PRINTED: 06/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		STRUCTION	(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/	05/2016
PENICK V	ROVIDER OR SUPPLIER			500 EAS	TADDRESS, CITY, STATE, ZIP CODE ST RHODE ISLAND AVENUE HERN PINES, NC 28387		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
SS=E	The facility must conda comprehensive, according reproducible assessment functional capacity. A facility must make a assessment of a resident assessment by the State. The assleast the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-bei Physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ard Discharge potential; Documentation of sur the additional assession areas triggered by the Data Set (MDS); and Documentation of paragraphs.	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information; atterns; ng; and structural problems; d health conditions; status;		272	TITI E		6/2/16

05/27/2016 **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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (DENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.00.2010
				500 EAST RHODE ISLAND AVENUE	
PENICK V	ILLAGE			SOUTHERN PINES, NC 28387	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 272	Continued From page	e 1	F 272		
	This REQUIREMENT by:	is not met as evidenced			
	•	ew and staff interview, the		This corrective action plan will serve a	s
		etely assess residents in the		Penick Village □s allegation of complian	
		s, mood, pain and health		with the requirements of 42 CFR, Part	
		dents #15, #77, #42, #16,		483, Subpart B for long-term care facili	ties
	#3 & #31) of 12 samp	led residents reviewed with		as of November 19, 2009.	
	comprehensive Minim	num Data Set (MDS)			
	assessments. Finding	-		Residents #15, #77, #42, #16, #3 and	I
		admitted to the facility on		#31 will have updated comprehensive	
		MDS assessment dated		assessments by June 2nd.	
		The assessment indicated			
		d clear speech, usually able		All residents have potential to be affect	red
	to make herself under			by this practice. An audit of the	
		he assessment revealed		comprehensive assessments due in M	ay
		not interviewed for the Brief		was completed on 5-26-16 by MDS	
		Status (BIMS), mood and		Coordinator to identify any other	
	dashes on the boxes.	he areas were blank or with		incomplete assessments. As a result o the audit performed by MDS Coordinat	
		ducted on 5/3/16 at 2:20 PM		all assessments due in were complete	
		er (SW). She indicated she		and locked by 6-2-16. Our MDS	1
		(cognitive patters/mental		coordinator is putting into place a caler	ndar
		(mood)of the MDS. She		system she has used for years to track	
		dinator completed Section J		quarterly and annual assessments. Or	
		n). She indicated she		MDS coordinator educated all	
		and Section D for Resident		Inter-Disciplinary Team (IDT) members	on
	•	she was unable to complete		the calendar system on 5-11-16. Our i	
		esident #15 during the seven		calendar system tracks all assessment	
	day look back period,	so she had not answered		that are due each week and each mon	th.
	the questions. The un	answered questions were		IDT members will be given a weekly	
	indicated with a dash	or were left blank. The SW		calendar each week by our MDS	
		#15 would have been able to		Coordinator identifying all assessments	
	•	erview for mental status and		be completed that week. We have als	
		erview if she had asked the		started using a 100 Day Tool for each	and
		d not done so during the		every resident that is using Medicare	
	•	period. She indicated she		Benefits as a way to keep track	
		sessment was due and that completed the interviews in		Assessment Reference Dates. DON w perform a weekly audit of 3 assessmen	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING	·····		05/05/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 272	MDS Coordinator corassessments that we routinely over the past received a schedule interviews in the requileft the questions bla voiced her concerns administrator, but the corrected. She state aware of the issues a concerns. An interview was conwith the Director of Nindicated the MDS Cat the facility. She st several issues with the MDS assessments, incomplete MDS assarea of concern. She Administrator was awaddressing the concern. An interview was conplete MDS assarea of concern. She Administrator was awaddressing the concern their MDS assessments accompleted a modification of their MDS assessments are of their MDS assessments. Incomplete MDS assarea of concerns awas aware of their MDS assessments are of their MDS assessments are assared to concomplete areas of concompleted a modification of the problem a was in the process of changes to address to 2. Resident # 77 was 2/9/16. The admission 2/16/16 was reviewed indicated that Reside	rame. The SW stated the impleted the schedule of re due. She revealed that it six months she had too late to complete the irred timeframe and she had had. She indicated she had to the previous is problem had not been did the new Administrator was and was addressing the indicated on 5/3/16 at 3:00 PM tursing (DON). She coordinator was not present atted that the facility had he MDS Coordinator and She revealed that the essments were an identified indicated the new vare of the issues and was erns. Inducted on 5/5/16 at 12:30 rator. He revealed the multiple issues they had with ints. He stated the facility of survey in March 2016 that incern. He indicated that the essments were identified as reas. He reported the facility implementing multiple the areas of concern. In admitted to the facility on MDS assessment dated	F 27	to be completed and report f meeting The Penick Village Nursing F Administrator (NHA), Director (DON) and Minimum Data S Coordinator (MDS) will meet the next 90 days to review the comprehensive assessments they are complete, create a document findings to be reponent QA meeting on June 27	Home or of Nursing et t weekly for ne 3 selected s to ensure POC and orted at our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345111	B. WING _			05/05/2016
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COI 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
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F 272	that the resident wa the boxes for pain a An interview was co with the Social Worl MDS Coordinator or conditions/pain). An interview was co with the Director of indicated the MDS o at the facility. She is several issues with MDS assessments. incomplete MDS as area of concern. Sh Administrator was a addressing the cond An interview was co PM with the Administ facility was aware of their MDS assessm had completed a mo identified areas of or incomplete MDS as one of the problem is was in the process of changes to address 3. Resident #42 wa 12/15/15. Cumulati Parkinson's disease The Admission Mini Resident #42 indica speech, was usually able to understand of Cognitive Patterns is	s. The assessment revealed is not interviewed for pain as issessment were blank. Inducted on 5/3/16 at 2:20 PM ker (SW). She stated the completed Section J (health of the state of the state of the state of the sessment was not present stated that the facility had the MDS Coordinator and She revealed that sessments were an identified ine indicated the new sware of the issues and was cerns. Inducted on 5/5/16 at 12:30 strator. He revealed the facility back survey in March 2016 that oncern. He indicated that sessments were identified as areas. He reported the facility of implementing multiple the areas of concern. Its admitted to the facility on we diagnoses included	F 2	772		

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345111	B. WING _		0	5/05/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 500 EAST RHODE ISLAND AVENU SOUTHERN PINES, NC 28387	CODE	
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F 272	(questions C0200 the conducted. Questions were coded with data questions were not Mood section, was D0100 was coded to interview (questions to be conducted. CD0300 were coded questions were not Con 05/03/2016 at 2 conducted with the completed sections was the one who has Resident #42. She taught on the MDS, to complete the intervito do the resident in period for this resident #42 would the questions, but a social worker said to and that was why so interview in the look worker stated the MDS coordinator are schedule, they were for an MDS. If she did not get to comp would insert dashes conduct the assess reference date (AR) due and the interview in the interview and the i	rview for mental status nrough C0500) was to be ns C0200 through C0500 shes that indicated the answered. Section D, the not fully completed. Question o indicate a resident mood s D0200 through D0300) was suestions D0200 through with dashes that indicated the	F2	272		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345111	B. WING _		05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 272	happened routinely is schedules-over the I said it hadn't happer The social worker st concerns about six r MDS coordinator an time. She stated, six came, he realized the and was addressing An interview was cowith the Director of Nindicated the MDS of at the facility. She several issues with the MDS assessments incomplete MDS asserse of concern. She Administrator was an addressing the concern An interview was cop M with the Administrator was an addressing the concern their MDS assessments incompleted a more identified areas of coincomplete MDS assessments as a several issues with the Administrator was an addressing the concern their MDS assessments and completed a more identified areas of coincomplete MDS assessments as a several issues was a several issues with the Administrator was an addressing the concern their MDS assessments are also assessments and complete areas of coincomplete MDS assessments are also assessments and completed a more identified areas of coincomplete MDS assessments are also assessments and complete areas of coincomplete MDS assessments are also assessments and complete areas of coincomplete MDS assessments and complete areas of coincomplete MDS assessments are also assessments and complete areas of coincomplete MDS assessments are also assessments and complete areas of coincomplete MDS assessments are also assessments and control of the problem and complete MDS assessments are also assessm	that she would get late MDS ast six months or more. She hed in the past week or two. ated she started voicing her months ago or more to the d the administrator at that hee the new administrator in e MDS's were not up to date the concerns. Inducted on 5/3/16 at 3:00 PM Aursing (DON). She coordinator was not present tated that the facility had he MDS Coordinator and She revealed that sessments were an identified in indicated the new ware of the issues and was erns. Inducted on 5/5/16 at 12:30 trator. He revealed the multiple issues they had with ents. He stated the facility lock survey in March 2016 that concern. He indicated that sessments were identified as areas. He reported the facility of implementing multiple the areas of concern. It is admitted to the facility of ediagnoses included arthritis and long term use of	F2	272	
	indicated Resident #	t16 had clear speech, was s and was able to understand			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 272	section, was not fully C0100 was coded to mental status (quest was to be conducted C0500 were coded v questions were not a Mood section, was n D0100 was coded to interview (questions to be conducted. Qu D0300 were coded v questions were not a A Quarterly MDS dat Resident #16 had cle others and was able MDS indicated she v Section J, the Health fully completed. Que answer to indicate if was to be completed question was coded question was not ansquestions in the pain questions J0300 throwith dashes that indianswered. On 05/03/2016 at 2:2 conducted with the scompleted sections 0 was the one who had Resident #16. She staught on the MDS, it to complete the interview.	the Cognitive Patterns of completed. Question indicate a brief interview for ions C0200 through C0500) . Questions C0200 through with dashes that indicated the inswered. Section D, the ot fully completed. Question indicate a resident mood D0200 through D0300) was itestions D0200 through with dashes that indicated the	F 2	72	
