SEP 1 1 2014

PRINTED: 09/05/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	
		0.5000		_	•	С	
		345383	B. WNG			08/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	****	
SCOTTISH	I PINES REHABILITATIO	N AND NURSING CENTER		6:	20 JOHNS ROAD		
				L	AURINBURG, NC 28352		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 470	400 404 \ DEGIDEN:				DISCLAIMER		-
	483.10(n) RESIDENT	SELF-ADMINISTER	F	176	i and the state of the state s		
SS=D	DRUGS IF DEEMED	SAFE			acknowledges receipt of the Statement of	Deficiency	
	Am implicated configuration of	Language of the state of			and proposes the plan of correction to the	extent tha	ıt
	An individual resident	may self-administer drugs if			the summary of findings is factually correct order to maintain compliance with applica	ot and in	vd
	the interdisciplinary to				the provision of quality care to residents.	nie i dies ai	iu
	§483.20(d)(2)(ii), has practice is safe.	determined that this	-				
	practice is sale.				The below response to the Statement		
					and plan of correction does not denote	e agreeme	nt
	This RECHIREMENT	is not met as evidenced			with the citation by (facility name).	The facili	ty
	by:	is not met as evidenced			reserves the right to submit documentat the stated deficiency through inform	ion to retu	te
		n, resident, responsible			procedures and/or other administrativ	re or lea	al
	party (RP) and staff in	nterviews and record review,			proceedings.	/	
	the facility failed to as	sess 1 of 1 resident for self					<b>_</b> '
	administration of med	ication (Resident #3) who			ALLEGATION OF COMPLIAN		
		g glucose tablets, lubricating			The plan of correction is submitte	d as	
		nicone (a medication to			written allegation of compliance.		
	relieve gas).	·			The below plan of correction perta	ins to F	_
	Findings included:				Tag F 176		
	The facility policy, title	ed SELF-ADMINISTRATION					
1	of DRUGS, revised A	ugust 2006, indicated that			<ol> <li>A) Resident #3 assessed on</li> </ol>	9/2/14 by	
	residents that wished				facility Director of Nursing	and not	
ĺ	medications could do	so if they were determined		- 1	deemed safe to self-adminis	ter	
ļ	to be capable of self-a	administration. Under			medications, therefore gluco	se tablets	.
	POLICY INTERPRET				Simethicone and eye drops v		'
İ	indicated the staff and	Paragraph 1, the policy		-	removed from resident room		
	each resident's mento	practitioner would assess I and physical abilities to			placed in medication cart.	*****	9/2/14
1	determine whether a	esident was capable of		J	proces in incurcation care,		11-11-4
	self-administering med	dications. Additionally,			B) Resident care plan sched	uled with	
		e policy indicated a skills			resident, spouse and residen		.
	assessment that could	include the ability to read,		- 1	daughter on 9/11/14 to revie	w finding	s
	comprehend, remove				of self administration assess		-
	containers and recogn		1		completed by facility Direct		
	consequences would	be conducted. Per the	-		Nursing Services on 9/2/14.		9/11/14
		pt at the bedside must be		- 1			i " <b>''</b>
	kept in a safe and sec				2) A) On 9/9/14, monthly Residual	dent	ļ
	Resident # 3 was read			- 1	Council meeting took place		ļ <b> </b>
	diagnoses that include			- 1	residents present were re-edi		
	gastroesophageal refl				facility Unit Coordinator on		
BORATORY D	RECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>		TITLE		N DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5RDH11

Facility ID: 953087

		TOTAL CENTRAL				OMB N	<u>. 0. 0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		-					С	
114115.00.0		345383	B. WNG_			08	8/22/2014	
	ROVIDER OR SUPPLIER H PINES REHABILITATIO	N AND NURSING CENTER		620 J	ET ADDRESS, CITY, STATE, ZIP CODE OHNS ROAD RINBURG, NC 28352			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>,</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X6) COMPLETION DATE	
F 176	The Minimum Data Srindicated the resident A Consent Form, data resident's Responsible informed of the right to medications. The RF	et (MDS), dated 7/16/14, was cognitively intact. ed 8/8/14, indicated the e Party (RP) had been	F	76	resident right to self-administer medication and facility policy in for them to do so. See Attachme  B) An audit was completed on 9 by facility Unit Coordinator on e resident room in the facility to e resident rooms were free of	nt A. /5/14 each nsure	9 9 14	
