sne			
	kept in her room.	ninistrator tolling har an			
		ninistrator telling her an or an inhaler, but she did not			
		dent #1 to self-administer			
	her inhaler.	dent #1 to sen-administer			
	nei iiiialei.				
	Telephone interview v	with the Administrator on			
	10/29/20 revealed:				
		not have any medication in			
	her room.	•			
	-She was not aware F	Resident #1 had an inhaler in			
	her room.				
	-She expected staff to	o administer Resident #1's			
	medication.				
	Telephone interview v	with Resident #1's PCP's			
	nurse on 11/02/20 at	•			
	-He was not aware R				
	self-administering her				
	-	ed an order for Resident #1			
	to administer her own				
	-	t #1 would be "okay" to			
	administer her own in				
		w how often Resident #1			
	was using her Pro-Air	r ınhaler.			
	0 D	1 #01 FL O L L L			
		at #3's current FL-2 dated			
	11/01/19 revealed dia	agnoses included seizures,			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		FCL093012	B. WING		11/04	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		NKLIN STREE			
			ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 350	Continued From page	e 130	C 350			
	Review of Resident # was no order for an o	3's record revealed there ral tooth medication.				
	Review of Resident #3's medication administration record (MAR) for October 2020 and November 2020 revealed there was no order for an oral tooth medication.					
	10/29/20 at 2:09pm re-She was made awar complaint of tooth pair October 2020. -She knew Resident appointment schedule medication aides (MA-She took Resident # in the middle of October medicated oral tooth pain. -Resident #3 did not be she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she should have gotte she was made awar and self-administering the she was made awar and self-administ	e Resident #3 had a in around the middle of #3 had a dentist ed for 11/03/20; one of the as) made the appointment. 3 to the store on a Saturday per 2020 to purchase drops to put on her tooth for have an order for e medicated oral tooth drops; en an order for				
	medicated oral tooth -She did not think above Resident #3 to self-act tooth drops. -Resident #3 kept the	esident #3 to have the drops. Out getting an order for dminister the medicated oral medicated oral them when she needed				
	on 11/02/20 at 2:48pr -The facility's RN tool oral tooth medication -Resident #3 kept the roomShe told Resident #3	Resident #3 to purchase				