		even if they were unable to w. She said she was unable			

CENTER	S FOR WEDICARE &	MEDICAID SERVICES				OIVID IV	7. 0930 - 0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05/	05/2016
NAME OF P	ROVIDER OR SUPPLIER			500	REET ADDRESS, CITY, STATE, ZIP CODE 0 EAST RHODE ISLAND AVENUE DUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	period for this resider Resident #16 would he questions, but she social worker said that and that was why she interview in the look he worker stated the MDM MDS coordinator and schedule, they were for an MDS. If she did did not get to comple would insert dashes. conduct the assessman reference date (ARD) due and the interview look-back period. The happened routinely the schedules-over the last aid it hadn't happen. The social worker state concerns about six memory may be stated, sin came, he realized the and was addressing. An interview was conwith the Director of Nindicated the MDS Cat the facility. She st several issues with the MDS assessments. Incomplete MDS assarea of concern. She Administrator was awaddressing the concerns.	erview within the look back of the social worker stated have been able to answer edidn't ask them. The set she didn't know it was due to wasn't able to do the back period. The social DS schedule came from the land the schedule came from the land to get the schedule, she to the interview and she land the stated she would lent after the assessment land worker stated it hat she would get late MDS last six months or more. She led in the past week or two. In the administrator at that late the new administrator at the concerns. Inducted on 5/3/16 at 3:00 PM lursing (DON). She loordinator was not present lated that the facility had like MDS Coordinator and She revealed that lessments were an identified en indicated the new ware of the issues and was	F 2	772			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET	(X3) DATE SURVEY COMPLETED	
345111 B. WING 05/05/	5/2016	
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272 Continued From page 8 PM with the Administrator. He revealed the facility was aware of multiple issues they had with their MDS assessments. He stated the facility had completed a mock survey in March 2016 that identified areas of concern. He indicated that incomplete MDS assessments were identified as one of the problem areas. He reported the facility was in the process of implementing multiple changes to address the areas of concern. 5. Resident #3 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and severe intellectual disabilities. The annual Minimum Data Set (MDS) assessment dated 2/12/16 indicated Resident #3 had clear speech, was able to make herself understood, and was usually able to understand others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 was coded to indicate a brief interview for mental status (questions C0200 through C0500) was to be conducted. Questions C0200 through C0500) was to be conducted. Questions C0200 through C0500 were coded with dashes that indicated the questions were not answered. Section D, the Mood section, was not fully completed. Question D0300 was to be conducted. Questions D0200 through D0300 were coded with dashes that indicated the questions were not answered. Section J, the Health Conditions section, was not fully completed. Questions wore not answered. Section J, the Health Conditions section, was not fully completed. Questions was coded with a dash that indicated the question was coded with a dash that indicated the question was not answered. The remaining questions in the pain assessment interview, questions J0300 through J0600, were also coded with dashes that		

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		345111	B. WING			05/	05/2016
NAME OF PI	ROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE OUTHERN PINES, NC 28387	1 00	00/2010
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F 272	with the Social Work completed Section C She stated the MDS Section J. She indict C and Section D for I she was unable to co Resident #3 during the period, so she had not the unanswered que dash. The SW state have been able to comental status and the	ducted on 5/3/16 at 2:20 PM er (SW). She indicated she and Section D of the MDS. Coordinator completed ated she completed Section Resident #3. She stated that emplete the interviews with the seven day look back to answered the questions. Estions were indicated with a end that Resident #3 would emplete the brief interview for the resident mood interview if questions, but she had not	F	2272			
	She indicated she had was due and that was the interviews in the SW stated the MDS schedule of assessment revealed that routine she had received a sthe interviews in the had left the questions had voiced her conceadministrator, but the corrected. She state	even day look back period. Id not known the assessment Is why she had not completed appropriate timeframe. The Coordinator completed the Identity that were due. She Identity over the past six months Inchedule too late to complete Increase timeframe and she Identity timeframe and she Identit					
	with the Director of N indicated the MDS C at the facility. She st several issues with the MDS assessments.	oordinator was not present ated that the facility had ne MDS Coordinator and She revealed that essments were an identified					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 272	Administrator was avaddressing the concern An interview was corp PM with the Administ facility was aware of their MDS assessment had completed a movidentified areas of coincomplete MDS assone of the problem a was in the process or changes to address to	vare of the issues and was erns. Inducted on 5/5/16 at 12:30 Irrator. He revealed the multiple issues they had with ints. He stated the facility ck survey in March 2016 that incern. He indicated that essments were identified as reas. He reported the facility of implementing multiple the areas of concern. Is admitted to the facility on diagnoses including aortic on, and hyperlipidemia. Inum Data Set (MDS) 2/14/15 indicated Resident intact. Section J, the Health was not fully completed. Irred an answer to indicate if interview was to be completed is question was coded with a ne question was not an equestions just on the pain w, questions J0300 through died with dashes that ins were not answered. Inducted on 5/3/16 at 2:20 PM er (SW). She stated the inducted on 5/3/16 at 3:00 PM	F 2'	72			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PENICK V	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	
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F 272	Continued From page	e 11	F 272	2	
	several issues with the MDS assessments. Sincomplete MDS assessments area of concern. She Administrator was awaddressing the concern.	essments were an identified indicated the new eare of the issues and was erns.			
F 273 SS=D			F 27	3	6/3/16
	after admission, excluthere is no significant physical or mental co	dent within 14 calendar days uding readmissions in which change in the resident's ndition. (For purposes of sion" means a return to the apporary absence for			
	by: Based on record rev facility failed to comp Minimum Data Set (N first fourteen (14) day	is not met as evidenced lew and staff interview, the lete a comprehensive IDS) assessment within the rs of admission for five (5) of residents (Resident #42,		Residents #42, #16, #49, #56 and #3 have a comprehensive Minimum Data completed. ¿ May 26, 2016	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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				50	0 EAST RHODE ISLAND AVENUE		
PENICK V	ILLAGE			S	OUTHERN PINES, NC 28387		
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F 273	Continued From page	age 12	F 2	273			
		#31). The findings included:			All residents have potential to be affect	ed	
	, ,	,			by this practice. An audit of		
	1. Resident #42 w	as admitted to the facility			comprehensive assessment completion	า	
	12/14/15.				was completed on 5-26-16 by our new		
					MDS Coordinator. MDS coordinator		
		dical record revealed an			audited charts from March 2016 to May		
		m Data Set (MDS) dated			2016 to ensure all MDS assessments h	nad	
		npletion date for the Care Area			been transmitted. Any outstanding	3	
		of the Admission MDS (VB 1) vas fifty one (51) days after			assessments were transmitted 6-3-16 (Jur	
	admission to the fa				new Penick Village MDS Coordinator reviewed, signed off, and completed ar	nv.	
	An interview was conducted on 5/3/16 at 3:00 PM				assessments that needed completion.	ıy	
					accessmente that needed completion.		
		f Nursing (DON). She					
		Coordinator was not present			Our new MDS coordinator is putting int	0	
	at the facility. She	stated that the facility had			place a calendar system she has used	for	
		the MDS Coordinator and			years to track quarterly and annual		
		s. She revealed that			assessments. Our MDS coordinator		
		ssessments were an identified			educated all Inter-Disciplinary Team (IE	OT)	
		She indicated the new			members on the calendar system on		
		aware of the issues and was			5-11-16. Our new calendar system trac		
	addressing the cor	icems.			all assessments that are due each wee		
	An interview was o	onducted on 5/5/16 at 12:30			and each month and will drive completi of MDS assessments. IDT members w		
		istrator. He revealed the			be given a weekly calendar each week		
		of multiple issues they had with			our MDS Coordinator identifying all	. J	
		nents. He stated the facility			assessments to be completed that wee	k.	
		nock survey in March 2016 that			DON will audit 3 of the assessments du		
		concern. He indicated that			during the week for completion and rep	ort	
	incomplete MDS a	ssessments were identified as			findings to QA meeting. We have also		
		areas. He reported the facility			started using a 100 Day Tool for each a	and	
		of implementing multiple			every resident that is using Medicare		
	changes to addres	s the areas of concern			Benefits as a way to keep track		
	0 D				Assessment Reference Dates.		
		as admitted to the facility on			The Deniels Village Name of Land		
	11/10/15.				The Penick Village Nursing Home		
	A ravious of the ma	dical record revealed an			Administrator (NHA), Director of Nursin (DON) and Minimum Data Set	ıy	
		ated 11/17/15. The completion			Coordinator (MDS) will meet weekly for	r	
	, withouton Midd ut	ALOG 11/11/10. THE COMPLETION	1	- 1	Coordinator (WIDO) Will flict Weekly IO		1

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		05/0	5/2016	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	CODE	0.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 273	Continued From pag	e 13	F 27	73			
t f	Admission MDS (VB twenty three (23) day facility. An interview was con	ea Assessment (CAA) of the 1) was 12/3/15. This was ys after admission to the nducted on 5/3/16 at 3:00 PM		the next 90 days to review comprehensive assessment any incomplete assessment POC. Documented finding completion dates will be renext QA meeting June 27,	nts to identify nts and create a gs and eported at the		
	at the facility. She s several issues with t MDS assessments. incomplete MDS ass area of concern. Sh	coordinator was not present tated that the facility had the MDS Coordinator and She revealed that tessments were an identified the indicated the new ware of the issues and was					
	PM with the Administ facility was aware of their MDS assessment had completed a moderatified areas of concomplete MDS assone of the problem awas in the process of changes to address	anducted on 5/5/16 at 12:30 trator. He revealed the multiple issues they had with ents. He stated the facility ck survey in March 2016 that concern. He indicated that dessments were identified as a sureas. He reported the facility of implementing multiple the areas of concern.					