	signed she understoo administered then the assessed for self adm decision was made, it medications. On 08/22/14 at 9:30 A with Resident #3. Durglucose tablets was of the resident's over beshe took the tablets was low. Review of the residen orders did not include Review of the residen reveal an assessment medications.	d if the resident self resident would be inistration and until that ne facility would administer  M an interview was held ring the interview, a bottle of bserved, clearly visible on d table. Resident # 3 stated hen she felt her blood sugar t's most current monthly			medications. Those residents were witnessed to have medicational bedside, were assessed by facility Director of Nursing to determine resident's mental and physical at to determine whether the resident capable of self-administering medications. If deemed approprimedication to be kept at bedside safe and secure place, if not deem appropriate, medication was remfrom resident room and placed in nurses' medication cart. Resident was not deemed appropriate alth four residents in the facility were deemed appropriate. See Attach	ons at y collities at was late, in ned loved t #3 ough	9 5 14	
	held on 8/22/14 at 10: member had been ide the person that knew a The family member si provided by the family added she "assumed" medication since it wa reach of the resident. An interview with Adm on 8/22/14 at 10:37 At information on self-adi was in the Admission I with the RP. After rev	30 AM. This family ntified by Resident # 3 as about her care in the facility. The family member the facility knew about the skept at the bedside within dissions Director was held of the AD stated ministration of medications Packet that was reviewed riew of the self tion, a consent form was		3)	B.  C) On 8/22/14, letter was mailed resident's family to explain facil policy of self-administration of medication. See Attachment C.  A) All staff was re-in-serviced b facility Administrator and Direc Nursing Services on facility poliself-administration of medication 8/26/14. This information will b included in new hire orientation through annual reviews. See Attachment D.	y tor of cy of is on	8/22/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345383	B. WNG		С	
	ROVIDER OR SUPPLIER H PINES REHABILITATIO	ON AND NURSING CENTER	S: 62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHNS ROAD AURINBURG, NC 28352	08/22/2014	
(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)	E COMPLETION DATE	
	administer medication administer medication selected, then the resteam and are deemed self-administer medical.  At 12:45 PM on 8/22/Director of Nursing (Din Resident # 3's room the over bed table by glucose tablets and the also found eye drops. All medications were this time. The DON's been assessed and conself-administration of 483.25 PROVIDE CA HIGHEST WELL BEINT Each resident must reprovide the necessary or maintain the highes mental, and psychosol accordance with the conditional plan of care.  This REQUIREMENT by:  Based on staff and fall and review of records a physical assessmen reviewed (Residents #	n or if the facility would n. If self-administration was sident met with the care plan d to be safe or not to ations.  14, Nurse # 1 and the PON) made an observation n. Medications found on Nurse # 1 included the ne Simethicone. Nurse # 1 at the resident's bedside. removed by Nurse # 1 at tated Resident # 3 had not are planned for medication. RE/SERVICES FOR NG receive and the facility must or care and services to attain at practicable physical, cial well-being, in omprehensive assessment  is not met as evidenced milly member interviews the facility failed to provide t for 2 out of 3 residents	F 176	B) Department head in-service of completing "Resident and Resident Room Audits" on all resident roweekly by facility department he See Attachment E.  C) "Resident and Resident Room Audits" will include for department heads to ensure that resident roof free of medications, unless deem safe to self-administer medication See Attachment F.  4) A) Results of plan and audits with discussed during morning administrative meeting weekly x weeks with adjustments to plan ras needed followed by:  B) Results of audits and complian with plan will be discussed and minutes recorded x 4 months dur the facility's monthly QA meetin with adjustments to plan made as needed, followed by:  C) Results of audits and complian with plan will be discussed and minutes recorded quarterly x 3 quanting the facility's quarterly QA committee meeting, with adjustment to plan made as needed followed  D) Should revisions be necessary appropriate staff will be re-in-serve by DON or appropriate designee.	ent oms eads.  8   25   14    n tent ms are aed ons.  9   19   14    outpoint of the series of the s	
