		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345415	B. WING		0	C 1/16/2014
	ROVIDER OR SUPPLIER	) LIVING CTR	101	REET ADDRESS, CITY, STATE, ZIP COE 10 Lakeview drive Neville, NC 28134		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 156 SS=C	complaint investigatio 483.10(b)(5) - (10), 4	cited as a result of the on. Event ID MP0E11. 83.10(b)(1) NOTICE OF RVICES, CHARGES	F 156			2/19/14
	<ul> <li>RIGHTS, RULES, SERVICES, CHARGES</li> <li>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</li> </ul>					
	entitled to Medicaid b of admission to the nu- resident becomes elig- items and services th facility services under which the resident ma other items and servi- and for which the resident the amount of charge inform each resident	m each resident who is enefits, in writing, at the time ursing facility or, when the gible for Medicaid of the at are included in nursing the State plan and for ay not be charged; those ces that the facility offers ident may be charged, and s for those services; and when changes are made to s specified in paragraphs (5) section.				
	at the time of admissi the resident's stay, of facility and of charges	m each resident before, or on, and periodically during services available in the s for those services, s for services not covered				
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE 02/06/2014

**Electronically Signed** 

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/07/2014

		ND HUMAN SERVICES MEDICAID SERVICES					FORM	): 02/07/2014 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION			SURVEY LETED
		345415	B. WING					_ 16/2014
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE,	ZIP CODE		
PINEVILLE	E REHABILITATION AND	LIVING CTR			010 LAKEVIEW DRIVE PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 156	Continued From page under Medicare or by The facility must furni- legal rights which incl A description of the m personal funds, under section; A description of the re- for establishing eligibit the right to request ar 1924(c) which determ non-exempt resource- institutionalization and spouse an equitable sc cannot be considered toward the cost of the medical care in his or down to Medicaid elige A posting of names, a numbers of all pertine groups such as the St agency, the State lice ombudsman program advocacy network, ar unit; and a statement complaint with the Sta agency concerning re misappropriation of re- facility, and non-comp directives requiremen The facility must infor name, specialty, and p	e 1 the facility's per diem rate. sh a written description of udes: nanner of protecting r paragraph (c) of this equirements and procedures lity for Medicaid, including n assessment under section nines the extent of a couple's s at the time of d attributes to the community share of resources which available for payment institutionalized spouse's her process of spending juility levels. addresses, and telephone ent State client advocacy tate survey and certification ensure office, the State , the protection and nd the Medicaid fraud control that the resident may file a ate survey and certification esident abuse, neglect, and esident property in the oliance with the advance its. m each resident of the way of contacting the e for his or her care.		156				
	The facility must prom	ninently display in the facility						

If continuation sheet Page 2 of 20

			()(0) 100		OMB NO. 0938-0 (X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>		` '	E SURVEY PLETED
						С
		345415	B. WING			/16/2014
NAME OF P	ROVIDER OR SUPPLIER		<b>_</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	/10/2014
				1010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	D LIVING CTR		PINEVILLE, NC 28134		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 450		0				
F 156			F 15	6		
		nd provide to residents and				
	applicants for admiss	ion oral and written w to apply for and use				
		aid benefits, and how to				
		revious payments covered by				
	such benefits.					
		is not met as evidenced				
	by:			Desidente #40 #400 #450 hou		
		iew and staff interviews the de residents with the Denial		Residents, #49, #123, #150 have identified and are no longer resid		
		are Coverage and their		Pineville Rehabilitation & Living (		
		3 residents. (Resident # 49,				
	Resident # 123 and F	-		Facility Social Worker is responsi	ible for	
		,		ensuring that residents/family s		
	The findings included	1:		informed of the Denial of Paymer	nt of	
				Medicare coverage and their app	eal	
		the Liability Notices/Notice		rights.		
		Non-Coverage forms				
		49 was not provided with a		Facility Social Worker was in-ser this process by Regional Director		
		and Medicaid(CMS) form for prmed the resident/family of		Reimbursement on January 13, 2		
		o have a claim or demand				
	-	icare as the resident no		The facility started issuing Denial	of	
	longer qualified for se			Payment of Medicare Coverage a		
				appeal rights on 1/13/14		
		on 01/16/14 at 4:40 PM the				
		ed she is responsible for		Facility has implemented an audi		
		form for notification which		monitor and track that patients/fa		
		/family of the resident 's		members are provided with Denia		
		or demand bill submitted to esident is no longer qualified		Payment of Medicare Coverage a appeal rights. Facility Social Wo		
		ther stated that these		be responsible for completing an		
	notifications had not l			monitoring this audit tool. This pro-		
		e May of 2013 when the		started on 2/5/14		
	Business Office Mana	ager left and she became				
	responsible for comp	leting them. She further		Administrator/Assistant Administr	ator will	