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FOI 002040	B. WING		44/04/0000	
		FCL093012			11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		303 W FI	RANKLIN STREE	ET .		
PIVOTAL (CARE	WARREI	NTON, NC 27589)		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
C 350	Continued From page	e 131	C 350			
	use it.)				
		B to wash her hands and				
		s on the resident's clean				
	-	ut the drop of medication on				
	her tooth herself.	ation was not on the MAR				
		nented the administration				
	anywhere.	iented the administration				
		ything about an order for				
		dminister the oral tooth				
	medication.					
	medication.					
	Telephone interview v	vith a second MA on				
	11/03/20 at 10:26am					
	-Resident #3 had [bra	and named] medicated oral				
	tooth drops.					
	-Resident #3 had bou	ight the oral tooth				
	medication herself an	d kept them with her in her				
	room.					
	-Resident #3 got the					
	sometime in October					
	-	Resident #3's finger tip and				
		rops on her tooth herself.				
		lp Resident #3 use the oral				
		she had used oral tooth ne Resident #3 had before.				
		t #3 use the oral tooth				
	•	; the medication seemed to				
	help with the resident					
		nt helping Resident #3 with				
		nd the medication was not				
	on the MAR.					
	-The facility's RN kne	w Resident #3 had the oral				
	tooth drops because					
	Resident #3 to the sto					
		vith Resident #3's dentist on				
	11/02/20 at 11:16am					
		er requested pain medication				
	for Resident #3.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 350	Resident #3 if she han needed something for She never ordered of self-administer order in Telephone interview wat 1:47pm revealed: -The facility's RN took medication for her took but did not know when the staff would help medication on her took applied the oral took. Telephone interview wat 10/29/20 at 4:42pm resumed and the staff should call (PCP) for an order for should be added to the She did not know about the staff should about the she did not know about the staff should should be added to the she did not know about the staff should should be added to the she did not know about the staff should should be added to the she did not know about the staff should should be added to the she did not know about the staff should should be added to the she did not know about the staff should should be added to the she she should should be added to the she she should should be added to the she she she should should be added to the she she she she should should be added to the she she she she she she she she should she	ered a pain medication for d known the resident pain. ral tooth medication or a for Resident #3 . with Resident #3 on 11/03/20 The her to buy oral tooth both pain. The medication in her room re they were at the time. Ther put the oral tooth of the oral tooth of the oral tooth of the oral tooth of the medication herself. With the Administrator on evealed: I on was needed before dication, even over the eveded an order. The primary care provider or a medication and then it the MAR. The out an oral tooth medication is the first she had heard of the ded to be an order for	C 350		
C 367	10A NCAC 13G .1008 (a) A family care homeotrievable record of a documenting the recedisposition of controller records shall be main	B(a) Controlled Substances B Controlled Substances B Se shall assure a readily controlled substances by lipt, administration and Bed substances. These tained with the resident's B order that there can be	C 367		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL093012	B. WING		11	1/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
PIVOTAL	CARE		NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 367	Continued From page	e 133	C 367			
	accurate reconciliation	n.				
	interviews, the facility of controlled substance reconciled accurately receipt and administrations substances for 1 of 1 an order for a controll an anti-anxiety medic. The findings are: Review of Resident # 12/30/19 revealed diamellitus, major depresion, diaphoresis, and dyspan. Review of Residen dated 03/16/20 revea	as, record reviews, and failed to ensure the record des was maintained and with the documented ation of controlled sampled resident (#1) with ed sleeping medication and ation. 1's current FL-2 dated agnoses included diabetes ssive disorder, myasthenia hypothyroidism,				
	-There was an entry f daily with a scheduled pm.	1's September 2020 ation record (MAR) revealed: or Zolpidem Tartrate 5mg d administration time of 8:00 tation Zolpidem Tartrate				
	5mg was administere 09/01/20-09/17/20, 09/09/24/20-09/30/20. -There were no exception and the contract of the	d at 8:00pm on 0/22/20, and otions documented for the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		COMPLETED
			A. BUILDING: _		
			D MINO		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		303 W FR	ANKLIN STREE	:T	
PIVOTAL	CARE		TON, NC 27589		
0(1) ID	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	M OVE
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
C 367	Continued From page	e 134	C 367		
		for Zolpidem Tartrate 5mg			
	_	d administration time of 8:00			
	pm.	tation Zalaidam Tartrata			
	5mg was administere	tation Zolpidem Tartrate			
	10/01/20-10/02/20, 10	•			
	· ·	0/15/20-10/22/20, and			
	10/24/20-10/26/20.	0/10/20-10/22/20, and			
		otions documented for the			
	Zolpidem Tartrate not				
	'				
	Review of Resident #	1's controlled substance			
	logs revealed:				
	-There was a controll	ed substance log provided			
		Zolpidem Tartrate 5mg at			
		nse date of 08/01/20 for 28			
	tablets.				
		tation Zolpidem Tartrate			
	5mg was administere	d daily from			
	08/01/20-08/20/20.				
		page with documentation g was administered daily			
	from 08/21/20-09/17/2				
		controlled substance log			
		nacy for Zolpidem Tartrate			
		a dispense date of 09/01/20			
	for 28 tablets.	a anopomor acre or 00/0 //20			
	-There was no docum	nentation on the second			
	controlled substance	log dated 09/01/20.			
	-There was no contro	lled substance log dated for			
	October 2020.				
		ent #1's medication on hand			
	on 10/26/20 at 9:00ar				
		ation was in a pre-packaged			
	bubble pack.				
		medication was packaged in			
		was dated and labeled			
	morning and bedtime				
	medications listed on	іпе вирріе раск.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DIVOTAL	CADE	303 W FR	ANKLIN STREE	ET .	
PIVOTAL	CARE	WARRENT	TON, NC 27589)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
C 367	Continued From page	e 135	C 367		
0 00.	-Zolpidem Tartrate 5n	ng was listed on Resident ed 10/26/20 labeled bedtime			
	Refer to the interview on 10/26/20 at 9:53ar	with a medication aide (MA) m.			
	Refer to the interview 10/26/20 at 10:30am.				
	Refer to the telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm.				
	Refer to the telephone Administrator on 10/2				
		t #1's physician's order led an order for Lorazepam (an anti-anxiety			
		1's physician's order dated order for Lorazepam 1mg			
	Review of Resident # revealed:	1's September 2020 MAR			
	times daily with a sch of 8:00am, 2:00pm, a -There was documen	or Lorazepam 1mg three eduled administration time nd 8:00 pm. tation Lorazepam 1mg was nm from 09/01/20-09/08/20.			
	administered at 2:00p -There was documen administered at 8:00p -There was a hand-w Lorazepam 1mg three	e times daily had been			
	discontinued on 09/04 -There was a second	4/20. entry for Lorazepam 1mg			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´COMP		(X3) DATE SURVEY COMPLETED
7.1.12 . 27.1.1		.52	A. BUILDING: _		00 22.25
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DD (074)		303 W FR	ANKLIN STREE	т	
PIVOTAL	CARE	WARREN'	TON, NC 27589	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 367	Continued From page	136	C 367		
C 367	twice daily with a sch 8:00am and 2:00pmThere was documen administered at 8:00a 09/21/20, 09/23/20, a -There was documen administered at 2:00p 09/17/20, and 09/22/2 -There were no exceptorazepam not administered at 2:00pmThere was an entry fidaily with a scheduled 8:00am and 2:00pmThere was documen administered at 8:00a 10/06/20, 10/08/20, 1 10/21/20, 10/23/20, a -There was documen administered at 2:00pmThere was documen administered at 2:00pm.	tation Lorazepam 1mg was am from 09/11/20-09/19/20, and 09/25/20-09/27/20. tation Lorazepam 1mg was am from 09/11/20-09/15/20, and 09/23/20. tation Lorazepam 1mg was am from 09/11/20-09/15/20, and 09/23/20. bitions documented for a consistered. 1's October 2020 MAR for Lorazepam 1mg twice and administration time of administration time of administration time of administration Lorazepam 1mg was am from 10/01/20-10/03/20, 0/14/20, 10/16/20-10/19/20, and 25/20-10/27/20. tation Lorazepam 1mg was am on 10/01/20, 10/06/20, 0/18/20, 10/20/20, 10/23/20, 10/26/20. bitions documented for anistered. 1's controlled substance log are de substance log provided corazepam 1mg three times date of 08/10/20 for 84	C 367		
	log where dates, time were documented but	entries dated the controlled substance s, and medication counts t there was no signature stration of Lorazepam 1mg			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING: _		COMPLETED
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589		
040.45	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON OUT
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C 367	Continued From page	e 137	C 367		
C 367	for these dates and ti -The last count docur a count of 38There were signature and 09/29/20 with no -There were 11 of 39 10/01/20-10/23/20 on log where dates, time were documented but confirming the admini for the dates and time Observation of Resid on 10/26/20 at 9:00ar -Resident #1's medicate bubble packAll of Resident #1's redated bubble packs with the name of the subbble packLorazepam 1mg was 10/26/20 bubble pack 10/27/20 labeled mor available for administ Refer to the interview on 10/26/20 at 9:53ar	mes documented. mented was on 09/25/20 for es on 09/26/20, 09/27/20, count carried over. entries dated if the controlled substance es, and medication counts it there was no signature distration of Lorazepam 1mg es documented. eent #1's medication on hand in revealed: ation was in a pre-packaged medication was packaged in abeled morning and bedtime medications listed on the solisted on Resident #1's to labeled bedtime and ining and bedtime was ration. with a medication aide (MA) in.	C 30/		
	Refer to the telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm.				
	Refer to the telephon Administrator on 10/2				
	Interview with a medi 10/26/20 at 9:53am re -Resident #1 received	, ,			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE	303 W FRA	NKLIN STREE	ΞT	
TIVOTAL	OAKE .	WARRENT	ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 367	Continued From page	2 138	C 367		
	-She did not count the before she signed the -She did not know sh medication before she -She followed what "e -She "sometimes forg	e controlled medication control log. e should count the control e signed the controlled log. everyone else was doing." not to sign the control log."			
	10:30am revealed: -She did not count the "every time." -She followed the nur downThe facility's contracthe controlled medica	en she had last counted the			
	-She signed the contr				
	on 10/29/20 at 1:16pr -Resident #1's controlincluded in Resident pharmacyThe MAs were support MAR and the controlinedication was admited.	lled medications were #1's bubble packs from the psed to document on the log when a control pistered.			
	medication, but she k	osed to count the control new they did not always nedication. the control sheets were not			
	10/29/20 at 4:39pm re- -She was not aware t being completed to re- administered.	he control logs were not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	11/04/2020
			NKLIN STREE		
PIVOTAL	CARE	WARRENTO	ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 367	Continued From page and documented. -She was concerned to documenting controller administered.		C 367		
C 601	and Control Program 10A NCAC 13G .1701 Control Program (a) In accordance with Subchapter and G.S. shall establish and implement a compreh and control program (federal Centers for Disease Control and I on infection preventio (b) The facility shall e facility's IPCP, related and guidance or	131D-4.4A(b)(1), the facility rensive infection prevention IPCP) consistent with the Prevention (CDC) guidelines n and control. nsure implementation of the policies and procedures, ne CDC, the local health e North Carolina	C 601		
	interviews, the facility recommendations and the Centers for Diseas North Carolina Depar Services (NC DHHS) maintained to provide during the global coro	ns, record reviews, and failed to ensure d guidance established by se Control (CDC) and the tment of Health and Human were implemented and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
	_	303 W FF	RANKLIN STREET			
PIVOTAL	CARE		NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 601	Continued From page	e 140	C 601			
	risk of transmission a staff not wearing face a social distance of 6	ol practices to reduce the nd infection as related to masks, staff not maintaining feet from residents when ks, and no screening of staff				
	The findings are:					
	guidelines for the pre- Coronavirus (COVID-	for Disease Control (CDC) vention and spread of the 19) disease in long-term d personnel should always le in the facility.				
	through droplet, there	COVID-19 is transmitted fore the mouth and nose covered when wearing a contamination and				
	for Preventing Spread Living Facilities updat -Personnel should alw they are in the facility -Designate one or mo actively screen all vis including essential copresence of fever and COVID-19 (fever or copreath or difficulty bre body aches, headach smell, sore throat, connausea or vomiting, deach shift/when they -Designate one or more ensure all residents him to the control of th	ore facility employees to itors and personnel, itors and personnel, itors and personnel, for the disymptoms consistent with shills, cough, shortness of eathing, fatigue, muscle or e, new loss of taste or ingestion or runny nose, liarrhea) before starting				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 11 2012511101		
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE		
			TON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
C 601	Continued From page	: 141	C 601		
	difficulty breathing, fa aches, headache, nev	w loss of taste or smell, sore runny nose, nausea or			
	-The policy was not d -The facility policy inc temperature check, pi known exposure to Ci staff, particularly thos visits or time outside of -The facility reference for following policies a established and imple federal CDC guideline procedures for screer restricting visitors who procedures for screer	luded daily screening for resence of symptoms and OVID-19 of all residents and e returning from extended of the facility. d the current CDC guidance			
	there was a sign post "Attention: need to resafety of our residents -The CDC notification spread of COVID-19 i (LTCF) was posted or -A facility staff could be through the window of not wearing a faceman	evealed: facility was unlocked and ed on the door that read strict all visitors for the s". for strategies to prevent the in Long Term Care Facilities in the door. for seen inside the facility of the kitchen; the staff was			
	10/26/20 at 7:33am re				