		olicy titled, CHANGE in a		<ul> <li>E) Any revisions to plan will requested monitoring steps to begin again at 4(A).</li> </ul>	istep Ougoing	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION :	(X3) DATE S	
		345383	B. WNG		c	
NAME OF D	ROVIDER OR SUPPLIER	340303			08/2	2/2014
		N AND NURSING CENTER	6	STREET ADDRESS, CITY, STATE, ZIP CODE 320 JOHNS ROAD LAURINBURG, NC 28352		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	April 2006, indicated b, that in the event a condition, documenta shift for 72 hours or u Resident # 3 was adn readmitted on 8/8/14. diabetes, congestive respiratory failure. The Minimum Data Scindicated the resident required extensive/tot activities of daily living On 7/22/14 at 7:05 Ph the physician had bee morning to assess the problems, although shantibiotics for pneumowas transferred to the evaluation. She return orders for Augmenting to increase her Ventol improve breathing) to and every 6 hours as there was no document assessment complete. On 7/23 at 9:02 AM, the shortness of breath ar respirations. No lung to determine if the antiresident's pneumonia. Notes for 7/24/14 at 4: AM the nurse heard the The nurse documented difficulty breathing. Pt 85-86% (Normal range breathing treatment was preathing treatm	TION or STATUS, revised under Paragraph 8, section resident had a change in tion would continue every ntil the condition resolved. nitted on 8/9/12 and Diagnoses included heart failure (CHF) and let (MDS), dated 7/16/14, was cognitively intact. She at assistance for all let assistance for all let assistance for continued the currently received in in the building that the resident for continued the currently received in in. At noon, Resident #3 hospital for further the hospital for further in (a medication used to every 4 hours scheduled in the nurses. The nurse documented no	F 309	The below plan of course the course the	B were aluation. from the doto facility were really Clinical B/29/14.  Were re-ument 4-hour spolicy cation.  If was a "Change al IDT to to ensure resing include of tent I.  Were re-istrator	

NAME OF PROVIDER OR SUPPLIER  SCOTTISH PINES REHABILITATION AND NURSING CENTER  SUMMANY STATEMENT OF GENERALITY OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
SCOTTISH PINES REHABILITATION AND NURSING CENTER  SCOTTISH PINES REHABILITATION AND NURSING CENTER  SUMMANY STATEMENT OF CERCICINCIES TAG  SUMMANY STATEMENT OF CERCICINCIES TAG  SUMMANY STATEMENT OF CERCICINCIES TAG  CONTINUED FOR ISC IDENTIFYING INFORMATIONS  FROM CENTER TO SERVICE TO		i	345383	B. WNG				_
SCOTTISH PINES REHABILITATION AND NURSING CENTER    COUNTY OR LSD DESCRIPTION OF DESCRIPTION OF SUBJECT ON PREFIX TAG   SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PAIL). TAG   PROPERTY ACTION SHOULD DE ENCIRCISMON TO RESOLUTION OF LSD DEPITIVING INFORMATION)   PREFIX TAG	NAME OF P	ROVIDER OR SUPPLIER			,	TOTAL PROPERTY OF THE PARTY OF	0	8/22/2014
CA9 ID PREFIX (2A) DEFICIENCY MUST OF PRECEDED BY FULL (2A) DEFICIENCY MUST OF			M AMD MURONIO OPUTER		1			
F 300  Continued From page 4 hospital for evaluation. Resident # 3 was readmitted on 8/8/14 at 1:38 PM. Nursing assessment documentation indicated the resident had been documented diffuse from the dagnoses that inclidated the resident had been hospitalized with respiratory failure and hypoxia. The physician documented diffuse from constructive pulmonary disease and acute pneumonia.  The care plan for Resident # 3 added on 8/14/14, instructed staff to give the resident had been documented and fishers was and symptoms of respiratory distress were noted, to refer to the physician and hospical on the first to the resident had pean for the staff to the resident had pean for the staff to the resident had been documented. Results of a chest X-ray performed on 8/16/14, instructed staff to give the resident had pean for the staff that pean for the staff that the staff to the resident had pean for the staff that the s	00011101	THINES REHABILITATIO	N AND NURSING CENTER		l ∟	AURINBURG, NC 28352		