Facility ID: 923298

If continuation sheet Page 3 of 20

	S FOR MEDICARE &					0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
					(	
		345415	B. WING		01/	16/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	D LIVING CTR		PINEVILLE, NC 28134		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 156		a 3	E 156			
F 156	stated she had had n until January 13, 201 During an interview of Administrator revealed had not been providir notification which info the resident 's right t bill submitted to Medi June 2013. He further expectation and the to have the facility So CMS forms. He reve his Social Worker in a and incouraged her to forms. He further rev place in January of 2 Social Worker with tra they were not being of 2. A record review of of Medicare Provider revealed Resident # one of the correct CM which informed the re- 's right to have a clai to Medicare as the re- services on11/22/13. During an interview of Social Worker reporte completing the CMS informed the resident right to have a clain Medicare when the re-	o training on these forms 4. In 01/16/14 at 4:59 PM the ed he was aware the facility ng the CMS forms for ormed the resident/family of o have a claim or demand icare since he arrived in er reported that his Corporate expectation was ocial Worker complete the aled he had shared this with June and again in October o receive training on these realed a plan was put in 014 to provide the facility aining on the notifications as done. If the Liability Notices/Notice Non-Coverage forms 123 was not provided with 125 forms for notification esident/family of the resident m or demand bill submitted usident no longer qualified for In 01/16/14 at 4:40 PM the ed she is responsible for form for notification which of amily of the resident ' s or demand bill submitted to esident is no longer qualified ther stated that these	F 156	conduct weekly audits of the au 1 Month, bi-weekly audits for 2 m and then monthly audits for 3 m addition the audit tool will be brown and reviewed at the facility mone meeting. Social Worker is responsible for compliance The facility will be in substantial compliance on 2/19/14	months, onths in ought to thly QA	

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB N (X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
			D. MINO			С
		345415	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	0'	1/16/2014
NAME OF P	ROVIDER OR SUPPLIER			1010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	) LIVING CTR		PINEVILLE, NC 28134		
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 156	Continued From page	e 4	F 156			
		leting them. She further o training on these forms 4.				
	Administrator reveale had not been providir notification which info the resident 's right to bill submitted to Medi He further reported th Corporate expectatio Social Worker's to co revealed he had shar Worker in June and a incouraged her to rec He further revealed a January of 2014 to pr	ormed the resident/family of o have a claim or demand care since June of 2013. hat his expectation and the n was to have the facility mplete the CMS forms. He ed this with his Social				
	of Medicare Provider revealed Resident # ' one of the correct CM which informed the re 's right to have a clai	the Liability Notices/Notice Non-Coverage forms 150 was not provided with 1S forms for notification esident/family of the resident m or demand bill submitted sident no longer qualified for				
	Social Worker reporte completing the CMS informed the resident right to have a claim Medicare when the re					

If continuation sheet Page 5 of 20

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLETE	
	CORRECTION	IDENTIFICATION NOWDER.	A. BUILDING		C	_D
		345415	B. WING		01/16/2014	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PINEVILLI	E REHABILITATION ANI	D LIVING CTR		110 LAKEVIEW DRIVE INEVILLE, NC 28134		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) DMPLETIO DATE
F 156	Continued From page	e 5	F 156			
	Business Office Manager left and she became responsible for completing them. She further stated she had had no training on these forms until January 13, 2014.					
F 309 SS=D	Administrator revealed had not been providin notification which info the resident 's right t bill submitted to Med He further reported th Corporate expectation Social Worker's to con- revealed he had share Worker in June and a incouraged her to reac He further revealed a January of 2014 to pro- Worker with training of were not being done. 483.25 PROVIDE CA HIGHEST WELL BEI	ormed the resident/family of o have a claim or demand icare since June of 2013. nat his expectation and the n was to have the facility omplete the CMS forms. He red this with his Social again in October and ceive training on these forms. I plan was put in place in rovide the facility Social on the notifications as they	F 309		2/1	9/14
	provide the necessar or maintain the higher mental, and psychos accordance with the and plan of care.	y care and services to attain st practicable physical,				
	by: Based on observation interviews, and physion	ons, record reviews, staff cian interviews the facility and obtain orders for an eye		Resident #1 no longer resides in the facility. He was discharged home on 1/20/14		