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DIVISION OF RESIDENCE REGULATION				T		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
		ECI 002042	B. WING		44/04/0000	
		FCL093012	1		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	_	303 W FR	ANKLIN STREE	ET .		
PIVOTAL (CARE		TON, NC 27589			
040.15	STIMMADV ST				N OVE	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
C 601	Continued From page	140	C 601			
C 001	Continued From page	9 142	001			
	-A medication aide (M	IA) was working at the				
	facility and did not gre	eet the survey team at the				
	door.	•				
		common area and she did				
		team for fever or with				
	screening questions.	todin for fever of with				
	coroning quodions.					
	Observation of the fac	cility on 10/26/20 at 7:39am				
	revealed:	omity on 10/20/20 at 7:00am				
		nto the facility to take a				
	resident to a schedule					
	-The staff came into t	• •				
	answer screening que	estions of take a				
	temperature.	£ = 111414141				
		facility with the staff and got				
		facility staff nor the resident				
	had on a facemask.					
	0	A				
		A office on 10/26/20 at				
	8:38am revealed:					
		ermometer with protective				
	sleeves and a box of					
		erature log sheets for staff				
	or residents and no se	creening questionnaires				
	available.					
		returning with a resident				
		pointment on 10/26/20 at				
	9:12am revealed:					
	-The MA entered the	facility and did not take her				
	temperature.					
	-The resident did not	have his temperature taken				
	upon returning to the	facility.				
	Interview with a reside	ent on 10/26/20 at 7:39am				
	revealed:					
	-She had not had her	temperature taken by staff.				
		owed outside and could not				
	come into the facility.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CADE	303 W FR	ANKLIN STREE	т		
FIVOIAL	CARL	WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 601	Continued From page	e 143	C 601			
		nd resident on 10/26/20 at one took her temperature.				
	7:53am revealed:	resident on 10/26/20 at e her temperature every day;				
	"it depends on who is	working."				
	-She had her temperathe facility's registered	ature taken "last Friday" by d nurse.				
	Interview with a fourth resident on 10/26/20 at 7:36am revealed no one checked his temperature.					
	Interview with a MA o	n 10/26/20 at 8:00am				
		emperature before coming				
	-She had never taker temperatures.	the residents'				
	-She had not had CO	VID-19 training.				
	8:11am revealed:	nd MA on 10/26/20 at				
	-The staff were not pr into the facility.-Staff did not take her	rescreened prior to coming				
	beginning work and new	either did she.				
		he provider questions over				
	the facility.	was nothing documented at				
	-The providers' temper- -Residents were not be returning from physic					
		to physicians' appointments				
		ne at a time outside and they				

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-The symptoms she knew to watch for included

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		FCL093012	B. WING		11/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CARE		NKLIN STREE			
		WARRENT	ON, NC 27589			_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
C 601	C 601 Continued From page 144		C 601			
	fever, flu like symptor -The residents' temper takenThe facility's Registe facility two times a we RN took temperatures facilityShe had not had CO working at this facility Interview with a third revealed: -The facility staff were temperatures and doe had stopped doing the 2020She did not know wh residents' temperatures -There was an oral th sleeves and alcohol p thermometer after ear taking daily temperature -She had not had any shown a policy related Telephone interview w 10/29/20 at 3:01pm re	ms and loss of smell. eratures were not being ared Nurse (RN) came to the eek; she did not know if the s when she was at the VID-19 training while MA on 10/26/20 at 10:48am e taking the residents' cumenting them, but they at in June 2020 or July by they stopped taking the es and documenting them. were never taken. ermometer with protective orep pads to sanitize the ch use, but she was not ures of residents. a training and had not been d to COVID-19. with the facility's RN on evealed:				
	-She did not know if the staff were taking their own temperatures prior to entering the facilityShe did not know if the staff were taking the residents' temperature; they had been done at one time but did not think they were still being takenShe did not know if she ever told the staff to self					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
FCL093012		B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE	
		303 W FR	ANKLIN STREE	т	
PIVOTAL	CARE	WARREN	TON, NC 27589		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 601	Continued From page	e 145	C 601		
	exhibited symptoms while at workShe was not aware of a policy specific to the facility; she had given the staff the information concerning long term care facilities that had been sent out by the state.				
	10/26/20 at 11:19am -She required staff to pre-screening for any -She did the pre-scre phone when someon -She had the question and when there was a come into the facility, verbally over the pho decision when someo facilityShe did not take tem expected the staff to report the temperatur -She had pre-screeni houseHer questions includ anyone with COVID-	call her to conduct any one coming into the facility. ening questionnaire over the e came into the facility. In so not a list she kept with her a reason for someone to she would do a screening one and she would make the one could come into the superatures herself; she take temperatures and the to her. In go documentation at her led "Have you been around 19?", "Have you had a			
anyone with COVID-19?", "Have you had a temperature or a cough?"; "Have you been out of the country?". -The staff had a no-touch thermometer at the facility; she had a half a dozen at her house and could bring one to the facility if the staff could not find the thermometer, she had given them. -She had a copy of the COVID-19 focused infection control policy at her home. -She was not sure there was a copy of the policy at the facility; "it may not be there". -She went over the policy with new staff and when there were updates and changes made by the government. -She did not have staff sign off on any COVID-19 training, but she did do a training in April 2020.					

