	-	ID HUMAN SERVICES				RM APPROVED
		MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>	PLE CONSTRUCTION G		TE SURVEY
		345397	B. WING			C )2/20/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		)2/20/2014
	AND HLTH CARE & RETI	DEME		200 FLOWER-PRIDGEN DR		
SHOKELA				WHITEVILLE, NC 28472		
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 431 SS=E	483.60(b), (d), (e) DF LABEL/STORE DRU		F 4	31		3/7/14
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a	bloy or obtain the services of and disposition of all ifficient detail to enable an and that an account of all aintained and periodically				
		y and cautionary				
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys.				
	permanently affixed of controlled drugs lister Comprehensive Drug Control Act of 1976 a abuse, except when package drug distribu	vide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can				
	This REQUIREMENT by: Based on observatio	「 is not met as evidenced n, facility policy and		The statements made on t	this plan of	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					03/07/2014

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

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SURV	<u>38-039</u> /=~
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETE		
			A. BUILDING	с		
		345397	B. WING	02/20/20	014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		/14
				200 FLOWER-PRIDGEN DR		
SHORELA	ND HLTH CARE & RETI	REME		WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COM THE APPROPRIATE	(X5) MPLETION DATE
F 431	Continued From page	o 1				
1 401	-		F 43	correction are not an adm	incian to and do	
		kage insert review and staff / failed to label medications		not constitute an agreeme		
		ing and failed to refrigerate		alleged deficiencies.		
	unopened insulin flex					
		<b>F</b>		To remain in compliance v	vith all federal	
	The findings included	1:		and state regulations the f	acility has taken	
				or will take the actions set		
		's package insert for		plan of correction. The pla		
		pen revealed that once		constitutes the facility □s a		
		ation could be used for up to		compliance such that all a deficiencies cited have be	•	
	28 days.			corrected by the dates ind		
	The facility 's undate	d policy titled (Name of				
	Pharmacy 's) Long T			F 431		
		age for Selected Items read:				
		must have a date opened		Corrective Action for Resid	dent Affected	
	sticker attached and	the date & initials of person		No residents were adverse	ely affected by	
		nust be written on the		the alleged deficient pract		
	-	except Lantus) good for only		the five Lantus flex pens a		
	28 days not			Diskus were discarded an	•	
	refrigerated. "			200 Hall Nurse and 300 H	all Nurse.	
	An observation was r	nade of the medication cart				
	for the 300 Hall on 2/	20/14 at 11:55 AM with		Corrective Action for Resid	dent Potentially	
	Nurse #1. A Novolog	Insulin Flexpen stored in a		Affected		
	•	led with the name of		All residents are potentiall		
		have a label to convey when		alleged deficient practice.		
		lispensed by the pharmacy		each medication cart was		
		with the date the medication 1 stated that the medication		undated flex pens and ope multi-dose Advair Diskus o		
		s after opening and should		systems. Any undated or e		
		en opened. The Nurse stated		found were discarded and	-	
		I need to be thrown away.		was completed by Directo Staff Development Coordi	r of Nursing,	
	An interview was cor	ducted with the Director of				
	Nursing (DON) and t	he Administrator on 2/20/14		Systemic Changes		
	at 2:20 PM. The DO			An in-service was conduct	-	
		tion had not been stored		Staff Development Coordi		
	properly and offered	no additional information.		who attended were all RN	s. I PNs. and	