Facility ID: 923298

If continuation sheet Page 6 of 20

					O. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	E SURVEY IPLETED
				С	
	345415	B. WING		01	/16/2014
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
E REHABILITATION AND	LIVING CTR				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETIOI DATE
Continued From page	<u>ه د</u>	E 30			
infection for 1 of 3 sat for conjunctivitis. (Re The findings included Resident #1 was adm 11/17/13 with diagnos weakness, abnormali infection), depression order dated 11/17/13 ordered Tobramycin- ointment (eye ointme infection ) to both eye 5 days for bacterial ey A review of the curren identified conjunctiviti interventions to monit notify physician of cha- symptoms of infection identified self care de functional level, admi for changes in conditi as needed. A review of the admi (MDS) dated 12/14/13 severely impaired cog making skills. Reside assistance with staff f skills (ADL) s which in transfers, bathing, pe A review of the nurse through January 15, 2	mpled residents reviewed esident #1). : initted to the facility on ses which included muscle ty of gait, conjunctivitis (eye a, and stroke. A physician revealed Resident #1 was Dexamethasone 0.3%-0.1% int medication for bacterial es 1 drop every 12 hours for ye infection. Int care plan dated 11/29/13 is which included for for watery eyes, and anges and signs and b. The care plan also ficit, which included assess inster medications, monitor on and notify the physician ssion Minimum Data Set 3 coded Resident #1 as gnitively for daily decision ent #1 required extensive for his activities of daily living included bed mobility, rsonal hygiene, and toileting. s notes December 2013 2014 for Resident #1 ents reflecting the	F 30	To determine that all resident a from eye infection, an assessm residents will be completed by The results to be presented to the Director Four in-services have been corn Licensed staff where in service and 1/24/14. C.N.A. □ s where in on 1/28 and 1/29/14. These in- stressed the importance of obs and the need to report anything appropriate staff. The nurses w instructed on the proper use of when reporting any change in of A review of completed SBAR for conducted, weekly, by the DON review will ensure that any/all of conditions have been acted up Results of the eye assessment SBAR reviews will be presenter monthly QA Director of Nursing is responsible compliance	ent of all 2/7/14 the Medical aducted. d on 1/23 n serviced services ervation g new to the vere also the SBAR condition. orms will be N. This shanges in on. 2/3/14 s and d at the	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E REHABILITATION AND SUMMARY ST. (EACH DEFICIENCY REGULATORY OR I Continued From page infection for 1 of 3 sat for conjunctivitis. (Re The findings included Resident #1 was adm 11/17/13 with diagnos weakness, abnormali infection), depression order dated 11/17/13 ordered Tobramycin ointment (eye ointme infection), depression order dated 11/17/13 ordered Tobramycin ointment (eye ointme infection ) to both eye 5 days for bacterial ey A review of the currer identified conjunctiviti interventions to monifi notify physician of cha symptoms of infection identified self care de functional level, admi for changes in conditi as needed. A review of the admi (MDS) dated 12/14/13 severely impaired cog making skills. Reside assistance with staff f skills (ADL) s which in transfers, bathing, pe A review of the nurse through January 15, 2 revealed no assessma assessment of Reside symptom of infection	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345415         ROVIDER OR SUPPLIER         E REHABILITATION AND LIVING CTR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 6 infection for 1 of 3 sampled residents reviewed for conjunctivitis. (Resident #1). The findings included:         Resident #1 was admitted to the facility on 11/17/13 with diagnoses which included muscle weakness, abnormality of gait, conjunctivitis (eye infection), depression, and stroke. A physician order dated 11/17/13 revealed Resident #1 was ordered Tobramycin-Dexamethasone 0.3%-0.1% ointment (eye ointment medication for bacterial infection ) to both eyes 1 drop every 12 hours for 5 days for bacterial eye infection.         A review of the current care plan dated 11/29/13 identified conjunctivitis which included interventions to monitor for watery eyes, and notify physician of changes and signs and symptoms of infection. The care plan also identified self care deficit, which included assess functional level, administer medications, monitor for changes in condition and notify the physician	S FOR MEDICARE & MEDICAID SERVICES         OP DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING         345415       B. WING         ROVIDER OR SUPPLIER       JD         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       JD         Continued From page 6 infection for 1 of 3 sampled residents reviewed for conjunctivitis. (Resident #1). The findings included:       F 309         Resident #1 was admitted to the facility on 11/17/13 with diagnoses which included muscle weakness, abnormality of gait, conjunctivitis (eye infection), depression, and stroke. A physician order dated 11/17/13 revealed Resident #1 was ordered Tobramycin-Dexamethasone 0.3%-0.1% ointment (eye ointment medication for bacterial infection ) to both eyes 1 drop every 12 hours for 5 days for bacterial eye infection.         A review of the current care plan dated 11/29/13 identified conjunctivitis which included interventions to monitor for watery eyes, and notify physician of changes and signs and symptoms of infection. The care plan also identified self care deficit, which included assess functional level, administer medications, monitor for changes in condition and notify the physician as needed.         A review of the admission Minimum Data Set (MDS) dated 12/14/13 coded Resident #1 as severely impaired cognitively for daily decision making skills. Resident #1 required extensive assistance with staff for his activities of daily living skills (ADL) s which included bed mobility, transfers, bathing, personal hygiene, and toileting.         A review of the nurses notes December 2013 through January	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLIENCIAL IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         STREET ADDRESS, CITY, STATE, ZP CODE         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE         REHABILITATION AND LIVING CTR       STREET ADDRESS, CITY, STATE, ZP CODE         BUILDING       PREVIDENCES         IEACH DEFICIENCY       PREVIDENCES         IEACH DEFICIENCY       PRECEDED BY FULL         REGULATORY OR LEC DENTIFING INFORMATION)       PREVIDENCES         Continued From page 6       F 309         Infection for 1 of 3 sampled residents reviewed for conjunctivitis, (Resident #1).       F 309         Continued From page 6       F 309         Infection for 1 of 3 sampled residents reviewed for conjunctivitis, (Resident #1).       To determine that all resident a from eye infection, an assessment residents will be completed to Director         Infection in, beak admitted to the facility on infection in, depression, and stroke, A physician order dated 11/12/13 (revealed Resident #1 was ordered Tobramycin-Dexamethasone 0.3%-0.1%, ointment (eye infection.         A review of the current care plan dated 11/29/13 identified conjunctivitis which included and the need to report anything appropriate staff. The nurses w instructed on the proper use of when reporting any change in conditions have been acted up for changes in condition and notify the physician as severely impaired cognitively for daily decision making skills. Resident #1 r	S FOR MEDICARE & MEDICAID SERVICES     OMB N       OP DEFICIENCIES     (X) PROVIDERSUPPLERCIA IDENTIFICATION MARGER     (X) MULTIPLE CONSTRUCTION A BUILDING     (X) MULTIPLE CONSTRUCTION A BUILDING     (X) MULTIPLE CONSTRUCTION A BUILDING     (X) PROVIDERSUPPLERCIA IDENTIFICATION MARGER     (X) MULTIPLE CONSTRUCTION A BUILDING     (X) PROVIDERSUPPLERCIA IDENTIFICATION MARGER     (X) MULTIPLE CONSTRUCTION A BUILDING     (X) PROVIDERSUPPLERCIA IDENTIFICATION AND LIVING CTR     (X) PROVIDERS ILAN OF CORRECTION IDENTIFICATION AND LIVING CTR     (X) PROVIDERS PLAN OF CORRECTION IDENTIFICATION AND LIVING CTR     (X) PROVIDERS PLAN OF CORRECTION IDENTIFICATION AND LIVING CTR     IDENTIFICATION AND LIVING CTR     IDENTIFICATION AND LIVING CTR     (X) PROVIDERS PLAN OF CORRECTION IT CACI CORRECTIVE ACTION SPALLO BE IDENTIFICATION AND LIVING CTR     IDENTIFICATION AND LIVING AND LIV