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DIVISION	n nealth Service Negu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			1			
		FCL093012	B. WING		11/0	4/2020
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON SOIT LIEN					
PIVOTAL	CARE		ANKLIN STREE			
		WARREN	TON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
C 601	Continued From page	1/16	C 601			
0 00.						
	-The staff should be t	aking their temperatures				
	prior to entering the fa	acility.				
	-She did not require a	a pre-screening				
	· -	f prior to beginning of work.				
		require screening of the				
	_	t the facility and came back				
	to work.	tine facility and came back				
		are staff went when they left				
		nere staff went when they left				
		she should do screening of				
	the staff.					
	-Staff took temperatu					
	watched them for syn					
	-If a resident had sym	nptoms or a fever, she would				
	expect staff to send the	ne resident to the hospital;				
	she told the staff to se	end residents to the hospital				
		mptoms of COVID-19 and a				
	fever.	,				
		from an organization she				
	belonged to and she					
	information for update					
		ated information from any				
		d she did not refer to the				
	_					
		Control (CDC) web site for				
	guidance.					
		with 10A NCAC 13G .1701				
	Infection Prevention a	and Control dated on				
	10/23/20.					
		facility upon entrance on				
	10/26/20 at 7:33am re	evealed a medication aide				
	(MA) came to the con	nmon area and did not have				
	on a facemask.					
	Observation of the fa	cility on 10/26/20 at 7:39am				
	revealed:	•				
		nto the facility to take a				
	resident to a schedule					
		he facility and did not wear a				
	facemask.	facility and the second second				
	- I ne resident left the	facility with the staff and got				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED			
			A. BUILDING: _			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
	T		TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETE	
C 601	Continued From page	e 147	C 601			
	into a car without a fa	cemask.				
	from a physician's app 9:12am revealed:	returning with a resident pointment on 10/26/20 at facility without a facemask.				
	revealed: -Staff did not wear fact the facilityShe wore a facemas physician's office duri while riding in the car -Staff did not wear a face she rode with themShe was not allowed	cemasks when working in k when she went into the ng an appointment, but not accemask in the car when to go anywhere except to ents since the pandemic.				
	10:29am revealed: -The Administrator an Manager (BOM) did n they came to the facil -The facility's Registe mask when she came took it off when she ta -The Administrator ga	ot wear facemasks when ity. red Nurse (RN) wore a into the facility, but she				
	while at work.	about wearing a facemask ning shift and stayed at the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 20.125			
		FCL093012	B. WING		11/04	/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
			ON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 601	Continued From page 148		C 601			
	8:11am revealed: -Residents only went and nowhere elseShe wore a facemas own choice; she had a facemaskShe saw some staff staff without facemasThe facemasks at thresidents to wear whe physicianStaff could use the fathey did not have a facemask and used the farwas now wearing her literview with a third revealed: -She transported resiphysicians' appointmenshe would wear a faphysicians' office but carThe residents did no but would put one on physician's officeShe had been told by sure the residents wo physician's officeShe had not been to a facemask while ridiinshe had not been to the resident was in the not think about wear a not think about wear and the staff of the residentShe did not wear a not staff of the staff of the staff of the residentShe did not wear a not staff of the staff of	e facility were for the en they went to see the encemasks from the facility if ocemask from the facility but own surgical facemask. MA on 10/26/20 at 10:48am dents in her personal car to ents. cemask once she got to the not when she was in the encemask in the car before they went into the encemask when at the encemask when at the encemask wear encemasks wear encemasks.				

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DIVISION	n nealth Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
					1	
		FCL093012	B. WING		11/04/2	2020
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF FI	NOVIDER OR SUFFLIER					
PIVOTAL (CARE		ANKLIN STREE			
		WARREN	TON, NC 27589			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
C 601	Continued From page	149	C 601			
0 00 .	Continued From page	, 140				
	10/29/20 at 3:08pm re					
	-She had told the staf	f to wear facemasks when				
	in the facility.					
		they were not following good				
		ng the right thing because				
	they could make the r					
	_	nask when she was in the				
		nask when she was in the				
	facility.					
	Tolonhono intonvious v	with the Administrator on				
	-	vith the Administrator on				
	10/26/20 at 11:19am					
		osed to wear facemask the				
	entire time they were					
		oosed to wear a facemask				
	when in the car going	to a physician's				
	appointment and whil					
	-Staff should wear a f	acemask when in the car				
	with a resident.					
	-The staff should be v	vearing facemasks while at				
	work.					
	-She expected staff to	wear facemasks while in				
	•	taff to wear a facemasks				
	while at the facility.					
	at the identity.					
	3 Observation of the	PPE and cleaning supplies				
	on hand on 10/26/20	3				
	-	lon bottle of bleach for				
	cleaning surfaces.					
		sanitizer in a pump and a				
	spray bottle of hand s					
	 There was an empty desk in the medication 	box of facemasks on the n office.				
	-There were no other	facemasks in the facility.				
		shields or gowns in the				
	facility.	or gomio in the				
	•	of extra-large gloves in the				
	facility; there were no	oulei gioves.				
	Interview with a media	cation aide (MA) on				