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telephone orders. Clinical IDT will continue to review all telephone orders during daily clinical meeting and will review section that indicates and left lower lobe crackles (crackles are a sound heard in the lungs that can indicate congestive heart failure). The upper lobe was described as diminished (this could describe decreased air flow).  The Physician's readmission note, dated 8/9/14, indicated the resident had been hospitalized with respiratory failure, end typpo discretify and easily).  The Pharmacist Chart Review, dated 8/13/14, indicated the resident had diagnoses that included respiratory failure, end stage chronic obstructive pulmonary disease and acute pneumonia.  The care plan for Resident #3 added on 8/14/14, instructed staff to give the resident coxygen and nebulizer treatments as ordered and if any signs and symptoms of respiratory distress were noted, to refer to the physician and Hospice for treatment instructions.  Results of a chest X-ray performed on 8/16/14 readmission until 8/22/14 indicated no respiratory assessment had been documented, although the resident had exhibited signs of respiratory issues on hor 8/8/14 readmission.  On 8/21/14 at 2:50 PM, Nurse #1 stated		(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	ULD BE	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245000			С
NAME OF PROVIDER OR SUPPLIER	345383	B. WNG		08/22/2014
SCOTTISH PINES REHABILITA	TION AND NURSING CENTER	6	OTREET ADDRESS, CITY, STATE, ZIP CODE 120 JOHNS ROAD AURINBURG, NC 28352	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
nurse's notes. She documented for resident days, every 2 assessments would medical record. The first 3 days of "acuresident continued days. Nurse # 2 sepneumonia, she we listen to the resident newly adrassessed every she was admitted with nurses to documer cough, oxygen sate short of breath with The DON was una Resident # 3's medical assessments had be assessments and be assessments and listen to the facility of the facility o	ald be daily and recorded in the e stated lung sounds should be spiratory problems.  Arviewed on 8/21/14 at 3:19 PM. We admissions were charted on thours. Documentation of the defound in the electronic menurse added that after the tell charting was completed, a to be charted on daily for 3 tated if a resident had CHF or could check vital signs and int's lungs.  Arsing (DON) was interviewed and any interviewed and the stated that any interviewed are readmitted should be altered for 72 hours. If a resident pneumonia, she expected that if the resident had a fever, curation, if the resident was an exertion and lung sounds. The ble to find documentation in dical record that indicated been completed.  As admitted on 7/31/14 with suded congestive heart failure the policy titled, CHANGE in a DITION or STATUS, revised	F 309	DEFICIENCY)	ne orders and will for H.  will be y x 4 n made  liance d during sting, as  liance d uarterly eeded  ary, serviced
b, that in the even condition, documer shift for 72 hours o	d under Paragraph 8, section a resident had a change in ntation would continue every r until the condition resolved.		<ul> <li>E) Any revisions to plan will remonitoring steps to begin again 4(A).</li> </ul>	equire n at step ongoing

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345383	B. WING				C	
	ROVIDER OR SUPPLIER	ON AND NURSING CENTER	I	620	EET ADDRESS, CITY, STATE, ZIP CODE JOHNS ROAD JRINBURG, NC 28352	1	08/22/2014	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	) BE	(X6) COMPLETION DATE	
F 309	(Edema is measured (being a little edema edema).  Review of the Admis 7/31/14, indicated th medications as orde resident to elevate hedema as needed.  A telephone order, dresident's Lasix (Last control blood pressur from the body) from daily to twice daily. The nurse's notes the in Lasix was needed that addressed the obligation.  Review of the electrothe next nurse's door at 7:59 AM. This was There is no documer resident's edema or admission until her to 8/11/14.  The resident # 1 had edema explained that on addresident's foot was at the edema got worse over the resident's to holding her fingers or the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's to holding her fingers or the resident's to the sedema got worse over the resident's	lescribe the degree of edema in degree by using 1+ ) to 4+(a large amount of  sion Care Plan, dated e resident should receive red and encourage the er lower extremities for  ated 8/6/14, increased the ix is a diuretic used to help re by eliminating extra fluid 40 milligrams (mgs) once There is no documentation in at indicated why the increase . There is no documentation utcome of the increased onic medical record revealed umentation was dated 8/2/14 as 2 days after admission. Intation that addressed the lung sounds from the time of transfer to the hospital on onsible Party (RP) was 14 at 11:47 AM. She stated ema on admission. During	F	309				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	O, 0936-0391 E SURVEY PLETED