Facility ID: 923298

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 02/07/2014 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION			SURVEY LETED
		345415	B. WING			-		_ 16/2014
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PINEVILLE	E REHABILITATION AND	LIVING CTR			1010 LAKEVIEW DRIVE PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	27	F	309				
	2013 and January 20 ointment was given to 2013 through January During an observation 01/13/14 at 10:30 AM with reddened watery During an observation Resident #1 was obset both his eyes noted to right eye to be more r During an observation Resident #1 was obset the hallway next to the reddened watery eyes with his left hand. During an interview of Nurse #1 stated Reside eyes, and had been li Nurse #1 further state eyes drops when he we eye infection. Nurse # communicated with the continuation of Reside eyes. Nurse #1 furthet written a nurses note watery eyes and had doctor since her last of Resident #1's condition	ds (MAR) dated December 14, indicated no medication of the eyes in December 7 15,2014. In of the tour of facility on Resident #1 was observed eyes. In on 01/14/14 at 10:48 AM erved in the dining room with the be red and watery with the eddened than the left. In on 01/15/14 at 9:39 AM erved in his wheelchair in e nurse's station with as and was rubbing his eyes In 01/15/2014 at 10:12 AM dent #1 had red and watery ke that since his admission. ed the resident had received was first admitted to treat an e1 revealed she had he doctor regarding the ent #1's red and watery r revealed that she had not regarding Resident #1's red not followed up with the communication regarding						
	the Director of Nursin	g (DON) confirmed that she nt #1's eyes were red and						

FATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			C
		345415	B. WING		0	1/16/2014
NAME OF PI	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEVILLI	E REHABILITATION ANI	D LIVING CTR		10 LAKEVIEW DRIVE NEVILLE, NC 28134		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	signs and symptoms eyes November 2013 The DON further veri additional orders for eye infection for Res admission date in No that it was her expec observed the Reside and watery should ha to the doctor and folle interventions were do During and interview the physician stated Resident #1's red an this morning to asses Resident #1 had a hi and he had requeste ophthalmologist rega physician confirmed	rified there was no the doctor regarding the of infection of Resident #1's 3 through January 15, 2014. fied there were no new or any medications for bacterial ident #1 since his original ovember. The DON stated tation that nurses who nt #1's eyes to be reddened ave reported the symptoms owed up to be sure that one. on 01/15/2014 at 11:54 AM that the nurses had brought d watery eyes to his attention ss. He further stated story of chronic conjunctivitis d medical records from the rding this history. The Resident #1 had swelling,	F 309			
F 329 SS=D	redness and watery e 483.25(I) DRUG REC UNNECESSARY DR	GIMEN IS FREE FROM	F 329			2/19/14
	unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use adverse consequence	regimen must be free from An unnecessary drug is any ccessive dose (including r for excessive duration; or nitoring; or without adequate e; or in the presence of es which indicate the dose r discontinued; or any reasons above.				
		ensive assessment of a nust ensure that residents				

Facility ID: 923298

If continuation sheet Page 9 of 20

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, í		· · /	PLETED
			A. BOILDING			С
		345415	B. WING		01	U/16/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/10/2014
				1010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	D LIVING CTR		PINEVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIO
F 329	Continued From page 9		F 32	9		
	_	ntipsychotic drugs are not		-		
		less antipsychotic drug				
		to treat a specific condition				
		cumented in the clinical				
		who use antipsychotic				
	drugs receive gradua	I dose reductions, and				
	behavioral intervention	ons, unless clinically				
	contraindicated, in ar	n effort to discontinue these				
	drugs.					
	This REQUIREMENT	⊺ is not met as evidenced				
		ns, medical records, staff		Resident #s 140, 8, and 178, stil	l reside	
		cian interviews the facility		in the facility.		
		cian orders for over the				
	counter medications			A facility sweep was conducted of	on	
	(Residents #140, #8,	#178).		1/17/14, in order to remove all		
				unauthorized medications. Medic	ations	
	The findings included	1:		were placed in the DON s office		
				returned to the family or to secur		
		s originally admitted on		order for the needed medications	<b>.</b>	
		admitted on 12/30/14 with		A Decident Coursel Masting was	hold or	
	•	uded urinary tract infections,		A Resident Council Meeting was 1/21/14 in order to inform the res		
	lumbar degenerative	joint disease, spinal e pain, insomnia, anxiety,		about keeping unauthorized med		
	depression, and hype	• • • • • •		at the bedside. The staff advised		
				residents to refrain from buying C		
	A review of the quart	terly Minimum Data Set		while on a shopping excursions.		
		4 coded Resident #140 as		Activity staff has been alerted, ar		
	. ,	ily decision making skills but		deter residents from purchasing		
	-	mory recall. Resident #8				
		ssistance with staff for her		A letter has been drafted, and wi		
		g skills (ADL) ' s which		to all family members. The letter	advises	
	included bed mobility			families to refrain from bringing		
	I have the transmission of the filler three as	. Resident was also coded	1	medications from home, without		1