	Admission MDS date date for the Care Are Admission MDS (VB twenty (20) days after An interview was conwith the Director of Nindicated the MDS C	cal record revealed an ed 1/22/16. The completion ea Assessment (CAA) of the 1) was 2/4/16. This was er admission to the facility. Inducted on 5/3/16 at 3:00 PM Nursing (DON). She coordinator was not present tated that the facility had					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/05/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	3.33.20.13	
(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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 273	MDS assessments. incomplete MDS assarea of concern. She Administrator was avaddressing the concern. An interview was corp M with the Administ facility was aware of their MDS assessme had completed a movidentified areas of coincomplete MDS assone of the problem a was in the process or changes to address the 4. Resident #56 was 9/14/15. A review of Resident revealed an Admission assessment dated 9/for the Care Area Assa Admission MDS (Voz was sixty-seven (67) admission to the facility. She stated the issues with the MDS assessments were a She indicated the ner of the issues and was a sixty-seven was and was a sixty-seven and was sixty-seven assessments. She reassessments were a She indicated the ner of the issues and was a sixty-seven was and was a sixty-seven	she MDS Coordinator and She revealed that essments were an identified e indicated the new ware of the issues and was erns. Iducted on 5/5/16 at 12:30 arator. He revealed the multiple issues they had with ints. He stated the facility ck survey in March 2016 that incern. He indicated that essments were identified as reas. He reported the facility of implementing multiple the areas of concern. admitted to the facility on #56's medical record on Minimum Data Set (MDS) 27/15. The completion date sessment (CAA) of the 200B1) was 11/20/15. This days after Resident #56's	F 2'	73			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345111	B. WING_			05/05/2016
NAME OF P	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZI 500 EAST RHODE ISLAND AVENU SOUTHERN PINES, NC 28387	P CODE JE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 273	PM with the Administ was aware of multip MDS assessments. completed a mock sidentified areas of continuous in the process of changes to address	trator. He revealed the facility le issues they had with their He stated the facility had urvey in March 2016 that concern. He indicated that sessments were identified as areas. He reported the facility of implementing multiple the areas of concern. It admitted to the facility on the sessment was a series of the sessment on Minimum Data Set (MDS) 2/14/15. The completion are a Assessment (CAA) of the 200B1) was 1/5/16. This was a safter Resident #31's	F2	273		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	1' '	E SURVEY PLETED
		345111	B. WING _		05	5/05/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 273 F 276 SS=D	changes to address the 483.20(c) QUARTER LEAST EVERY 3 MO A facility must assess quarterly review instru	implementing multiple ne areas of concern. LY ASSESSMENT AT NTHS a resident using the ument specified by the State S not less frequently than	F 2			6/2/16
	by: Based on record revifacility failed to compl Set (MDS) assessme Assessment Reference recent MDS assessme residents (Residents included: 1a. Resident #56 was 9/14/15. A review of Resident revealed an Admission assessment with an A (ARD) of 9/27/15. Resident #56 had a q with an ARD of 12/28 required a signature of Assessment Coordina This quarterly MDS a be completed on 2/10 This quarterly assess	ew and staff interviews, the ete quarterly Minimum Data nts within 92 days of the ce Date (ARD) of the most ent for 2 of 12 sampled #31 and #56). The findings admitted to the facility on #56's medical record in Minimum Data Set (MDS) assessment Reference Date uarterly MDS assessment of a Registered Nurse (RN) ator to verify its completion. Seessment was indicated to 10/16 (Question Z0500B). In ment was completed 136 ecent MDS assessment's		Residents #31 and #56 have a question Minimum Data Set completed on 5 by this practice. An audit of quarter Minimum Data Set assessment was completed on 5-26-16 by our new Coordinator. Our new Penick Villa Coordinator reviewed, signed off, completed any quarterly assessment eeded completion by 5-9-16 and 5-10-16. All quarterly and annual assessments due in May 2016 we opened and completed by 6-2-16. Our new MDS coordinator is puttir place a calendar system she has u years to track quarterly and annual assessments. Our MDS coordinated educated all Inter-Disciplinary Teamembers on the calendar system 5-11-16. Our new calendar system all assessments that are due each and each month and will drive conformed to the system of MDS assessments. IDT members	affected erly as MDS ge MDS and ents that wre mg into used for all tor m (IDT) on m tracks a week appletion	

PRINTED: 06/14/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345111	B. WING _		05/05/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 500 EAST RHODE ISLAND AVEN SOUTHERN PINES, NC 2838	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETION	
F 276	An interview was cowith the Director of she signed the MDS completion. She staseveral issues with MDS assessments. assessments not be manner was an ider DON indicated their of the issues and was aware of multip MDS assessments. completed a mock sidentified areas of completed are	Inducted on 5/3/16 at 3:00 PM Nursing (DON). She indicated assessments to verify their ated that the facility had the MDS Coordinator and She revealed that MDS sing completed in a timely ntified area of concern. The new Administrator was aware as addressing the concerns. Inducted on 5/5/16 at 12:30 strator. He revealed the facility had survey in March 2016 that concern. He indicated that assessments were identified am areas. He reported the ocess of implementing address the areas of It #56's medical record Minimum Data Set (MDS) Assessment Reference Date It #56's medical record quarterly MDS assessment assessment as end assessment assess	F 2	be given a weekly caler the MDS Coordinator id assessments to be com DON will audit 3 charts completion using calend findings to QA meeting. started using a 100 Day every resident that is us Benefits as a way to kee Assessment Reference The Penick Village Nurs Administrator (NHA), Di (DON) and Minimum Da Coordinator (MDS) will the next 90 days to revir quarterly assessment POC. Documented find completion dates will be next QA meeting June 2	entifying all pleted that week. weekly for dar and report We have also or Tool for each and sing Medicare ep track Dates. sing Home rector of Nursing ata Set meet weekly for ew 3 selected to identify any s and create a lings and e reported at the	

Facility ID: 923395

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345111	B. WING	·····		5/05/2016
NAME OF PI	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 276	days after the most ARD (12/28/15). An interview was cowith the Director of she signed the MDS completion. She state several issues with MDS assessments. assessments not be manner was an ider DON indicated their of the issues and was aware of multip MDS assessments. completed a mock sidentified areas of cotimeliness of MDS as one of the proble facility was in the promultiple changes to concern. 2. Resident #31 was 12/7/15. A review of Resident revealed an Admission of the proble facility was in the promultiple changes to concern.	sment was completed 113 recent MDS assessment's Inducted on 5/3/16 at 3:00 PM Nursing (DON). She indicated assessments to verify their ated that the facility had the MDS Coordinator and She revealed that MDS eing completed in a timely nitified area of concern. The new Administrator was aware as addressing the concerns. Inducted on 5/5/16 at 12:30 atrator. He revealed the facility had survey in March 2016 that concern. He indicated that assessments were identified are areas. He reported the ocess of implementing address the areas of It #31's medical record ion Minimum Data Set (MDS)	F 2'			
	identified areas of c timeliness of MDS a as one of the proble facility was in the pr multiple changes to concern. 2. Resident #31 was 12/7/15. A review of Residen revealed an Admiss assessment with an (ARD) of 12/14/15.	oncern. He indicated that assessments were identified an areas. He reported the ocess of implementing address the areas of admitted to the facility on at #31's medical record				
	with an ARD of 3/15 required a signature	quarterly MDS assessment i/16. The MDS assessment of a Registered Nurse (RN) nator to verify its completion.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE COMP	SURVEY
		345111	B. WING _		05/	05/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	,	
(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 SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 276			F 2	76		
	be completed on 3/30 This quarterly assess	ssessment was indicated to 0/16 (Question Z0500B). ment was completed 108 ecent MDS assessment's				
	with the Director of N she signed the MDS completion. She stat several issues with th MDS assessments. Sassessments not beir manner was an ident DON indicated the new sheet sheet assessments.	ducted on 5/3/16 at 3:00 PM ursing (DON). She indicated assessments to verify their ed that the facility had be MDS Coordinator and She revealed that MDS ag completed in a timely lifted area of concern. The ew Administrator was aware				
F 278 SS=D	An interview was con PM with the Administ was aware of multiple MDS assessments. Hompleted a mock suidentified areas of contimeliness of MDS as as one of the problem facility was in the promultiple changes to a concern. 483.20(g) - (j) ASSES	ddress the areas of	F 2	78		6/2/16
	resident's status.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345111	B. WING _			5/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		0/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From pag	e 20	F 2	78		
	A registered nurse massessment is comp	ust sign and certify that the leted.				
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.					