Facility ID: 923452

		MEDICAID SERVICES					O. 0938-03
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
							С
		345397	B. WING		02/20/2014		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
SHORELAND HLTH CARE & RETIREME					00 FLOWER-PRIDGEN DR VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIOI DATE
F 431	Continued From page	- 2	F	131			
		-		101	FT, PT, and PRN. Any in-house staff		
	2. The manufacturer	's package insert for			member who did not receive in-service	2	
		ben revealed that unopened,			training will not be allowed to work unt		
	the medication was g			training has been completed. The			
	if stored in a refrigera			in-service topics included:			
	good for 28 days.			" Recommended Storage for Select	ted		
	good ioi io dayoi				Items after Opening (exhibit 1)		
	The facility 's undate			<ul> <li>Also see In-service Training Reco</li> </ul>	rd		
	Pharmacy 's) Long T			(exhibit 2)			
	Recommended Stora			This information has been integrated in	nto		
	" All Insulins (except I			the standard orientation training and ir			
	refrigerated. Unopene			required in-service refresher courses f			
	refrigerator. "				all employees and will be reviewed by		
	5				Quality Assurance Process to verify the		
	for the 300 Hall on 2/2	nade of the medication cart 20/14 at 11:55 AM with			the change has been sustained.		
		ag with a Novolog Insulin					
		with the name of Resident			Quality Assurance		
	#98. The label on the			The Staff Development Coordinator wi	II		
	-	ensed by the pharmacy on			monitor this issue using the "Survey		
	1/14/14. A label on th				Quality Assurance Tool for Monitoring		
		ned. " Nurse #1 stated the			Medication Storage". The monitoring	will	
		nsed by the pharmacy in a			include verifying that all multi-dose		
		opened was stored in a			Flexpens and Multi-dose medication		
	· ·	the resident 's name on the			dispensers or vials are dated when		
		The Nurse stated that the			opened and not expired. See attache		
		#98 had not been opened			monitoring tool. This will be done wee	ĸly	
		n stored in the refrigerator.			times four weeks then monthly times		
		medication would need to			three months or until resolved by Qual	ity	
	be thrown away.				Of Life/Quality Assurance Committee.	alite	
	An intonvious	ducted with the Director of			Reports will be given to the weekly Qu	anty	
		ducted with the Director of			of Life- QA committee and corrective		
	• • •	ne Administrator on 2/20/14			action initiated as appropriate. The	ho	
	at 2:20 PM. The DOI	tion had not been stored			Quality of Life Committee consists of the Administrator, Director of Nursing, Sta		
					Administrator, Director of Nursing, Sta		
		no additional information.			Development Coordinator, Unit Manag Health Information Manager, MDS	jei,	
	3. The manufacturer				Coordinator.		
	Novolog Insulin Flexp	pen revealed that unopened,					

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If continuation sheet Page 3 of 7

UMAN SERVICES				FOR	D: 05/14/2014 M APPROVED O. 0938-0391
PROVIDER/SUPPLIER/CLIA	i í		(X3) DATE SURVEY COMPLETED		
345397	B. WING				C 2/ <b>20/2014</b>
		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SHORELAND HLTH CARE & RETIREME			FLOWER-PRIDGEN DR		
		WH	ITEVILLE, NC 28472		
ST BE PRECEDED BY FULL	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
licy titled (Name of Care Pharmacy or Selected Items read: us) good for 28 days not als should be kept in the e of the medication cart 4 at 11:55 AM with ith a Novolog Insulin the name of Resident revealed the d by the pharmacy on expen read: " " Nurse #1 stated the y the pharmacy in a ned was stored in a resident ' s name on the Nurse stated that the had not been opened ored in the refrigerator. dication would need to ed with the Director of dministrator on 2/20/14 d Administrator had not been stored dditional information. ackage insert for evealed that unopened, until the expiration date	F	431			
	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345397	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDI         345397       B. WING         E       ID         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       ID         PREFIL DENTIFYING INFORMATION)       PREFIL TAG         until the expiration date and once opened was       ID         licy titled (Name of Care Pharmacy or Selected Items read: us) good for 28 days not als should be kept in the       F4         e of the medication cart 4 at 11:55 AM with ith a Novolog Insulin the name of Resident or evealed the d by the pharmacy on expen read: " " Nurse #1 stated the y the pharmacy in a ned was stored in a resident ' s name on the Nurse stated that the had not been opened ored in the refrigerator. dication would need to         ed with the Director of dministrator on 2/20/14 d Administrator had not been stored dditional information.       Administrator had not been stored dditional information.	DICAID SERVICES         PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE C A. BUILDING         345397       B. WING         345397       B. WING         E       200 WH         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       PREFIX TAG         Interpretation date and once opened was       F 431         Ilicy titled (Name of Care Pharmacy or Selected Items read: us) good for 28 days not als should be kept in the       F 431         e of the medication cart 4 at 11:55 AM with ith a Novolog Insulin the name of Resident prevealed the d by the pharmacy on expen read: " " Nurse #1 stated the y the pharmacy in a ned was stored in a resident's name on the Nurse stated that the had not been opened ored in the refrigerator. dication would need to         ed with the Director of dministrator on ad not been stored dditional information.       Additional information.         ackage insert for evealed that unopened, until the expiration date       Additional information	DICAID SERVICES         PROVIDERSUPPLIERCIA IDENTIFICATION NUMBER:         345397         B. WING         345397         B. WING         E         STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)         PREFIX TAG         PREFIX TAG         PROVIDERS PLAN OF CORRECTIN (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTING (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTING (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTING (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE OF CLEAR OF CROSS ACTION HOUSE CROSS-REFERCED TO THE APPROVIDENT PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOUSE ACTION TO ACTION ACTION (EACH CORRECTIVE ACTION HOUSE ACTION TO ACTION ACTION (EACH CORRECTIVE ACTION HOUSE ACTION WOULD APPROVIDE (EACH CORRECTIVE ACTION HOUSE ACTION TO ACTION ACTION (EACH CORRECTIVE ACTION HOUSE (EACH	DICAID SERVICES     OMB N       PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:     (2) MULTIPLE CONSTRUCTION A BUILDING     (X3) DAT COM       345397     B. WING     02       E     STREET ADDRESS, CITY, STATE, ZIP CODE     02       200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472     02       ENT OF DEFICIENCIES IS THE EPRECEDED BY FULL DENTIFYING INFORMATION)     D PROVIDERS PLAN OF CORRECTION WHITEVILLE, NC 28472       Until the expiration date ind once opened was     D PREFIX TAG     PROVIDERS PLAN OF CORRECTION WHITEVILLE, NC 28472       Until the expiration date ind once opened was     F 431     F 431       Until the expiration date ind once opened was     F 431       Using outfor 28 days not als should be kept in the     F 431       e of the medication cart 4 at 11:55 AN with the name of Resident inevealed the d by the pharmacy in a ned was stored in a resident 's name on the Nurse stated that the had not been opened red in the refigerator. dication would need to       ed with the Director of dication would need to     I       ed with the Director of dication information. ackage insert for evealed that unopened, until the expiration date