Facility ID: 923298

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
		345415	B. WING		C 01/16/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
PINEVILLI	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	
F 329	Continued From page	9 10	F 32	29	
	as being compliant wi	ith care.		approval of the DON 2	/3/14
	for 12/30/13 for Resid physician order for me antibacterial cream. A review of facility physicial	elatonin, Vitamin C or ysician orders for January 40 revealed no physician		Continuous monitoring by the licensed staff. Ea search will be conducte staff member. These co be returned to the DON medications will be give Family will then be notif ongoing	ach week, a room ed by the assigned ompleted audits will I. Any removed en to the DON.
	revealed no current re			Completed audits will b monthly QA meeting for Director of Nursing is re compliance	r further review.
		n on 01/14/14 at 9:00 AM 3 ying on Resident #140 ' s		The facility will be in sul compliance on 2/19/14	bstantial
		n on 01/14/14 at 12:01 PM 3 ying on Resident #140 ' s			
	•	n on 01/14/14 at 5:59 PM 3 ying on Resident #140 ' s			
	Resident #140 stated ginseng and that she further stated the thre the floor earlier this at them away. Resident	n 01/15/14 at 5:11 PM the three white pills were took them for energy. She we white pills had fallen on fternoon and she had thrown t declined to say where she but did state the nurse had			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/07/2014 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345415	B. WING _				C 16/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEVILLI	E REHABILITATION AND	) LIVING CTR			010 LAKEVIEW DRIVE INEVILLE, NC 28134		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 329	During an interview o Nurse #3 revealed Re have any medication always places resider and pours them into h hands shake. Entere and observed Nurse # drawer. Nurse #3 pul with no lid, bottle of V antifungal cream. During a phone interv with the physician he notified of any medications th have a better clinical treatment. During an interview o Director of Nursing (D Regional Director of O stated her expectation	e 11 In 1/16/14 at 2:51 PM with esident #140 should not on her night stand and she nt 's medications in a cup her mouth as Resident #140 ed Resident #140 's room #3 open nightstand top lled out bottle of melatonin (itamin C and a tube of <i>v</i> iew on 01/16/14 at 3:50 PM stated he should have been ation that comes into the ted he needed to be aware hat a resident was taking to judgment in determining In 01/16/14 at 4:14 PM with DON) and Administrator and Clinical Services the DON n was for all medications to illity pharmacy and have a	F 3	329			
	weakness, depression edema, recurrent urin neurogenic bladder. A Minimum Data Set (M Resident #8 as cognit						

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		· · ·	TE SURVEY IPLETED
						С
		345415	B. WING		01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEVILL	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From page	e 12	F 32	9		
		for her activities of daily				
	• • • •	ch included bed mobility,				
	transfers, dressing, b	athing, and toileting.				
	A review of Resident	#8 's Medication				
		(MAR) for December 2013				
		vealed no current record of contract co				
	topical skin product th	nat is used as a protective				
	coating for mild skin i	rritations).				
	A review of physician	orders for December 2013				
		Resident #8 revealed no				
	oxide dimethicone sp	he administration of zinc ray.				
		#8 's most recent care plan				
	for potential for impai 11/04/10 revealed int	red skin integrity dated				
		veekly skin audits, treat as				
		e to be kept at bedside.				
	During an observatio	n on 01/13/14 at 10:30 AM a				
	tube of zinc oxide dim					
	observed on Residen	t #8's bedside table.				
	During an observation	n on 01/14/14 at 6:05 PM the				
	same tube of zinc oxi	de dimethicone spray was				
	observed on Residen	t #8's bedside table.				
	During an observation	n on 01/15/14 at 09:25 AM				
		icone spray was observed				
	again on the bedside	table.				
	During an interview o	n 01/15/14 at 9:25 AM				
		e zinc oxide spray was				
	÷ .	rtment store on one of her urther stated that she buys				
		ne counter creams to treat				

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	): 02/07/2014 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345415	B. WING					C 16/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP COI	DE		
PINEVILLI	E REHABILITATION AND	) LIVING CTR			010 LAKEVIEW DRIVE INEVILLE, NC 28134			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 329	Continued From page her dry skin.	÷13	F 3	29				
	Director of Nursing (E oxide spray was on R along with other lotior confirmed there were zinc oxide spray and medication assessme #8. The DON stated h providing care for res over the counter med	n 01/16/14 at 9:35 AM The DON) confirmed the zinc Resident #8's bedside table ns. The DON further no physician orders for the no self administrations of ents completed for Resident ner expectations for nurses idents were to remove any lications, notify the physician the administration of these						
	Nurse #2 who was fail of Resident #8 stated prescription medication	n 01/16/14 at 3:05 PM miliar with the medications any over the counter or ons should have had a ere kept in the medication cart.						
	with the physician he notified of any medica facility. He further sta of any medications th	view on 01/16/14 at 3:50 PM stated he should have been ation that comes into the ted he needed to be aware at a resident was taking to judgment in determining						
	10/11/13 with diagnos weakness, abnormali Alzheimer's, depressi kidney disease. A rev Minimum Data Set (M Resident #178 as sev	s admitted to the facility on ses which included muscle ty of gait disturbance, ion, stroke, and chronic view of the quarterly IDS) dated 12/31/13 coded verely impaired cognitively king skills. Resident #178						