		345383	B. WING			00	C 3/22/2014
	ROVIDER OR SUPPLIER H PINES REHABILITATI	ON AND NURSING CENTER		620	REET ADDRESS, CITY, STATE, ZIP CODE JOHNS ROAD URINBURG, NC 28352	1 00	12212014
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	not wear her shoes. receiving therapy, the larger shoes. The Repush the top of the refingers, there would of the resident's foot Resident was not get RP stated she noted but could not identify. The RP added the reand more short of broncern was so great on 8/11/14, arriving the She spoke with the Land told her she felt resident somewhere RP to the resident's never touched the resident shoes.	ot so bad, the resident could Since the resident was the RP stated she had to buy the stated when she would the sident's foot with her the a large indentation on top	F	309			
	# 1 during her admis remembered her. The had 2 + edema. He documented about he decrease the edema had listened to lung so Nurse # 1 was intervishe stated she was to Rehabilitation Unit. If admitting new reside had been the one that 7/31/14. New admissions assessed daily with continuous processes.	f 5 had worked with Resident sion and stated he ne nurse added the resident admitted he had not er edema or interventions to . The nurse was unsure if he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345383	B. WING		1	C
	ROVIDER OR SUPPLIER  I PINES REHABILITATIO	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 JOHNS ROAD LAURINBURG, NC 28352	1 08/	/22/2014
(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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	check lung sounds. The not remember if Resident admission. The not note that was written of 7/31/14 and acknowled documentation about The nurse reviewed the Resident # 1 and state days should not go by added without a note, the resident had been added when a medicate the Lasix for Resident reason documented in On 8/21/14 at 3:19 Phinterviewed. The nurse during her facility stay resident had CHF, she document the presence signs and an assessment as the stated Resident admission adding the +. Nurse # 1 added so but does not recall if stated for Resident all notes for Resident all notes for Resident all notes for Resident and resident and several stated for Resident all notes for Res	In she would look for the pulse and definitely the nurse stated she could then the theory of the nurse reviewed her admission on 8/4/14 as a late entry for adged there was no redema or lung sounds. The definition was 2 without assessment. She there was no way to prove assessed. Nurse # 1 tion was changed, such as # 1, there should be some in the chart.  If, Nurse # 2 was the worked with Resident # 1 to Nurse # 2 stated when a the would assess for and the of edema, coughing, vital then the flung sounds. The # 1 did have edema on the decumented her as unaware the resident's sed. Nurse # 2 reviewed # 1 and acknowledged then of edema, lung sounds.	F 309			
	The nurse worked with facility admission. Nur for CHF should include sounds, oxygen satura	wed on 8/21/14 at 4:05 PM.  Resident # 1 during her rese # 3 stated assessments presence of edema, lung attornion and any difficulty attornion of the assessments	The state of the s	.'	A. P. C. L. A. M.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345383	B. WING		·		C
	PROVIDER OR SUPPLIER H PINES REHABILITATIO	N AND NURSING CENTER		620	REET ADDRESS, CITY, STATE, ZIP CODE D JOHNS ROAD URINBURG, NC 28352	<u>{ 08/</u>	22/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E XTE	(X6) COMPLETION DATE