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10/26/20 at 8:11am revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		NKLIN STREE ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 601	office. -There was an oral th sleeves and alcohol p taking resident temperature. She brought her own work. -There had only been at the facility. -She had told the Adr 10/23/20 they were orall she with the state of the facility, but she could she did not know with the state provided. Telephone interview with 10/26/20 at 11:19am. The prior staff took the state provided and she had not replessed to the she could not give a personal protective encythe had purchased times; the last time she was around Septembers	ermometer with protective orep pads for sanitizing when eratures. In facemask to wear while at the one box of facemasks ministrator on Friday, but of facemasks. In ad provided PPE to the not find it now. In the Administrator on revealed: In the	C 601		
	The facility failed to in guidelines and recome the Centers for Disea health department (LI Department of Health	nplement and maintain the mendations established by se Control (CDC), the local HD), and the North Carolina and Human Services (NC revention and transmission			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04	1/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	: ZIP CODE		
			RANKLIN STREET	, =		
PIVOTAL	CARE	WARREI	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 601	not wear facemasks will did not screen the rest themselves daily. The staff and visitor scree facemasks placed the for transmission and it resulting in substantial harm and neglect, an Violation. A plan of protection was accordance with G.S. this violation. CORRECTION DATE	pandemic in which staff did within the facility and staff sidents, visitors, or a facility's failure to complete nings and properly use a residents at increased risk infection from COVID-19, all risk of serious physical did constitutes a Type A2	C 601			
C 912	G.S. 131D-21 Declar Every resident shall had 2. To receive care an adequate, appropriate relevant federal and stregulations. This Rule is not met Based on observation interviews, the facility resident had the right services which are accompliance with rules to training on cardio-page and the services.	e, and in compliance with state laws and rules and as evidenced by: as, record reviews, and failed to assure every to receive care and lequate, appropriate, and in and regulations as related bulmonary resuscitation, ication aides training and on requirements,	C 912			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			
		FCL093012	B. WING		11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE			
			TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 912	Continued From page	e 152	C 912			
	substances.					
	The findings are:					
		rs and record reviews, the e 4 of 4 staff sampled (Staff				
		e 4 of 4 stall sampled (Stall administered medications				
	had completed their r	nedication clinical skills				
		n prior to administering				
	medications and completed the 5-hour and 10-hour medication aide training courses under					
	_	stered nurse or licensed				
	pharmacist or succes	sfully completed the nation (Staff A). [Refer to				
		D-4.5B(b) Adult Care Home				
		nining and Competency				
	Evaluation Requirem	ents (Type B Violation)].				
	2. Based on observat	ions, interviews and record				
	_	iled to ensure at least one				
	-	ne premises at all times who rse on cardio-pulmonary				
	=	ind choking management,				
	including the Heimlich	n maneuver, within the last				
		sampled staff (Staff A, Staff				
	B, and Staπ D). [Refe 13G .0507 Training o	r to Tag C176 10A NCAC n Cardio-Pulmonary				
	Resuscitation (Type B	-				
	3. Based on interview	s and record reviews, the				
	facility failed to ensur					
	screening for the pres	sence of controlled pleted for 4 of 4 sampled				
		nd D) prior to hire. [Refer to				
	Tag C992 G.S. 131D-	45 Examination and				
	Screening for the Pre					
	Substances Required Employment in Adult					
	Violation)].	Sais Homos (Type D				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ΓE, ZIP CODE	
PIVOTAL	CARE	******	RANKLIN STREE	•	
	OLIMANA DV. OTA		ITON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 912	Continued From page	153	C 912		
	facility failed to ensure C, D,) completed a tw skin test according to by the Commission fo	eviews and interviews, the e 4 of 4 sampled staff (A, B, ro-step tuberculosis (TB) control measures adopted r Health Services. [Refer to 13G .0405(a) Test for Violation)].			
C 914	G.S 131D-21(4) Decla	aration Of Resident's Rights	C 914		
		ave the following rights: al and physical abuse, ion.			
	This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure each resident was free of neglect related to health care, management and other staff, medication administration, and infection prevention and control program.				
	The findings are				
	reviews, the facility fa acute and routine hear residents sampled (#" who had a referral app Epileptologist for seizure toothache (#3); and a increased weakness a being administered ar and whose primary car referred the resident to	ures, notification to the es and complaint of resident who experienced and slurred speech after nother resident's medication, are physician (PCP) had o a Neurologist due to). [Refer to Tag C246 10A			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	DF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		ED
		FCL093012	B. WING		11/04/	/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE		ANKLIN STREE TON, NC 27589			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 914	914 Continued From page 154		C 914			
	reviews, the Administ total operation of the rules related to infecti program related to Coadministration, health cardio-pulmonary restuberculosis, adult catraining and competer requirements, house building service equipself-administration of qualifications. [Reference of the control of the competer requirements]	care, training on uscitation, test for re home medication aide ncy evaluation seeping and furnishing, oment, orders for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
PIVOTAL	CARE		ANKLIN STREE		
040.1-	CLIMMADV CT.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON OUT
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C 914	914 Continued From page 155		C 914		
		an oral tooth medication 330 10A 10A NCAC 13G ninistration (Type B			
C935	G.S. § 131D-4.5B (b) Aides;Training and Co		C935		
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requireme	ining and Competency			
	home is prohibited from any unsupervised methat individual has presented in the individual has presented in an adult care home or of the following: (1) A five-hour training Department that incluin all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days frow individual must have the a. An additional 10-hod developed by the Department individual must have the control of the contro	g the previous 24 months in r successfully completed all g program developed by the des training and instruction of medication s for Disease Control and on infection control and, if tion practices and oring or testing in which e potential for bleeding aluation consistent with 10A 110A NCAC 13G .0503. In the date of hire, the completed the following: our training program partment that includes			
	training and instructio 1. The key principles administration.	n in all of the following: of medication			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		FCL093012	B. WING		11	/04/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE		
PIVOTAL	CARE	303 W FR	ANKLIN STREET	Г		
		WARREN	TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C935	2. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. b. An examination de	s of Disease Control and on infection control and, if the cion practices and pring or testing in which be potential for bleeding the colored and administered	C935			
		alth Service Regulation in section (c) of this section. as evidenced by:				
	facility failed to ensure A, B, C, and D) who a had completed their recompetency validation medications and com 10-hour medication a	de training courses under stered nurse or licensed sfully completed the				
	(SIC), personnel reco -Staff A was hired on -There was documen 15-hour medication tr 09/16/20 signed by a 09/16/20. -There was documen	09/23/20. tation Staff A completed the aining on 09/14/20 and registered nurse (RN) on tation Staff A completed the ills competency validation				