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/07/2014 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345415	B. WING			_		C 16/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
PINEVILL	E REHABILITATION AND	) LIVING CTR			010 LAKEVIEW DRIVE PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	required extensive as her activities of daily I included bed mobility, bathing, personal hyg A review of Resident Administration Record and January 2014 rev administration of nyst & 1 mg triamcinolone cream that kills yeast A review of physician January 2014 for Res physician orders for th triamcinolone ointmer A review of Resident plan for at risk for skin revealed interventions hydration, assess skin with hygiene and gen During an observation tube of nystatin 30 g triamcinolone ointmer bathroom on resident During an observation tube of nystatin triamo observed on Resident During an observation tube of nystatin triamo observed on Resident During an observation the tube of nystatin triamo observed on Resident During an observation the tube of nystatin triamo observed on Resident	ssistance with one staff for living skills (ADL) which , transfers, dressing, giene, and toileting. #178's Medication d (MAR) for December 2013 vealed no current record of tatin 30 g 100,000 usp units o intment (an antibiotic infections on skin). • orders for December and sident #178 revealed no he administration of nystatin nt. #178's most recent care n impairment dated 10/23/13 s to ensure adequate n condition daily, and assist ueral skin care. n on 01/13/14 at 10:30 AM a 100,000 usp units & 1 mg nt was observed in the	F	329				

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/07/2014 RM APPROVED IO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA1	TE SURVEY MPLETED
		345415	B. WING		0	C 1/16/2014
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PINEVILLE	REHABILITATION AND	) LIVING CTR		1010 LAKEVIEW DRIVE		
				PINEVILLE, NC 28134		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	<ul> <li>#178's bathroom. The of nystatin triamcinoloc Resident #178's bath lotions. The DON furt physician orders for the triamcinolone ointmer administrations of me completed for Reside her expectations for r residents were to rem medications, notify th orders for the administ medications.</li> <li>During a phone interview with the physician he notified of any medications the notified of any medications the have a better clinical treatment.</li> <li>483.35(i) FOOD PRO STORE/PREPARE/S</li> <li>The facility must - (1) Procure food from considered satisfacto authorities; and (2) Store, prepare, dis under sanitary conditional constructions in the sanitary conditional construction is the sanitary conditional construction in the sanitary conditional construction is considered satisfacto authorities; and (2) Store, prepare, dis under sanitary conditional constructional constructional</li></ul>	ht should not be in Resident e DON confirmed the tube one ointment was in room along with other her confirmed there were no he tube of nystatin nt and no self edication assessments were ent #178. The DON stated hurses providing care for nove any over the counter e physician and obtain stration of these view on 01/16/14 at 3:50 PM stated he should have been ation that comes into the ted he needed to be aware at a resident was taking to judgment in determining DCURE, ERVE - SANITARY	F 3			2/19/14

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTR	UCTION	OMB NO (X3) DATE	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· · ·	G		COMPLETED	
							)
		345415	B. WING			01/1	16/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE		
PINEVILL	E REHABILITATION AND			1010 LAKE			
				PINEVILL	E, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 371	Continued From page	e 16	F 3	71			
		ns, staff interviews, and a			ary manager and staff have been		
		dule, the facility failed to 1)			aware of the deficient practice	•	
		ne using warm water and			ding improper hand washing		
		ensils to serve rolls and a			iques, failure to use clean utens	ils to	
	grilled cheese sandw			serve	food to residents, as well as fail	ing	
		04, 85, 42, 35, 8, 178, 136,			sure that storage racks in dietary	are	
		, 57, 196 and 17) for 1 of 2			an condition. The utensils and		
	-	s, and 3) maintain 3 of 3		-	ge racks were cleaned by Dietar	y	
	storage racks clean.			staff.			
	The findings are:				ry staff will be in serviced on pro	-	
					washing techniques, proper clea	-	
		the lunch meal tray line			ods for dietary utensils, as well a		
		from 12:47 PM until 1:03		ensur	ing storage racks are kept clean	-	
	-	vation dietary staff #1 was steam table into the main			aning log and audit tool has beer	-	
	dining room (MDR) fr				ed and implemented to ensure	1	
	• · · ·	plugged the cord of the			r cleaning methods for dietary		
		Il outlet. Dietary staff #1 then			ils are in place, as well as ensur	ing	
		r of an alcohol-based hand			ge racks are kept clean. The au		
	sanitizer and applied	one pump to both hands,		tool w	ill also ensure proper hand was	ning	
		nen began the lunch meal		techn	iques are used by dietary staff.		
		at 12:48 PM dietary staff #1		5. (			
		door, placed her right			ry manager will conduct weekly	- Leber	
	-	oor handle while attempting ted on the glass window of			s of audit tool for 1 month, bi-wee s for 2 months, and then monthly	-	
		her right hand and rested			s for 3 months. In addition, the a		
		hand on the glass window.			ill be brought to and reviewed a		
		dle and glass window of the			$y \square s$ monthly QA meetings.		
		ved soiled with dried food			· · · · · ·		
		e and white and red food			ry Manager is responsible for		
	splatters.			comp	liance.		
	On 01/13/14 at 12:49	PM dietary staff #1 was		The fa	acility will be in substantial		
		he lunch tray line by picking			liance on 2/19/14		
		andwich with her right gloved					
	-	Resident #93 and served the					
		dent. Hand hygiene was not					
	performed, neither we	ere gloves changed prior to					