SS=D	should be found in the stated she was unaware the pool of the pool	e nurse's notes. The nurse are the resident had edema.  ewed on 8/22/14 at 11:25 sidents that were newly assessments with shift for 72 hours. If a with CHF, the expectation resident every 3 days to associated with fluid hortness of breath, jugular bunds and edema. If a edema, the expectation and what interventions  TER, PREVENT UTI,  s comprehensive y must ensure that a e facility without an not catheterized unless the ition demonstrates that cessary; and a resident ladder receives appropriate to to prevent urinary tract re as much normal bladder is not met as evidenced	F3	309 Ta	the below plan of correction pertain ag F315  1) A) Physician Order was writted indwelling urinary catheter for #3 on 8/22/14. Resident's cathe was secured with a leg strap of 8/22/14.  B) "Urinary Catheter Order Clarification" form completed facility Director of Nursing, si facility Medical Director and for resident chart on 8/22/14.  C) Resident's indwelling urinate catheter was discontinued per request on 8/23/14. Telephone was written and family was material aware of resident preference to discontinue indwelling urinary catheter.  2) A) Audit completed on 8/23/14 facility weekend nurse superviall resident's with urinary catheters.  B) All licensed nursing staff reserviced by facility Director of Nursing on 8/26/14 of facility I that physician's order to be in all residents with indwelling ur catheter and that catheter should remain secured with leg strap to friction and movement at the insite. See Attachment H.	en for resident heter n by Igned by Filed in ary resident e order ade order to rinary n place.	8/22/14

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345383	B. WING		08/22/2014
	ROVIDER OR SUPPLIER  I PINES REHABILITATIO	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 JOHNS ROAD LAURINBURG, NC 28352	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	residents (Resident # the presence of an inc Findings included: The facility policy, title revised December 200 Paragraph 15 that the secured with a leg stra movement at the inser Resident # 3 was read diagnoses that include tract infection, conges chronic pain and gene The Minimum Data Seindicated the resident Resident # 3 was code total assistance with a The resident was code of urine. Review of the readmis dated 8/8/14, did not in indwelling urinary cath A Resident Data Collection and size had been left 8/8/14 indicated an included the presence catheter. The area deand size had been left 8/8/14 indicated an indwas in place and drain A PROGRESS NOTE, the family nurse practif resident had an indwel placed. The note also asked if the catheter w FNP documented the caremoved and/or put bathe resident would like	3) that was assessed for iwelling urinary catheter. d Catheter Care, Urinary, 27 indicated under catheter should remain up to reduce friction and tion site. Imitted on 8/8/14 with use d respiratory failure, urinary tive heart failure, diabetes, ralized muscle weakness. Ut (MDS), dated 7/16/14, was cognitively intact. Ut as requiring extensive to as requiring extensive to as frequently incontinent usion physician's orders, include orders for the eter. Ution sheet, dated 8/8/14, is status on admission of an indwelling urinary signated to record the type blank. Nurse's notes for twelling urinary catheter ing clear yellow urine, dated 8/8/14, signed by ioner (FNP) indicated the ling urinary catheter indicated Resident # 3 as to remain in place. The could see risks both ways eatheter could always be ck in. The note indicated to leave it in for now. The	F 31	and readmissions charts times five days following all admissions/readmissions to the facility. During chart review, ID utilize form which indicates to che indwelling urinary catheter in plasmad if so order to be written appropriately. Chart review will indicate if indwelling urinary catheter Order Clarification" completed for residence of the completed of the completed on all resident and Resident Room Audits" to be completed on all resons weekly by facility departments. Audits will include for state ensure that is resident with indwest urinary catheter are positioned appropriately (with bag cover). Attachment F.  3) A) Audit completed on 8/23/14 by facility weekend nurse supervisor all resident's with urinary catheter ensure telephone order and "Uring Catheter Order Clarification" in pure catheter or der Clarification of Nursing on 8/26/14 of facility pothat physician's order to be in plasmal residents with indwelling uring catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a catheter and that catheter should remain secured with leg strap to a cat	T will leck if ce also neter lent. Ongoing sident tent off to alling see wood on to ary place. S/23/14