	Clinical disagreemen material and false sta	t does not constitute a atement.				
	by: Based on medical reinterviews, the facility behaviors for one of behaviors (Resident (Preadmission Screethe MDS (Minimum Dresidents reviewed for #3). The findings incomplete the MDS (Minimum Dresidents reviewed for #3). The findings incomplete the MDS (Minimum Dresidents reviewed for #3). The findings incomplete the MDS (Minimum Dresidents reviewed for #3). The findings incomplete the MDS (Minimum Dresidents reviewed for #42 was 12/15/15. Cumulative fibrillation and Parking for Minimum Dresidents reviewed for Minimum Dresidents revi	ening Resident Review) on Data Set) for one of one or PASRR level 2 (Resident eluded: s admitted to the facility on e diagnoses included atrial		Resident #42 will had an up comprehensive assessment 6-1-16. Resident #3 had an updated to reflect the current PASRR All residents have the potent affected by this practice. An comprehensive assessment completed on 5-26-16 by ou coordinator and a review of (PASRR) and Section E(Bel Discrepancies were corrected.	d assessment televel. tial to be a audit of the s was r new MDS Section A haviors).	
		sident 342 was moderately		שומטו ביים ביים שומטו ביים שומטו ביים ביים שומטו ביים ביים ביים שומטו ביים ביים ביים ביים ביים ביים ביים ביי	.u.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05	/05/2016
NAME OF PI	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PENICK V	II I AGE			50	00 EAST RHODE ISLAND AVENUE		
I LINION V	ILLAGE			S	OUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	noted. Behaviors we behaviors directed to behaviors directed to days during the assess. A review of Resident revealed an order for anxiety) 0.5 milligrams for agitation. A review of the March Administration Reconstruction and March 18 assessment period. A review of Resident conducted. There was behaviors. A Social work note da #42 was social with see behaviors were noted.	No mood indicators were re documented as physical wards others and verbal wards others occurred 1-3 sesment period. #42's physician's orders Lorazepam (medication for s every six hours as needed 1 2016 Medication dd (MAR) revealed Resident for seth which was during the #42's care plan was as no care plan for	F2	278	Our MDS coordinator is putting into plata calendar system she has used for yet to track quarterly and annual assessments. Our MDS coordinator educated all Inter-Disciplinary Team (II members on the calendar system on 5-11-16. Our new calendar system tra all assessments that are due each we and each month and will drive complet of MDS assessments. IDT members who be given a weekly calendar each week identifying all assessments to be completed that week. DON will perform weekly audit using the calendar to ensure assessments are completed and report findings to QA meeting. We have also started using a 100 Day Tool for each every resident that is using Medicare Benefits as a way to keep track Assessment Reference Dates. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for	ears OT) cks ek ion vill aure t and	
		was conducted. There			the next 90 days to review 3 quarterly assessments and comprehensive assessments to identify any incomplete assessments and create a POC.	е	
	conducted with the so was the person who of MDS for behaviors. The behavior charting stated Resident #42 I information on the MI she did not know why	correct and if behaviors were			Documented findings and completion dates will be reported at the next QA meeting June 27, 2016. A review of resident PASSR levels and the accurat of our MDSs will also be monitored earweek by the DON.	•	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G			TE SURVEY MPLETED
		345111	B. WING _				05/05/2016
PENICK V	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, 500 EAST RHODE SOUTHERN PINI		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278		son in her social work noted.	F 2	78			
	3/30/11 with multiple disorder and severe annual Minimum Dat dated 2/12/16 coded Preadmission Screet	admitted to the facility on diagnoses including autistic intellectual disabilities. The ta Set (MDS) assessment Resident #3 as a ning and Resident Review on the condition of Mental					
	On 5/2/16 the facility completed an entrance conference worksheet that listed PASRR level II residents. Resident #3 was listed as PASRR level II.						
	A record review of R electronic medical redocumentation of a R determination.						
	with the Director of N	nducted on 5/3/16 at 3:00 PM Nursing (DON). She ted the MDS to be coded					
	AM with the Social V revealed she reviewed and she was not a Prindicated the MDS wadditionally indicated the entrance confered incorrect. She stated identified Resident # SW revealed she pre-	ras coded incorrectly. She If the information provided on the ence worksheet was If the facility had mistakenly If as a PASRR Level II. The the eviously thought Residen #3 II, but after her review of the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345111	B. WING		05/	05/2016
PENICK V	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	1 33.	30/2010
(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) COMPLETION DATE
F 278	PM with the Administ facility was aware of	ducted on 5/5/16 at 12:30 rator. He revealed the multiple issues they had with	F 27	78		
F 279 SS=D	accuracy was one of reported the facility w	e changes to address the 1) DEVELOP	F 27	79		6/2/16
	to develop, review an comprehensive plan. The facility must developlan for each residen objectives and timetal medical, nursing, and	e results of the assessment and revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial fied in the comprehensive				
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's	escribe the services that are ain or maintain the resident's hysical, mental, and ng as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment				
	by:	is not met as evidenced cord review and staff failed to develop a		The Care Plan of resident #49 updated to include her behavior		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345111	B. WING	 -		05/05/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	•	
DENICK V	II I ACE			500 EAST RHODE ISLAND AVENUE		
PENICK V	ILLAGE			SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 279	reviewed for behavior medical conditions/ rassistance with active for one of twelve sand #49) and for the use with behaviors for one for unnecessary medication and the findings included to the findings included the findings and physical medication to the findings and findings and findings included the findin	plan for one of two residents ars (Resident #49), for active medications and the need for lities of daily living (ADL's) appled residents (Resident of psychotropic medication e of five resident reviewed dications (Resident #51). d: was admitted to the facility diagnoses included analysis and adjustment sion. all dated 1/25/16 indicated dimitted to the hospital with a superimposed on her orders included the following lone (antidepressant rams by mouth daily, ssant medication) 25 daily and Klonopin (anxiety grams twice daily as needed epressant) 15 milligrams ary Medication and (MAR) revealed Resident	F 2		e, and and need for w MDS mprehensive sludes but is medication rdinator by to be affected the will be r new MDS acy of the ncies are rehensive within 30 Plans were or PRN licensed sed by DON all of passeline care plans y June 2. Any ucated during ON. DON will care plans to priate and g.	
	An Admission Minimindicated Resident # in cognition. No mod	d by the physician. Klonopin d during January. um Data Set dated 1/22/16 49 was moderately impaired od or behaviors were noted ant period. Medications		in-services will be shared at meeting June 27, 2016. In-s refusal of medications and o non-baseline behavior repor care plans reflect baseline b be completed annually there	next QA services on or care, ting, and how ehaviors will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		0.	5/05/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	, -	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	received during the asix days of antidepre A Care Area Assessmedication stated ps would be addressed A CAA for falls stated daily use of antipsychrisk for adverse reach Resident #49 had a pantianxiety medication use during the look beginn which included physician 's order, mand periodic review bruse for possible grade. A psychiatric consult staff felt Resident #4 her outbursts of weel A nursing note dated was seen by psychiat psychotropic medical physician's order was Klonopin 0.5 milligrams daily a milligrams by mouth to 25 milligrams by mouth to 25 milligrams daily to 7.5 with Sertraline 25 milligrams daily to 7.5 with Sertraline 25 milligrams consult a psychiatric consult and psychiatric consult and psychiatric consult and psychiatric consult and provided the provided that are also provi	ssessment period included ssant medication. nent (CAA) for psychotropic ychotropic medications in the falls CAA. I Resident #49 required the notic medication and was at tions due to their use. Ohysician 's order for on but had not required its ack period. Proceed to care provide medications per nonitor for adverse reactions by physician/ pharmacist for ual dosage reduction. dated 2/18/16 stated facility 9 was depressed based on ping. 2/26/16 stated Resident #49 tric services and tions were evaluated. As sobtained to decrease ms twice daily as needed to as needed. Trazadone 50 every night was decreased nouth nightly. Remeron decreased from 15 milligrams daily. dated 3/17/16 indicated no . A request was made to d psychiatry staff felt	F 27	The Penick Village Nursing Hom Administrator (NHA), Director of (DON) and Minimum Data Set Coordinator (MDS) will meet we the next 90 days to review 3 sel quarterly and comprehensive assessments to identify any incomposite assessments and create a POC Documented findings and composite dates will be reported at the next meeting. The agenda and the alogs from the in-services mention above will also be reported at the meeting by DON. And In-service refusal of medications and or canon-baseline behavior reporting care plans reflect baseline behavior behavior reported at the completed annually thereafter	rekly for ected complete completion ct QA cattendance coned ce next QA ces on care, cond now conors will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345111	B. WING		05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 279	Continued From pa	ge 26	F 279		
	was increased to 0.	ated 3/25/16 stated Klonopin 5 milligrams every 12 hours tion. No other changes in ed.			
	indicated that Resid	ess note dated 4/20/16 lent #49 's anxiety may be vorse by constant itching.			
	Resident #49's care plan was reviewed. There was only one area care planned for Resident #49 which was for falls and did not include the use of psychotropic medications or behaviors.				
	conducted with the reviewed Resident at that Resident #49 included her use of behaviors. She stated Resident 49's care at The Director of Nursesponsibility of the care plans and the fire	27PM, an interview was Director of Nursing. She #49's care plan and stated s care plan should have psychotropic medications and ted she did not know why plan only consisted of falls. sing stated it was the MDS coordinator to write the facility had identified that there n they had conducted their ch.			
	D. Resident #49 was admitted to the facility 1/15/16. Cumulative diagnoses included dementia without behavior, chronic obstructive pulmonary disease (COPD), hypertension, diabetes hypothyroidism and adjustment disorder with depression.				