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Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			B. WING			
		FCL093012	B. WING		11/0	4/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		303 W FI	RANKLIN STREE	· :T		
PIVOTAL (CARE		NTON, NC 27589			
			110N, NC 27568			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	17.0	DEFICIENCY)		
C935	Continued From page	e 157	C935			
	-There were no new h	nire forms on file prior to				
	09/23/20.					
		nentation Staff A had passed				
	the written medication	•				
	uno willion modication	raide (Wirt) exam.				
	Interview with a Staff	A on 10/26/20 at 10:30am				
	and 2:00pm revealed					
	-Her previous employ					
	housekeeping.	mont nad boom in				
		dication aide (ma) training.				
	-She read a handbook she had been provided by					
	the facility's RN when she started working.					
	-	ng at the facility since March				
	2020.	ig at the lability since march				
		nen she started working at				
	the facility.	ien sie started working at				
	-She worked as a MA	at the facility and				
		tions independently when				
	she was working.	ions independently when				
		ner MA for a "couple of				
		ext day she worked, she				
	worked independently	·				
	medication.	y and administered				
		medication administration				
		medication administration				
	examination.					
	-She did not think she was "quite" ready to take the medication administration examination					
		ded to learn some of the				
		ded to learn some of the				
	terminologiesShe did not know the RN who signed her staff training certificates and competency validationShe had not demonstrated medication administration to the RN for completion of a medication clinical skills competency checklistShe had been provided blank forms by the					
		tructed to sign the forms in				
		udoted to sign the lottils in				
	September 2020.					
	Pavious of residents a	controlled medications loss				
		controlled medications logs				
	and medication admir	nistration records (MAR) for	1			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			R WING			
		FCL093012	B. WING		11/0	4/2020
NAME OF PRO	OVIDER OR SUPPLIER		RESS, CITY, STA			
PIVOTAL CA	ARE		NKLIN STREE ON, NC 27589			
()(1) ID	SLIMMARY ST/	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C935 (Continued From page	158	C935			
	June 2020, August 20 October 2020 reveale -The first time Staff A administration of med -Staff A documented t medications on 14 da -Staff A documented t medications on 12 da date of hire)Staff A documented t medications on 6 days Telephone interview w the facility on 10/26/20 -She was a registered -The Administrator ha staff and re-train "old" -She did medication to show and provided ea -She did medication to the facility; the resident during trainingShe completed the co with Staff AShe did not have the sheet, but the dates th were on the staff's tra -She was in the facility training. Interview with a resident facilityShe went into the livi multiple times.	de: documented the ication was on 06/30/20 he administration of ys in August 2020. he administration of ys prior to 09/23/20 (the he administration of s in October 2020. with a contracted trainer for 0 at 12:53pm revealed: I nurse (RN). d contacted her to train new staff in August 2020. raining that included a slide such staff with a handbook. raining in the living room of nts stayed in their rooms inical skills checklist on-site staff sign an attendance ne trainings were completed ining certificates. y "at least four-times" for yone do staff training in the ng room area every day, structed to stay in her room				

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Telephone interview with the Administrator on

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DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL093012	B. WING		11/04/2020
	20,4252 02 0422452	0.775.7.1	DD500 0171/ 074	TE 710 0005	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE	
PIVOTAL (CADE	303 W FR	ANKLIN STREE	:T	
FIVUIAL	CARE	WARREN	TON, NC 27589		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
C935	Continued From page	e 159	C935		
	10/26/20 at 1:14pm r	avodod:			
	10/26/20 at 1:14pm re				
		ed nurse had been on leave			
	•	s and not available to do			
	training with the MAs.				
	 -A contracted trainer 	who was a RN had been to			
	the facility three times	s to do "one on one" training			
	with the staff.				
	-Most of the training v	vas one on one with the			
	_	training was done as a			
	group.	g			
	-She did not recall the dates, but all training had				
	been completed within the last month.				
	-She did not know the dates the training forms				
		trainer had been at the			
	facility "so many time:				
	-The trainer was in the	e facility for never less than			
	5-hours.				
	Telephone interview v	vith the Administrator on			
	11/04/20 at 2:16pm re				
	-	king one day a week when			
	she "first started work	•			
		aff A would be working out.			
		•			
		September 2020 and she			
	9	n full time and that was			
		ered Staff A as a full-time			
	employee.				
		, Supervisor-in-Charge			
	(SIC), personnel reco	rd revealed:			
	-Staff B was hired on	09/21/20.			
	-There was documentation Staff B completed the				
		aining on 09/14/20 and			
		registered nurse (RN) on			
	09/16/20.	109.510104 114100 (1114) 011			
		tation Staff D completed the			
		tation Staff B completed the			
		ills competency validation			
		y a RN on 09/16/20; the			
	employee signed the	form on 09/21/20.	1		

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DIVISION	Division of Health Service Regulation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE	
PIVOTAL (CADE	303 W FF	ANKLIN STREE	iT	ļ
FIVUIAL	CARE	WARREN	TON, NC 27589)	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
			+		
C935	Continued From page	e 160	C935		
	Intervious with Stoff D	on 10/26/20 at 9:09am and			
		on 10/26/20 at 8:08am and			
	1:06pm revealed:				
		at the end of the year in			
	2019 but went out on	maternity leave and "just			
	came back."				
	-She worked as a me	dication aide (MA) at the			
	facility and administer	red medications			
	independently when s	she was working.			
	•	medication aide class.			
		dy guide to review on her			
	own by the facility's nurse.				
	-				
		IA exam (January/February			
	2020) but did not pas				
		e RN who signed her staff			
	training certificates.				
	-She had not demons	strated medication			
	administration to the I	RN for completion of a			
	medication clinical sk	ills competency checklist.			
	-She had been provid	led blank forms by the			
		tructed to sign the forms;			
	she dated the forms t	•			
	09/21/20.	no date of her fine,			
		raining or paperwork for the			
	facility prior to 09/20/2				
	lacility prior to 03/20/2	20.			
	Di				
		controlled medication logs			
		nistration records (MAR) for			
		October 2020 revealed:			
	-The first time Staff B	documented the			
	administration of med	lication was on 09/25/20;			
	she also documented	administering medications			
	on 09/30/20.				
	-Staff B documented	the administration of			
	medication on 11 day				
	Telephone intonvious	vith a contracted trainer for			
	-	0 at 12:53pm revealed:			
	-She was a registered	, ,			
	-The Administrator ha	id contacted her to train new			

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staff and re-train "old" staff in August 2020.

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Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		F01 000040	B. WING		44/04/0000
		FCL093012	B. W. C		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		303 W FF	ANKLIN STREE	:T	
PIVOTAL	CARE		TON, NC 27589		
	CLIMMA DV CT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
C935	5 Continued From page 464		C935		
0933	Continued From page 161		0933		
	-She did medication t	raining that included a slide			
	show and provided ea	ach staff with a handbook.			
	-She did medication t	raining in the living room of			
	the facility; the reside	nts stayed in their rooms			
	during training.				
	-She completed the c	linical skills checklist on-site			
	with Staff A.				
	-She did not have the	staff sign an attendance			
		he training was completed			
	was on the staff's training certificates.				
		y "at least four-times" for			
	training.	,			
	3				
	Interview with a reside	ent on 10/26/20 at 2:22pm			
	revealed:	•			
	-She had not seen an	yone do staff training in the			
	facility.	,			
	•	ing room area every day,			
	multiple times.	<i>y y</i> ,			
	•	structed to stay in her room			
	while staff were being	<u> </u>			
	,	,			
	Telephone interview v	vith the Administrator on			
	10/26/20 at 1:14pm re				
	•	ed nurse had been on leave			
	for a couple of months	s and not available to do			
	training with the MAs.				
	_	who was a RN had been to			
		s to do "one on one" training			
	with the staff. -Most of the training was one on one with the MAs, but some of the training was done as a group.				
	-	e dates, but all training had			
	been completed within				
	•	e dates the training forms			
		trainer had been at the			
	facility "so many times				
	-	e facility for never less than			

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5-hours.