	note included "foley ca not include a size for th	re as per protocol", but did ne indwelling catheter and		friction and movement at the insestite. See Attachment H.	a11914

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/05/2014 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	<u>IO. 0938-0391</u> E SURVEY IPLETED
			A, BUILC	MNG_			C
		345383	B. WING			Of	8/22/2014
NAME OF	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	JIZZI ZU (4
SCOTT	SH PINES REHABILITATIO	N AND NURSING CENTER			20 JOHNS ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	7	<u> </u>	AURINBURG, NC 28352		1
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 31	a schedule for changi On 8/11/14 at 3:03 Ph resident had question keep the catheter. The physician would be in Resident # 3. Review of nurse's not documentation the ph resident's questions a for the resident regard indwelling urinary cath Resident # 3 was interested the recently and had return indwelling urinary cath she did not have probbut did experience incomplete the catheter had been plast frequent urinary tract is raised the covers to resecuring the catheter. with clear, dark urine, side of the bed rail.  A telephone interview member on 8/22/14 at member stated the indual been placed in the the catheter was the inindependently. The faresident didn't have the in wetness all the time.  An interview was held (DON) on 8/22/14 at 1 the policy for indwelling indicated the catheter.	Ing the catheter.  M, notes indicated the s about how long she would e note indicated the on 8/12/14 to follow up with less did not reveal ysician addressed the not did not reveal education ding risks of maintaining the neter.  The resident stated lems with urinary retention, ontinent episodes. The resident stated lems with urinary retention, ontinent episodes. The urine collection bag was attached to the lower was held with a family 10:30 AM. The family welling urinary catheter enospital. The reason for nability to tollet mily member stated if the exactheter she would "lay".  With the Director of Nursing 1:45 AM. The DON stated	F	315	C) Daily Clinical IDT Meeting v continue to review new admission and readmissions charts times five days following all admissions/readmissions to the facility. During chart review, ID utilize form which indicates to clindwelling urinary catheter in pla and if so order to be written appropriately. Chart review will indicate if indwelling urinary catin place, "Urinary Catheter Order Clarification" completed for resident See Attachment J.  D) "Resident and Resident Room Audits" to be completed on all rerooms weekly by facility departments. Audits will include for statement is resident with indwer urinary catheter are positioned appropriately (with bag cover). See Attachment F.  4) A) Results of plan and audits will discussed during morning administrative meeting weekly xeeks with adjustments to plan mas needed followed by:  B) Results of audits and compliant with plan will be discussed and minutes recorded x 4 months durithe facility's monthly QA meeting with adjustments to plan made as needed, followed by:  C) Results of audits and compliant with plan will be discussed and will be discussed and will be discussed and will be discussed	ons we T will neck if ace also heter r dent.  See I be dended ace ace ace ace also heter r dent.	9/19/14 orgoing

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345383	B. WING			С		
NAME OF PROVIDER OR SUPPLIER  SCOTTISH PINES REHABILITATION AND NURSING CENTER			D. Filino	STREET ADDRESS, CITY, STATE, ZIP CODE 620 JOHNS ROAD LAURINBURG, NC 28352				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X6) COMPLETION DATE	
F 315	size of the catheter, or a schedule for changir also indicated the cathorder to prevent traum.  A corporate represente Catheter Order Clarific facility on 8/22/14 at 1 was a section titled Cahad no clarification sheet. The DON observed the 12:45 PM and found the catheter was not securus unsecured catheter co	riders for catheter care and ing the catheter. The policy heter should be secured in na.  rative presented a Urinary cation sheet used by the 11:55 AM. Within the sheet atheter order. Resident # 3 neet in her chart.	F	315		nts  iced  ire	alialiti ongoins	