	1/22/16 indicated R	num Data Set (MDS) dated esident #49 was moderately n. Resident #49 required			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345111	B. WING _			05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	locomotion on and and personal hygie needed with ambul occurred 1-2 x in the was needed with beneeded with eating incontinent of bladd documented included thyroid disease, demetabolic encephal communication deficility walking. If as received scheduler professional was needed professional was administered during included: 2 days of days of antidepressional deficits and was about staff. She was parea would be care a CAA for activities Resident #49 requires a communication was about the communication of the care would be care as and made her needed in the care would be care. The CAA for urinary the care would be care.	off the unit, dressing, toilet use one. Limited assistance was lation in the room and only one hallway. Total assistance athing. Supervision was one was frequently der and bowel. Diagnoses led hypertension, diabetes, amentia, depression, COPD, allopathy, dysphagia, cognitive ficit, muscle weakness and Pain management was noted alled pain medication, received ain medications or was offered ght was noted as 110 pounds or gain. Medications gethe assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections, 1 day of insulin, 6 sant medication and 5 days of the assessment period injections of the planned.	F 2	279		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S00 EAST RHODE ISLAND AURINE SOUTHERN PINES, NC 28387	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		l' /	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE SUMMARY STATEMENT OF DEFICIENCIES SOUTHERN PILES, NC 28387			345111	B. WING _		0	5/05/2016	
F 279 Continued From page 28 noted that all the areas would be addressed in Resident #49's care plan. Physician orders were reviewed and revealed, in part, the following: Check fasting blood sugar before breakfast and supper. Check weekly weight related to weight loss. Lasix (diuretic) 20 milligrams daily Aricept (for dementia) 10 milligrams nightly Humalog sliding scale insulin (for diabetes) Strawberry ensure twice a day; magic cup with meals (due to weight loss). Ivermectin 3 mg 3 tabs (12 mg) on days 1, 2, 8, 9 and 15 (for scabies) Januvia (diabetic medication) 50 milligrams daily Levothyroxine (thyroid medication) 100 micrograms daily. Check pulse weekly. Metoprolol ER (for blood pressure) 25 milligrams twice daily Remeron (antidepressant medication) 15 milligrams nightly					500 EAST RHODE ISLAND AVENU	CODE	9.00.20.10	
noted that all the areas would be addressed in Resident #49's care plan. Physician orders were reviewed and revealed, in part, the following: Check fasting blood sugar before breakfast and supper. Check weekly weight related to weight loss. Lasix (diuretic) 20 milligrams daily Aricept (for dementia) 10 milligrams nightly Humalog sliding scale insulin (for diabetes) Strawberry ensure twice a day; magic cup with meals (due to weight loss). Ivermectin 3 mg 3 tabs (12 mg) on days 1, 2, 8, 9 and 15 (for scabies) Januvia (diabetic medication) 50 milligrams daily Levothyroxine (thyroid medication) 100 micrograms daily. Check pulse weekly. Metoprolol ER (for blood pressure) 25 milligrams twice daily Remeron (antidepressant medication) 15 milligrams nightly	PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETION	
gram twice daily Trazadone 50 milligrams 1/2 tab (25 milligrams) nightly Clonazepam (anxiety medication) 0.5 milligrams every 12 hours as needed for agitation A review of Resident #49's care plan revealed the only area addressed in Resident #49's care plan was falls. There was not a care plan for cognition, urinary status, nutritional status, pressure ulcers, pain, diabetes and/or the use of diuretic medication or psychotropic medications. On 5/04/2016 at 5:27PM, an interview was conducted with the Director of Nursing. She	F 279	noted that all the ar Resident #49's care Physician orders we part, the following: Check fasting blood supper. Check weekly weigl Lasix (diuretic) 20 n Aricept (for dementi Humalog sliding sca Strawberry ensure if meals (due to weigl Ivermectin 3 mg 3 trand 15 (for scabies Januvia (diabetic m Levothyroxine (thyromicrograms daily.) Metoprolol ER (for the twice daily Remeron (antidepre milligrams nightly Sodium chloride (for gram twice daily Trazadone 50 millignightly Clonazepam (anxie every 12 hours as reals.) There we cognition, urinary st pressure ulcers, paidiuretic medication On 5/04/2016 at 5:2	eas would be addressed in e plan. ere reviewed and revealed, in a sugar before breakfast and the related to weight loss. Inilligrams daily ia) 10 milligrams nightly ale insulin (for diabetes) twice a day; magic cup with int loss). In abs (12 mg) on days 1, 2, 8, 9 (12 mg) on days 1, 2, 8, 9 (13 mg) on days 1, 2, 8, 9 (14 mg) on days 1, 2, 8, 9 (15 mg) on days 1, 2, 8, 9 (16 mg) on days 1, 2, 8, 9 (17 mg) on days 1, 2, 8, 9 (18 mg) on days 1, 2, 8,	F2	279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/	05/2016
NAME OF P	ROVIDER OR SUPPLIER		l	500	REET ADDRESS, CITY, STATE, ZIP CODE DEAST RHODE ISLAND AVENUE DUTHERN PINES, NC 28387	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 279	that Resident #49 's included her need for medical conditions and medications and psy behaviors. She state Resident 49's care p The Director of Nurs responsibility of the I care plans and the fa was a problem when mock survey in March 2. Resident #51 was 9/11/15 with multiple dementia, anxiety, and Resident #51's admi 9/11/15 indicated Se milligrams (mg) once (antianxiety) 0.5mg to needed (prn) every 6 (antidepressant) 5mg. A review of the Septe Administration Reconfered by the physical An Admission Minim assessment dated 9, #51 had significantly mood or behaviors wassessment period. The assessment period the assessment period antipsychotic medical residual properties and provide and provide and provide antipsychotic medical medical provides and provide antipsychotic medical medical provides and prov	49's care plan and stated care plan should have rassistance with ADL's, her not the use of diabetic rehotropic medications and ed she did not know why lan only consisted of falls. ing stated it was the MDS coordinator to write the acility had identified that there is they had conducted their sh. admitted to the facility on diagnoses including and depression. ssion physician orders dated roquel (antipsychotic) 25 e every 12 hours, Ativan wice daily, Ativan 0.5mg as 6 hours, and Lexapro g once daily. ember 2015 Medication and (MAR) revealed Resident uel, Ativan, and Lexapro as cian. um Data Set (MDS) //22/15 indicated Resident impaired cognition. No vere noted during the Medications received during od included seven days of an on, and six days of an on, and six days of an	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/	05/2016
NAME OF PE	ROVIDER OR SUPPLIER		•	50	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST RHODE ISLAND AVENUE DUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From pag	e 30	F 2	279			
	psychotropic medica	ndicated the care area of tions was triggered by the not indicated to be care					
	The medical record what no care plan in S	vas reviewed. Resident #51 September 2015.					
	A Nursing Progress Note (NPN) dated 9/24/15 indicated Resident #51 refused to get up on three attempts.						
	Resident #51 refused 3 distinct calendar da	the October 2015 MAR revealed if refused a total of 19 medications on ellendar days. This included 2 refusals refusal for Lexapro, and 2 refusals l.					
	The medical record what no care plan in C	vas reviewed. Resident #51 October 2015.					
	A NPN dated 10/10/1 medications.	5 indicated resident refused					
		5 indicated Resident #51 bed that morning and medication.					
		5 indicated Resident #51 bed and was combative with aviors and refused					
	indicated Resident # non-compliant with ta with therapy that wee morning care. She h	es note dated 10/28/16 51 was combative, aking her medications and ek. She was combative with ad refused to get out of bed. dicated to have dementia					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	'	
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F 279	Resident #51 refuse 4 distinct calendar of for Ativan, 2 refusal for Seroquel. The medical record had no care plan in Nursing Assistant (Resident #51 had we behaviors, and had A NPN dated 11/10 spit out medications had verbal behaviors. A NPN dated 11/11 refused to get out of A physician's order increase in Lexapro once daily. A physician's order reduction in Ativan 0.25mg twice daily. A NPN dated 11/13 family was in the factor over her depressed.	rember 2015 MAR revealed ed a total of 36 medications on days. This included 3 refusals is for Lexapro, and 3 refusals was reviewed. Resident #51 November 2015. NA) documentation indicated erbal behaviors, physical rejected care. /15 indicated Resident #51 is, refused each attempt, and rs. /15 indicated Resident #51 if bed. dated 11/13/15 indicated an of from 5mg once daily to 10mg dated 11/13/15 indicated a from 0.5mg twice daily to	F 2	79		
	A NPN dated 11/20 was administered to	/15 indicated Ativan 0.5mg prn				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/	05/2016
NAME OF PE	ROVIDER OR SUPPLIER			50	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST RHODE ISLAND AVENUE OUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	e 32	F 2	279			
		ated 11/20/15 indicated a from 10mg once daily to					
		5 indicated Resident #51 and her breathing treatment.					
I		nted 11/27/15 indicated bal behaviors, physical ejected care.					
	A NPN dated 11/27/15 indicated Resident #51 refused to get out of bed, was combative with staff, and had verbal behaviors. A review of the December 2015 MAR revealed Resident #51 refused a total of 87 medications on 9 distinct calendar days. This included 9 refusals for Ativan, 6 refusals for Lexapro, and 9 refusals for Seroquel.						
	The medical record w had no care plan in D	vas reviewed. Resident #51 ecember 2015.					
	A NPN dated 12/2/15 refused medications of	indicated Resident #51 on several attempts.					