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 W FRANKLIN STREET WARRENTON, NC 27599 PROVIDERS PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCES WARRENTON, NC 27599 PROVIDER SUMMARY STATEMENT OF DEPICIENCES WARRENTON, NC 27599 PROVIDER SUMMARY STATEMENT OF DEPICIENCES WARRENTON, NC 27599 PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE WAS documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20 and signed by a registered nurse (RN) on 09/02/20 and signed by a registered nurse (RN) on 09/02/20. -There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20. -There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20. -There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20. -There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20 at 4.52pm revealed: -He did not take a 15-hour medication administration class at the facility, -He did not take a medication or complete a medication of complete a medication clinical skills competency validation form. -He signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facility. -The forms he signed were blank forms. REVIEW OF PROVIDENCE TO STATE, ZIP CODE 303 FRANCE TO STATE, ZIP CODE 4.52pm revealed: -He did not take a 15-hour medication or complete a medication of the complete and the complete		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER 303 W FRANKLIN STREET WARRENTON, NC 27589 (X4) ID PRETIX GAND REFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR ISC. IDENTIFYING INFORMATION) C93 COMPLETE C835 C935 C935 CONTinued From page 162 C935 Continued From page 162 C935 C935 Continued From page 162 C935 Continued From page 162 C935 Continued From page 162 C935 C935 Continued From page 162 C935 There was documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20, the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facility. -He did not have anyone observe him administration employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facility. -The forms he signed were blank forms.				A. BOILDING.			
SUMMARY STATEMENT OF DEPICIENCES PROVIDER'S PLAN OF CORRECTION PREFIX TAGE PRECIDED BY FULL PREFIX TAGE PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCES IN THE PRECIDED BY FULL TAGE PRECIDED TO THE APPROPRIATE PREFIX TAGE PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH ODRRICTIVE ACTION SHOULD BE COMPLETE BY TAGE PRECIDENCES TO THE APPROPRIATE PREFIX TAGE			FCL093012	B. WING		11/0	4/2020
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES IN PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C935 Continued From page 162 C935 Continued From page 162 C935 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20There was documentation Staff C completed the 15-hour medication fraining on 09/02/20 and signed by a registered nurse (RN) on 09/02/20There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20; the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facilityHe did not have anyone observe him administration gmedication or complete a medication clinical skills competency validation formHe signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facilityThe forms he signed were blank forms.	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C935 Continued From page 162 C935 Continued From page 162 C935 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20There was documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20; the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facilityHe did not have anyone observe him administering medication or complete a medication clinical skills competency validation formHe signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facilityThe forms he signed were blank forms.	PIVOTAL	CARE					
3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20There was documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20; the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facilityHe did not have anyone observe him administering medication or complete a medication clinical skills competency validation formHe signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facilityThe forms he signed were blank forms.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
(SIC), personnel record revealed: -Staff C was hired on 08/30/20There was documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20; the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facilityHe did not have anyone observe him administering medication or complete a medication clinical skills competency validation formHe signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facilityThe forms he signed were blank forms.	C935	5 Continued From page 162		C935			
and medication administration records (MAR) for September 2020 and October 2020 revealed: -The first time Staff B documented the administration of medication was on 09/10/20/20; he also documented administering medications on 09/21/20 and 09/23/20 -Staff B documented the administration of medication on 5 days in October 2020. Telephone interview with a contracted trainer for the facility on 10/26/20 at 12:53pm revealed:		(SIC), personnel reco- Staff C was hired on -There was documen 15-hour medication tr signed by a registereThere was documen medication clinical sk on 09/02/20 signed b employee signed the form. Telephone interview of 4:52pm revealed: -He did not take a 15- administration class a location since he beg -He did not have any administering medical medication clinical sk formHe signed an employ by the Administrator of was given the employ before he started wor -The forms he signed Review of resident's and medication admin September 2020 and -The first time Staff B administration of medical no 09/21/20 and 09/2 -Staff B documented medication on 5 days Telephone interview of	ord revealed: 08/30/20. tation Staff C completed the raining on 09/02/20 and do nurse (RN) on 09/02/20. tation Staff C completed the ills competency validation y a RN on 09/02/20; the form but did not date the form but did not date the with Staff C on 11/02/20 at the facility, or at any other an working at the facility. One observe him tion or complete a ills competency validation yee packet provided to him (he did not recall when he yee packet) but it was not king at the facility. I were blank forms. controlled medications logs inistration records (MAR) for October 2020 revealed: documented the dication was on 09/10/20/20; administering medications 13/20. The administration of sin October 2020. with a contracted trainer for				

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	OF DEFICIENCIES		(V2) MI II TIDI E	CONSTRUCTION	(V2) DATE SLIDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL093012	B. WING		11/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		303 W FR	ANKLIN STREE	ET .	
PIVOTAL	CARE		TON, NC 27589		
0(4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(7.0)
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
C935	5 Continued From page 163		C935		
	Cha was a registered	d puro (DNI)			
	-She was a registered	ad contacted her to train new			
		" staff in August 2020.			
		raining that included a slide			
		ach staff with a handbook.			
	-	raining in the living room of			
		nts stayed in their rooms			
	during training.	,			
	-She completed the c	linical skills checklist on-site			
	with Staff C.				
		staff sign an attendance			
		he training was completed			
	was on the staff's trai	•			
		y "at least four-times" for			
	training.				
	Interview with a resid	ent on 10/26/20 at 2:22pm			
	revealed:	on on 10,25,25 at 2.22pm			
	-She had not seen an	yone do staff training in the			
	facility.				
	-She went into the livi	ing room area every day,			
	multiple times.				
		structed to stay in her room			
	while staff were being	g trained.			
	Tolophono intervious	with the Administrator an			
	10/26/20 at 1:14pm re	with the Administrator on			
		red nurse had on leave for a			
	, ,				
	couple of months and not available to do training with the MAs.				
		who was a RN had been to			
	the facility three times to do "one on one" training with the staff. -Most of the training was one on one with the				
		training was done as a			
	group.				
		e dates, but all training had			
	been completed withi				
		e dates the training forms			
	were signed, but the t	trainer had been at the			