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						O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	· · · ·	E SURVEY IPLETED	
						С
		345415	B. WING		01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
			10	10 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND		PI	INEVILLE, NC 28134		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 371	Continued From page	e 17	F 371			
	plating the grilled che		1 0/1			
	staff #1 was observed gloved hand for Resid 35, 8, 178, 136, 7, 44 17. Hand hygiene wa were gloves changed	50 PM until 1:03 PM, dietary d to plate rolls with her right dents #12, 3, 104, 85, 42, , 70, 78, 111, 57, 196 and as not performed, neither l prior to plating the rolls.				
	stated she served lun past 2-3 years and ro the kitchen with soap seconds prior to start #1 further stated that during the tray line, s	interview, dietary staff #1 ach from the MDR for the butinely washed her hands in in warm water for 20-25 ing the tray line. Dietary staff if her gloves became soiled he would remove the soiled lcohol-based sanitizer and				
	don new gloves. Diet she pushed the stear plugged the cord into the alcohol-based ha	ary staff #1 stated that since n table into the MDR and the wall socket, she used nd sanitizer prior to donning				
	was trained and knew food for residents, bu using utensils when p Dietary staff #1 stated	#1 further stated that she v to use utensils to plate t had never considered blating rolls or sandwiches. d "I usually do not use and I did not use utensils to				
	plate the grilled chees #1 observed the glas	se (sandwich)." Dietary staff s window and door handle of confirmed that both the				
	certified dietary mana started as the CDM a 2013. The CDM state	B/14 at 3:48 PM with the ager (CDM) revealed he it the facility in October ed that staff should use during the meal service and				

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	RS FOR MEDICARE &					. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
						;
		345415	B. WING	01/1	6/2014	
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COI	DE	
PINEVILL	E REHABILITATION AND	D LIVING CTR	-	0 LAKEVIEW DRIVE IEVILLE, NC 28134		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 371	staff using soap and further stated that he the use of utensils by	e 18 warm water. The CDM monitored the tray line for spot checking, but on hing and did not notice it.	F 371			
	2. On 01/13/14 at 11:02 AM the kitchen was observed with three storage racks. One rack contained insulated bottom plate covers, a second rack contained insulated dome plate lids and a third storage rack was a four-shelved wire storage unit that contained items stored directly on the shelving to include 20 stainless steel pans stacked and inverted, 20 stainless steel sheet pans stacked and inverted, and 2 stainless steel bowls stacked and inverted. Each storage rack/cart was observed with a build-up of a greasy residue, dried food particles and dust. Follow-up observations of the storage racks/carts occurred on 01/15/14 at 07:20 AM and 01/16/14 at 5:00 PM in which the storage racks were observed in the same condition.					
	at 5:00 PM and revea weekly cleaning sche cleaning of the storag cleaning schedule re- storage racks/carts w completed for the cur 12th) or the two week 5th and December 25 checked the weekly of Monday to make sure	CDM occurred on 01/16/14 aled that he maintained a edule which included weekly ge racks/carts. Review of vealed that cleaning of the vas not documented as rrent week (week of January ks prior (weeks of January 9th). The CDM stated that he cleaning schedule each e all items were completed, ed the schedule for the past l stated he had not noticed				

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		ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/07/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345415	B. WING		_	C 01/16/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
PINEVILLE	REHABILITATION AND	LIVING CTR				
				PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA <sup>-</sup> DEFICIENCY)	
F 371	Continued From page		F 371			
	to why he had not mo	e offered no explanation as				
	schedule to ensure ta					

Event ID: MP0E11

Facility ID: 923298

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