	A NPN dated 12/3/15 refused all morning mattempts.	indicated Resident #51 nedications on three					
		ated 12/11/15 indicated bal behaviors, physical ejected of care.					
	NA documentation da Resident #51 had ver	ated 12/12/15 indicated behaviors.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From page 33		F 2	279		
	Resident #51 had ve	ated 12/16/15 indicated erbal behaviors, physical naviors, and had rejected				
		15 indicated Resident #51 ons on four attempts.				
	indicated no mood c	arterly note dated 12/22/16 oncerns reported by Resident noted during the seven day he quarterly MDS.				
	The quarterly MDS for Resident #51 dated 12/23/15 indicated she was cognitively intact. No mood or behaviors were noted during the assessment period. Medications received during the assessment period included seven days of an antipsychotic medication, seven days of an antianxiety medication, and six days of an antidepressant medication.					
	requested staff walk	15 indicated family had away from Resident #51 if of care or medication.				
	NA documentation dated 12/29/15 indicated Resident #51 had verbal behaviors and had rejected care.					
	Resident #51 refuse on 9 distinct calenda	ary 2016 MAR revealed d a total of 106 medications or days. This included 10 d refusals for Lexapro, and 10 d.				
	NA documentation d Resident #51 had ve	ated 1/3/16 indicated erbal behaviors.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345111	B. WING _	·····	0	5/05/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
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F 279	care conference wa Resident #51's fam A Care Plan was ini 1/8/16. There was prior to 1/8/16. The psychotropic medic Lexapro) with behar medication refusals A physician's order reduction in Ativan of 0.25mg twice daily: A physician's order discontinuation of A for Resident #51. A pharmacy note da Resident #51 had of medication refusals request for a Gradu Seroquel 25mg twice A NPN dated 1/24/19	Note dated 1/8/16 indicated a as held for Resident #51. illy was in attendance. Itiated for Resident #51 on no care plan for Resident #51 e care plan did not address ations (Seroquel, Ativan, and viors that included a pattern of dated 1/15/16 indicated a 0.5mg twice daily to Ativan for Resident #51. dated 1/15/16 indicated a ativan 0.5mg prn every 6 hours ated 1/18/16 indicated a casional resistance care and It additionally indicated a lad Dose Reduction (GDR) of the daily to once daily.	F 2	79		
	reduction of Seroqu Seroquel 25mg onc #51. A review of the Feb Resident #51 refuse 8 distinct calendar of	dated 1/25/16 indicated a lel 25mg twice daily to be every morning for Resident ruary 2016 MAR revealed led a total of 93 medications on days. This included 8 refusals is for Lexapro, and 8 refusals				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/05/2016	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page 35		F 2	279			
	The medical record was not updated in F	vas reviewed. The care plan ebruary 2016.					
	NA documentation do Resident #51 had ve behaviors, and had r	rbal behaviors, physical					
A NPN dated 2/4/16 indicated NAs ha to the nurse that Resident #51 becam to care on their last rounds.		ident #51 became resistant					
	NA documentation dated 2/10/16 indicated Resident #51 had verbal behaviors and physical behaviors.						
	NA documentation danger Resident #51 had rej	ated 2/13/16 indicated ected care.					
	An Activity note indic Resident #51's family mood/behavior at ac	-					
		ated 2/19/16 indicated rbal behaviors and had					
	Resident #51 refused on 10 distinct calend	h 2016 MAR revealed d a total of 108 medications ar days. This included 11 refusals for Lexapro, and 7					
	The medical record was not updated in N	vas reviewed. The care plan larch 2016.					
	NA documentation da Resident #51 had ve behaviors, and had r	rbal behaviors, physical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		05/	05/2016	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	1 33	30.20.10	
(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 CORRECTIVE ACTION SHOUTH CONSTRUCTION SHOUTH CONSTRUCTION SHOUTH CONSTRUCTION SHOUTH CONSTRUCTION SHOUTH CONSTRUCTION SHOUTH CONTRACT CON	OULD BE	(X5) COMPLETION DATE	
F 279	been combative with and refused care. A NPN dated 3/7/16 i refused NA care, had physical behaviors the Resident #51 had als medications. NA documentation da Resident #51 had verbehaviors. A NPN dated 3/8/16 i verbal behaviors and included kicking. Resmorning medications NA. A NPN dated 3/10/16 refused medications. A Care Conference needs a care care.	ndicated Resident #51 had NAs, had verbal behaviors, indicated Resident #51 verbal behaviors, and at included scratching. The orefused morning inted 3/8/16 indicated indicated resident #51 had physical behaviors and physical behaviors that sident #51 also refused and morning care from the indicated Resident #51 indicated a phone call at #51 is family to schedule	F 279	,			
	Resident #51 had ver A NPN dated 3/14/16 verbal behaviors and included attempting to NA documentation da Resident #51 had ver	indicated Resident #51 had physical behaviors that to hit staff. Ited 3/15/16 indicated behaviors.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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NAME OF PR	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	Resident #51 had ph toward staff and fami period. The quarterly MDS fo 3/24/16 indicated she impairment. She was behaviors, verbal bet one to three days dur		F 2	79		
	period included six da medication, seven da medication, and six d medication.	ays of an antipsychotic				
	#51 refused a total of distinct calendar days for Ativan, 8 refusals for Seroquel. The medical record w	2016 MAR revealed Resident f 128 medications on 15 s. This included 16 refusals for Lexapro, and 9 refusals vas reviewed. The care plan				
	rejected care. NA documentation da	ated 4/5/16 indicated ysical behaviors and had				
	NA documentation da	ated 4/9/16 indicated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05/05/2016
NAME OF PE	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP OF STATE AND AVENUE SOUTHERN PINES, NC 28387	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From pag		F 2	779		
	Resident #51 had ve behaviors, and had r	erbal behaviors, physical rejected care.				
		indicated Resident #51 was with staff, and refused all				
		ated 4/10/16 indicated rbal behaviors and physical				
		ated 4/11/16 indicated rbal behaviors and had				
		ated 4/12/16 indicated rbal behaviors and had				
		lated 4/12/16 indicated a new ng prn every 6 hours for				
		lated 4/12/16 indicated an from 5mg once daily to 10mg Resident #51.				
		lated 4/12/16 indicated a ion was ordered for Resident				
	verbal behaviors and	6 indicated Resident #51 had d physical behaviors toward orn was administered. A ion was ordered.				
		6 indicated Resident #51 coward staff and refused care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From pag	e 39	F 2	79		
	was administered to					
		e dated 4/13/16 indicated the spoke with Resident #51's ed to a psychiatric				
	A NPN dated 4/14/16 was administered to	indicated Ativan 0.5mg prn Resident #51.				
	Resident #51 had ref recent increase in be physical, and refusal:	ote dated 4/15/16 indicated fusals of medications and a haviors that included verbal, s of care. Resident #51's eduction in Lexapro from aily.				
		ated 4/15/16 indicated a from 10mg at bedtime to esident #51.				
	A NPN dated 4/17/16 was administered to	indicated Ativan 0.5mg prn Resident #51.				
		ated 4/18/16 indicated rbal behaviors and had				
	A psychiatric consulta 4/20/16 for Resident	ation was completed on #51.				