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ווטופועום	n rieaith Service Regu	1	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	.ETED
		FCL093012	B. WING		441	04/2020
		FOLU93012			1 11/0	J4/2U2U
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIVOTA:	CARE	303 W FR	ANKLIN STREE	ΕΤ		
PIVOTAL (CAKE	WARREN	TON, NC 27589)		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
				DEFICIENCY)		
C935	Continued From page	e 164	C935			
	. •					
	facility "so many time					
		e facility for never less than				
	5-hours.					
	1 Review of the facili	ity's nersonnel records				
		ty's personnel records				
	revealed Stall D dld f	not have a personnel record.				
	Telephone interview v	with Staff D on 11/04/20 at				
	12:04pm revealed:	With Stall B on 11/04/20 at				
		dication aide (MA) at the				
	facility and administered medications					
	independently when she was working.					
	-She had not had MA training at the facility, but					
		w she already had MA				
	training in the past.	w one anday had wire				
	-She had not been as	sked to provide				
	documentation of her					
		w. t.daninig.				
	Review of resident's	controlled medications logs				
		nistration records (MAR) for				
		October 2020 revealed:				
	-The first time Staff D					
		lication was on 09/12/20/20;				
		l administering medications				
	on 4 additional days i					
	-Staff D documented	-				
	medication on 6 days	in October 2020.				
	•					
	Telephone interview v	with the Administrator on				
	10/26/20 at 1:14pm re	evealed:				
	-Staff D did not have					
		who worked at a "peer's				
	facility."					
	-Staff D had been a lo	ong-term employee at the				
	peer's facility and had	d a personnel record at the				
	peer's facility.					
		0A 10A NCAC 13G .1004				
	Medication Administra	ation (Type B Violation).]				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W FRA	NKLIN STREE	ŧΤ		
		WARRENT	ON, NC 27589)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C935	935 Continued From page 165		C935			
	[Refer to Tag C342 10A NCAC 13G .1004j Medication Administration (Standard Deficiency).]					
		OA NCAC 13G .1008(a) es (Standard Deficiency).]				
		DA NCAC 13G .1005(a) Medications (Standard				
	[Refer to Tag C316 10A NCAC 13G .1002(b) Medication Orders (Standard Deficiency).] The facility failed to ensure 4 of 4 sampled staff had completed the medication clinical skills competency validation and completed the 5-hour and 10-hour medication aide training courses and continued to perform unsupervised medication aide duties with errors in medication administration, including a resident not being administered a maintenance medication who had asthma and had been having increased shortness of breath and wheezing and using her prn medication more often to relieve the increased symptoms, and a resident being administered the wrong medication which caused the resident to have adverse reactions which included slurred speech and overall weakness, residents self-administering medications without orders, medications being administered without orders, inaccurate MARs and controlled substance logs, and a medication aide failing the MA exam. The failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.					
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 11/04/20 for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 20.25		
		FCL093012	B. WING		11/04/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PIVOTAL (^ADE	303 W FRA	NKLIN STREE	т	
PIVOTAL	CARE	WARRENT	ON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C935	Continued From page 166		C935		
	CORRECTION DATE VIOLATION SHALL N 19, 2020	FOR THE TYPE B OT EXCEED DECEMBER			
C992	G.S. § 131D-45 G.S. and screening for	§ 131D-45. Examination	C992		
	_	mination and screening for olled substances required sloyment in adult care			
	(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING:		E SURVEY PLETED		
		FCL093012	B. WING			/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PIVOTAL	CARE		RANKLIN STREET			
		WARRE	NTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C992 Continued From page 167		e 167	C992			
	and screening to veri examination and scre	fy the results of the prior eening.				
	This Rule is not met as evidenced by: TYPE B VIOLATION					
	facility failed to ensur screening for the pre-	pleted for 4 of 4 sampled				
	The findings are:					
	1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20There was documentation on a named company on a form titled Toxicology Screen, Staff A completed the examination and screen for the presence of controlled substances on 09/17/20.					
	revealed: -She had not comple screening for controll -She had not used a	urine specimen cup provided to complete an examination				
	the toxicology screen 1:35pm revealed: -His company did not facilitiesHe did not know why documentation on his facility.	y there would be s agency's form on file at the v someone had obtained a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMILE	1120
		FCL093012	B. WING		11/0	4/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL	CARE	303 W FR/	ANKLIN STREE	ET .		
		WARREN	TON, NC 27589)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C992	Continued From page	e 168	C992			
		ff A, and had not performed				
	10/20/2020 at 3:31pm revealed: -She had requested a drug test from a friend	with the Administrator on and 10/21/20 at 12:06pm assistance to give her staff d who was a doctor. Online program to verify drug				
	10/26/20 at 1:14pm re -She completed drug -Drug screens were c employee bathroom u	screenings on all new hires. completed in the facility's using a urine specimen cup. ug screen on Staff A in the				
	(SIC), personnel reco -Staff B was hired on -There was documen form titled Toxicology	09/21/20. tation on a named company Screen, Staff B completed screen for the presence of				
	revealed: -She had not complet screening for controlle-She had not used a by the Administrator t and screening for controlled toxicology screening to toxicology screening to the screening toxicology screening to the screening toxicology screening to the screening to the screening to the screening to the screening toxicology screening to the scr	urine specimen cup provided o complete an examination				
	1:35pm revealed: -His company did not facilities.	do drug screens for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
FCL093012		FCL093012	B. WING		11/04/2020	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PIVOTAL (CARE		ANKLIN STREE			
			TON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C992	Continued From page 169		C992			
C992	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		C992			
	revealed: -He had not complete substances complete -He had not used a ur	on 11/27/20 at 8:12am d a screening for controlled d at the facility. rine specimen cup provided o complete a drug screen.				

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Telephone interview with a provider at the named

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		1.	1/04/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
PIVOTAL	CARE	303 W F	RANKLIN STREET				
FIVOIAL	CARL	WARRE	NTON, NC 27589				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C992	Continued From page	e 170	C992				
	1:35pm revealed: -His company did not facilitiesHe did not know why documentation on his facilityHe did not know how form from his agencyHe did not know Star a drug screen on Star Telephone interview v 10/20/2020 at 3:31pm revealed: -She had requested a drug test from a friend	there would be agency's form on file at the agency's form on file at the assomeone had obtained a to use. If C, and had not performed ff C. with the Administrator on and 10/21/20 at 12:06pm					
	10/26/20 at 1:14pm re-She completed drug -Drug screens were comployee bathroom uses -She completed a drug facility's employee bathroom of the facility	screenings on all new hires. completed in the facility's using a urine specimen cup. It g screen on Staff C in the throom. Ity's personnel records not have a personnel record. With Staff D on 11/04/20 at the had not had a screening three on her since she began With the Administrator on the evealed:					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL093012	B. WING		11/	11/04/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
PIVOTAL CARE 303 W FRANKLIN STREET WARRENTON, NC 27589							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
C992	facility." -Staff D had been a lopeer's facility and had peer's facility. The facility failed to escreening for the pressubstances was perfestaff (C and D) hired awas detrimental to the of all residents and control of the facility provided accordance with G.S. this violation.	ong-term employee at the lapersonnel record at the laperson examination and sence of controlled laperson for 4 of 4 sampled lafter 10/01/13. This failure laperson has been easily and welfare laperson laper	C992				

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