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345397	B. WING				C / <b>20/2014</b>	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SHORELA	SHORELAND HLTH CARE & RETIREME			200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	Continued From page	2 4	F	431	ſ			
	Pharmacy 's) Long Te Recommended Stora "All Insulins (except I refrigerated. Unopene refrigerator." An observation was n for the 300 Hall on 2/2 Nurse #1. A plastic ba Flexpen was labeled ' #79. The label on the medication was dispe 1/8/14. A label on the until opened. "Nurse dispensed by the pha once opened was sto with the resident 's na container. The Nurse Resident #79 had not have been stored in the	ge for Selected Items read: Lantus) good for 28 days not ed vials should be kept in the nade of the medication cart 20/14 at 11:55 AM with ag with a Novolog Insulin with the name of Resident						
	Nursing (DON) and th at 2:20 PM. The DON indicated the medicat	ducted with the Director of ne Administrator on 2/20/14 N and Administrator ion had not been stored no additional information.						
	the medication was g if stored in a refrigera good for 28 days. The facility 's undate Pharmacy 's) Long To	en revealed that unopened, ood until the expiration date tor and once opened was d policy titled (Name of						

Facility ID: 923452

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345397	B. WING				20/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SHORELAND HLTH CARE & RETIREME					200 FLOWER-PRIDGEN DR NHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 431	" All Insulins (except I refrigerated. Unopene refrigerator. " An observation was m for the 300 Hall on 2/2 Nurse #1. A plastic ba Flexpen was labeled #1. The label on the t was dispensed by the label on the Flexpen m opened. " Nurse #1 s dispensed by the pha once opened was sto with the resident ' s m container. The Nurse Resident #1 had not t have been stored in t An interview was com Nursing (DON) and th at 2:20 PM. The DOM indicated the medicat properly and offered m 6. Advair Diskus cont used to treat asthma Pulmonary Disease. disposable purple dev moisture-protective for s package insert reve discarded one month moisture-protective for The facility ' s undate Pharmacy ' s) Long T Recommended Stora " The following items	Lantus) good for 28 days not ed vials should be kept in the nade of the medication cart 20/14 at 11:55 AM with ag with a Novolog Insulin with the name of Resident bag revealed the medication e pharmacy on 2/17/14. A read: " Refrigerate until stated the Flexpen was armacy in a plastic bag and ored in a plastic container ame on the end of the stated that the Flexpen for been opened and should he refrigerator. ducted with the Director of ne Administrator on 2/20/14 N and Administrator tion had not been stored no additional information . ains an inhaled medication and Chronic Obstructive The Advair Diskus is a vice that is packaged in a bil pouch. The manufacturer ' ealed the device should be after removed from the bil pouch. d policy titled (Name of	F	431				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/14/2014 APPROVED ). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		345397	B. WING					) 20/2014
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STA			
SHORELAND HLTH CARE & RETIREME					200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 431	opening medication n sticker! Advair Diskus after removal from foi An observation was n for the 100 Hall on 2/2 Nurse #2. A plastic ba Advair Diskus labeled #89 was observed to the device was remov label on the plastic ba dispensed by the pha stated the medication opening and confirme the device to indicate removed from the foil An interview was con Nursing (DON) and th at 2:20 PM. The DON indicated the medication	hust be written on the - Discard diskus 4 weeks I pouch. " hade of the medication cart 20/14 at 12:48 PM with ag containing an opened I with the name of Resident not be dated with the date yed from the foil pouch. A ag revealed the device was rmacy on 1/10/14. Nurse #2 was good for 30 days after ad there was not a date on when the device was pouch. ducted with the Director of he Administrator on 2/20/14	F	431				

If continuation sheet Page 7 of 7