		ated 4/22/16 indicated rbal behaviors and had				
		ated 4/23/16 indicated rbal behaviors and physical				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05	/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			500 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST RHODE ISLAND AVENUE ITHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	behaviors. A NPN dated 4/25/16 spoke with Resident regarding the psychia requested contact with a NPN dated 4/28/16 spoke with Resident psychiatric consultation increase in Lexaprof 10 spoke with Resident psychiatric consultation increase in Lexaprof 10 spoke with Resident dincrease in Lex	6 indicated nursing staff #51's responsible party (RP) atric consultation. The RP th the psychiatric provider. 6 indicated nursing staff #51's RP regarding the ion and she agreed to an from 5mg to 10mg. ated 4/28/16 indicated an from 5mg at bedtime to Resident #51. ated 4/28/16 indicated rbal behaviors. 6 Ativan 0.5mg prn was	F2	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY
		345111	B. WING			05/	05/2016
PENICK V	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE		(X5) COMPLETION DATE
F 280 SS=E	She stated that Residestart date of 1/8/16. She start date of 2/8/16 she she start date of 2/8/16 she she start date of 2/8/16 she she she she start date of 2/8/16 she she she she she she start date of 2/8/16 she	record for Resident #51. Ident #51's care plan had a She indicated that Resident are plan prior to 1/8/16. She here was no care plan that pic medications with ed a pattern of medication ducted on 5/5/16 at 12:30 rator. He revealed the facility e issues they had with their I the facility had completed a n 2016 that identified areas ted that care planning was of concern. He reported the cess of implementing ddress the areas of (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. e plan must be developed		280			6/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING	 	0	5/05/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0.00.20.0	
DENICK V	II I ACE			500 EAST RHODE ISLAND AVENUE			
PENICK V	ILLAGE			SOUTHERN PINES, NC 28387			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 42	F 28	80			
	and revised by a tear each assessment.	n of qualified persons after					
	by: Based on record rev staff interview, the face comprehensive care the completion of the for 1 of 12 (Resident failed to include the reparty in the care plan review of 3 (Resident #42 and #16 failed to review and reviewed for falls. The sesident #51 was 9/11/15 with multiple dementia, anxiety, and Resident #51's Admis (MDS) assessment has Reference Date (ARI assessment required Nurse Assessment Completion. This Admis indicated to be confused to the confused plan review of the medical review of the m	admitted to the facility on diagnoses including and depression. ssion Minimum Data Set ad an Assessment D) of 9/22/15. The MDS a signature of a Registered coordinator to verify its mission MDS assessment		Resident #51 comprehensive care completed by MDS Coordinator on 5-26-16. Resident and/or family/ responsible of residents #3, #30, #42, & #16 had been invited to attend care plan medocumented in ELECTRONIC MEDICATION (AOD) by MDS Coordinator. The Family of resident #56 participals a care plan meeting on April 5, 2010. Resident #42 and #44 care plans we reviewed and revised June 2, 2010. All residents have potential to be a by this practice. An audit of the comprehensive was completed on 5-29-16 by MDS Coordinator to as accuracy of the care plans. As a resident incomplete care plans we updated and meetings scheduled we family. If deficiencies are identified updated comprehensive care plans.	e party ave eeting nas DICAL ator. Dated in 16 was 016 by ffected sure esult of ere with , an		
		Resident #51 prior to 1/8/16. fter the Admission MDS apleted (9/24/15).		completed within 30 days. All cognitively appropriate resident applicable family / responsible part			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0.0	1	12	FREET ADDRESS, CITY, STATE, ZIP CODE		05/05/2016
NAME OF T	NOVIDEN ON 3011 EIEN						
PENICK V	ILLAGE				00 EAST RHODE ISLAND AVENUE		
				50	OUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From page	age 43	F	280			
			' -	_00	be invited to participate in the care pl	an	
	An interview was o	conducted with the Director of			process going forward utilizing the M		
		5/3/16 at 3:40 PM. She stated			assessment calendar managed by th		
		rdinator was responsible for			new Penick Village MDS Coordinator		
		dicated the MDS Coordinator			c.man r.maga m.z.a acaramata.	-	
	1	the facility. The DON revealed			Our MDS coordinator is putting into p	lace	
		s aware that care plans were an			a calendar system she has used for		
		She indicated that issues with			to track quarterly and annual		
	care plans were fir	st identified several months			assessments. Our MDS coordinator		
	_	nat care plans continued to be			educated all Inter-Disciplinary Team	(IDT)	
		n even after the issues were			members on the calendar system on		
		licated the new Administrator			5-11-16. Our new calendar system to		
		ssues and was addressing the			all assessments that are due each w		
	concerns.				and each month and will drive completed of MDS assessments. IDT members		
	An interview was o	conducted with the Social			be given a weekly calendar each wee		
	Worker (SW) on 5/	/5/16 at 10:30 AM. She			MDS Coordinator identifying all	,	
	reviewed the medi	cal record for Resident #51.			assessments to be completed that we	eek.	
	She stated that Re	esident #51's care plan had a			We have also started using a 100 Da		
		She indicated that Resident			Tool for each and every resident that		
	#51 did not have a	care plan prior to 1/8/16.			using Medicare Benefits as a way to track Assessment Reference Dates.	-	
	An interview was o	conducted on 5/5/16 at 12:30			new Penick Village MDS Coordinator		
		nistrator. He revealed the facility			review care plans each time a reside		
	was aware of mult	iple issues they had with their			sent to the hospital and returns. The		
	care plans. He sta	ted the facility had completed a			Penick Village MDS Coordinator will	utilize	
	mock survey in Ma	arch 2016 that identified areas			our MDS assessment calendar to inv	ite all	
		icated that care planning was			cognitively appropriate residents and		
		ea of concern. He reported the			applicable family / responsible parties		
		process of implementing			participate in the care plan process g	oing	
		o address the areas of			forward.		
	concern.				The Decision Village No. 1		
	2 Decident #2	an admitted to the facility as			The Penick Village Nursing Home	ina	
		as admitted to the facility on			Administrator (NHA), Director of Nurs	sing	
		ole diagnoses including autistic re intellectual disabilities.			(DON) and Minimum Data Set	for	
	uisoruer and sever	re milenectual disabilities.			Coordinator (MDS) will meet weekly the next 90 days. The MDS Coordinates		
	Δ review of Reside	ent #3's medical record			will bring copies of the care plan mee		
		recent care plan meeting was			invitations sent to family / responsible		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		0	5/05/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Nursing (DON) on 5/3 that care plans were needed. She addition meetings were held of She indicated that the responsible for care previsions, care plan deare plan meeting invitation responsible party as a that the MDS Coording facility. The DON inconferences were to electronic medical recopy of the sign in short conference was also #3's electronic and has were reviewed with the last care plan mee 11/25/15. This was 1 date. She revealed shave had at least one 11/25/15. The DON interview of the facility was aware area of concern. She the timeliness of care specific area of concerns spe	ducted with the Director of 3/16 at 3:40 PM. She stated reviewed quarterly and as nally stated that care plan quarterly and as needed. MDS Coordinator was plan reviews, care plan documentation, scheduling and completion of the care insto the resident and/or applicable. She reported nator was not present at the dicated that care plan be documented in the cord. She stated that a hard eet from each care plan kept in the chart. Resident and copy medical record in EDON. She indicated that eting for Resident #3 was on 61 days prior to the current in expected Resident #3 to exare plan meeting since in that care plans were an eadditionally revealed that it that care plans was a ern. She indicated that is were first identified several atted that care plans in the concern even after the disconcern	F 2	parties for upcoming care and who attended the mer Documented findings and dates will be reported at the meeting June 27, 2016 by Coordinator.	etings. completion ne next QA		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345111	B. WING _			05/05/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 E APPROPRIATE	(X5) COMPLETION DATE	
F 280	PM with the Administ was aware of multiple care plans. He state mock survey in Marco of concern. He indict identified as an area facility was in the promultiple changes to concern. 3. Resident #56 was 9/14/15 with multiple dementia, anxiety, a Minimum Data Set (she had significant of the state of the s	Inducted on 5/5/16 at 12:30 Intrator. He revealed the facility le issues they had with their d the facility had completed a ch 2016 that identified areas lated that care planning was le of concern. He reported the locess of implementing laddress the areas of admitted to the facility on le diagnoses including land depression. The quarterly land model impairment. It #56's medical record lan meeting since admission land 205 days after Resident	F 2				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345111	B. WING		05/05/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 280	conference was also The DON interview the facility was awar area of concern. Sh the timeliness of car specific area of conc issues with care pla months ago. She sh continued to be an a issues were identified Administrator was a addressing the concern. An interview was concern. He state mock survey in Mar of concern. He indice identified as an area facility was in the pr multiple changes to concern. 4 a. Resident #42 w 12/15/15. Cumulati Parkinson's disease An Admission Minim 12/20/15 indicated for and long term memor extensive assistance transfers. No ambus indicated Resident #4 since admission to the A care plan dated 11 #42 had an actual for	continued. She revealed that re that care plans were an ne additionally revealed that re plan meetings was a cern. She indicated that ms were first identified several tated that care plans area of concern even after the ed. She indicated the new ware of the issues and was cerns. Inducted on 5/5/16 at 12:30 strator. He revealed the facility had completed a ch 2016 that identified areas eated that care planning was a of concern. He reported the focess of implementing address the areas of was admitted to the facility ve diagnoses included sec. Inum Data Set (MDS) dated Resident #42 had short term ory impairment. He required e with bed mobility and lation occurred. The MDS #42 had sustained one fall	F 280		

	(X3) DATE SURVEY COMPLETED
345111 B. WING	05/05/2016
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE STREET ADDRESS, C 500 EAST RHODE IS SOUTHERN PINES	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	VIDER'S PLAN OF CORRECTION (X5) ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 280 Continued From page 47 room clutter free and well lit. Call light within reach. Keep bed in low locked position. A mobility monitor for the bed and chair. Assistance needed to wear non-skid footwear. Extensive assist with transfers. A review of the incidents and accidents for the past six months revealed Resident #42 had falls on 12/16/15, 12/24/15, 1/24/16 and 4/28/16. An incident report dated 12/16/15 at 5:00AM stated Resident #42 was noted getting out of bed. An alarm was heard coming from the room and staff entered to find the resident lying on the floor. Follow up action indicated to have a fall mat in place when resident was in bed. Check placement every shift. Remind him to call for assistance. Use a bed/ chair alarm. An incident report dated 12/24/15 at 12:30AM stated resident was found on the floor in his room. Follow-up action stated: landing strip. Ensure bed/ chair alarm in place. An incident report dated 1/24/16 at 3:00PM stated staff heard the alarm sounding. Staff observed Resident #42 halfway out of bed with his legs on the fall mat. Follow-up action included the use of a concave mattress. An incident report dated 4/28/16 at 4:30PM stated Resident #42 halfway out of bed. Nursing students and their teacher were present and assisted him to the floor mat in a sitting position. No new interventions were indicated. On 5/04/2016 at 11:03 AM, an interview was conducted with Resident #42. He stated he had	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345111	B. WING _			05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 280	#42 stated he did no out when he needed kept an alarm on hir and in the bed. On 5/04/2016 at 11: Resident #42 was consisting in his wheeled alarm attached to him attress was noted on the floor beside to also noted on the mattress on the mattress of the care no documentation on 1/24/16 or 4/28/16. Interventions of the was indicated on the on 5/4/16 at 5:00PM with the Director of I	and did not walk. Resident of use his call bell but yelled of help. He also stated they in when he was in the chair. O5 AM, an observation of conducted. Resident #42 was nair with a personal care is shoulder. A concave on his bed and a fall mat was he bed. An alarm mat was attress. plan revealed there had been if the falls on 12/24/15, None of the added fall mat or concave mattress.	F 2	80		
	morning meeting. S the incident reports the incident report. stated the MDS coo and was supposed t said her expectation to update the care p morning meeting on 4 b. Resident #42 v 12/15/15. Cumulativ Parkinson's disease	the stated she made notes on with recommendations put on The Director of Nursing rdinator was in the meeting o update the care plan. She was for the MDS coordinator lan during or following the that day. The process of the was admitted to the facility we diagnoses included				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRU	JCTION	(X3) DATE COMF	SURVEY PLETED
		345111	B. WING _			05	/05/2016
PENICK V	ROVIDER OR SUPPLIER			500 EAST F	DRESS, CITY, STATE, ZIP CODE RHODE ISLAND AVENUE RN PINES, NC 28387	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 280	bed mobility, transfer unit, dressing, toilet Supervision was need assistance was need #42 had sustained to assessment. A review of the care plan conference was his family on 12/29/conferences had be there was no docum and/or family had be planning process sin On 5/03/2016 at 2:5 conducted with the I stated the MDS cool invited residents and conference, schedul documented the car interdisciplinary notes stated they had ider conferences not bein The issue was broug previous administration noted. She stated sadministrator of the coordinator in Januar mock survey in Markissue regarding the	red extensive assistance for ers, locomotion on and off the use and personal hygiene. Hedd with eating. Total ded with bathing. Resident wo falls since the last plan revealed that a care is held with Resident #42 and 15. No further care plan en held since that time and mentation that Resident #42 een involved in the care nice 12/29/15. O PM, an interview was Director of Nursing. She redinator was the person who did family members to the care led the care conference and e conference in the ess. The Director of Nursing hitfied the issue of care planing done several months ago. In the informed the new issues with the MDS ary. The facility conducted a children and also identified the lack of timely care planitated a new MDS coordinator	F2	280			
	11/10/15. Cumulativ	s admitted to the facility on ve diagnoses included arthritis and long term use of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345111	B. WING		05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 280	Continued From page	ge 50	F 280		
	11/17/15 indicated interview, had no shimpairment. Modifie with decision-makin A Quarterly MDS da Resident #16 was considered and/or her family under the stated the MDS considered with the stated the MDS considered the call interdisciplinary not stated they had ider conferences not being the issue was broup revious administration of the coordinator in Januar mock survey in Marissue regarding the conferences. She swill begin on May 9, expectation was that a care plan conference admission.	ated 2/17/16 indicated ognitively intact. lical record revealed a care is not held with Resident #16 with 4/22/16. 30 PM, an interview was Director of Nursing. She ordinator was the person who defamily members to the care led the care conference and reconference in the less. The Director of Nursing intified the issue of care plan ing done several months ago. In the attention of the several months ago. In the attention of the lack of timely conducted a chand also identified the lack of timely care plan is tated a new MDS coordinator 2016. She stated her it a new resident should have ince within the first 21 days of			
	5/18/15 with multiple	s admitted to the facility on e diagnoses including The quarterly Minimum Data			

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		1 ' '			(X3) DATE SURVEY COMPLETED	
		345111	B. WING _		0	5/05/2016
NAME OF P	ROVIDER OR SUPPLIER	A BUILDING				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	that Resident #44 h making problems ar The care plan dated of the care plan prol The approaches included assessment quarter total assist with tran lowest position, pad frequently. The incident reports reviewed. The reports reviewed. The reports reviewed. The reports reviewed. The reports reviewed at 6:50 PM, 4/10/16 at 4:00 PM) all the falls were been pommel cushion. On 5/4/16 at 9:45 A Nurse #2 indicated risk for falls. She tri unassisted. She has alert the staff that shed/chair. The MDS Nurse was On 5/3/16 at 2:50 P The DON indicated reviewed in the start had to write the correport and the MDS	ent dated 2/17/16 indicated and memory and decision and had one fall with injury. I 2/17/16 was reviewed. One plems was potential for falls. Ituded to complete a fall risk by and after any fall, needed sfer using a Hoyer lift, bed in at bedside and to check for the last six months were rest indicated that Resident he last six months (11/5/15 at 5:30 PM, 2/29/16 at 6:40 AM, 3/31/16 at 6:00 PM and The corrective actions for dischair alarm, monitoring and and that Resident #44 was a high led to get out of bed/chair d an alarm in bed and chair to the was trying to get out of the was trying to get out of the sective action on the incident Nurse was expected to to reflect the corrective	F 2	280		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY	
		345111	B. WING			05/	05/2016
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE COUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 SS=E	6/26/15 with multiple Dementia. The quart (MDS) assessment did Resident #30 had me problems. Resident #30 had four completed since admit (admission), 10/2/15 and 4/3/16 (quarterly) On 5/2/16, a family in was conducted. The fishe was not invited to planning meeting since to the facility. The ID (interdisciplination since admission and documentation that the was invited to the car Review of the records no care plan sign in son 5/3/16 at 3:15 PM (DON) was interviewed the MDS/care plan nuinterview. She expect document on the ID misgin in sheets that the member was invited to 483.25 PROVIDE CAHIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosol	admitted to the facility on diagnoses including erly Minimum Data Set ated 4/3/16 indicated that mory and decision making or MDS assessments ission to the facility, 7/2/15 (quarterly), 1/2/16 (quarterly). Iterview for Resident #30 family member indicated that to participate in the care be the resident was admitted ary) notes were reviewed there were no fer family of Resident #30 e plan meeting. It is for Resident #30 revealed heets in the chart. If the Director of Nursing ed. The DON indicated that factorize was not available for sted the MDS nurse to notes or on the care plan fer resident or the family of the care plan meeting. RE/SERVICES FOR NG		280			6/2/16

PRINTED: 06/14/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345111	B. WING	 	05/05/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 309	Continued From pag	e 53	F 30	99	
	by: Based on medical reinterview, the facility a pattern of behavior medication refusals recontinued behavioral antipsychotic medications, antidep other medications, antidep other medications. The find Resident #51) review medications. The find Resident #51 was ac 9/11/15 with multiple dementia, anxiety, and Resident #51's admit 9/11/15 indicated Se milligrams (mg) once (antianxiety) 0.5mg to needed (prn) every 6 (antidepressant) 5mg. A review of the Septe Administration Recond #51 received Seroque ordered by the physical An Admission Minimal assessment dated 9/151 had significantly mood or behaviors wassessment period. The assessment period antipsychotic medical antipsych	ressant medications, and rone of five residents wed for unnecessary dings included: Imitted to the facility on diagnoses including and depression. In the facility on diagnoses including and depres		Resident #51 had a new compreh care plan completed on 5-29-16 by MDS Coordinator that includes but limited to risk for refusing medication. Our Pharmacist consultant reviewed medications of resident #51 medicand provide recommendations to the appropriate physician(s) on 5-18-16. Resident # 51 has standing month appointment with visiting psychiatr practitioner which began in April 20. Resident #51 stamily has been in a care plan meeting by MDS Coordinated in documented IN electronic morecord (AOD). All residents have potential to be a by this practice. An audit of all merefusals was conducted on 6-1-16. All full-time, part-time, and PRN Lieunursing staff was in-serviced by Doproper response to refusal of medicand or care, non-baseline behavior reporting, and how care plans reflebaseline behaviors by June 2, 201 licensed staff will be educated during orientation period. Nursing staff wieducated on reporting medication to DON, family, and physician per during above mentioned in-service will monitor any medication refusal ensure appropriate follow-up action occurred. MD will be notified of any	y new is is not on. ed the ations he 3. ly ic nurse 016. nvited to dinator nedical ffected dication censed ON on cations r ect 6. New ng II be refusals policy c. DON ds to ns have

Facility ID: 923395

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345111	B. WING _			05	5/05/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,		
DENION				50	0 EAST RHODE ISLAND AVENUE			
PENICK V	ILLAGE			SC	OUTHERN PINES, NC 28387			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 54	F3	309				
	antidepressant med	dication.			medication refusals in excess of 3			
	-				refusals in a 30 period. Any pattern of			
	The medical record	was reviewed. Resident #51			behaviors or medication refusals will be	e		
	had no care plan in	September 2015.			brought to MD attention immediately to	0		
					determine the need for psych services			
		Note (NPN) dated 9/24/15			DON will perform audit of any medicat	tion		
		#51 refused to get up on three			refusals or behaviors to ensure			
	attempts.				appropriate interventions are in place	and		
	A review of the Oct	ober 2015 MAR revealed			report findings to QA meeting.			
		ed a total of 19 medications on			Agenda and attendance results of abo	N/A		
	3 distinct calendar days. This included 2 refusals				in-services will be shared at the next (
		for Lexapro, and 2 refusals			meeting by DON. In-services on refus			
	for Seroquel.				of medication and or care, non-baselir			
					behavior reporting, and how care plan			
	The medical record	was reviewed. Resident #51			reflect baseline behaviors will be			
	had no care plan in	October 2015.			completed annually moving forward by DON.	y		
	A NPN dated 10/10	/15 indicated resident refused						
	medications.				The Penick Village Nursing Home			
					Administrator (NHA), Director of Nursi	ng		
		/15 indicated Resident #51			(DON) and Minimum Data Set			
	_	f bed that morning and			Coordinator (MDS) will meet weekly for	or		
	refused her antibiot	ic medication.			the next 90 days to review 3 resident			
	A NIDNI dated 10/27	/15 indicated Resident #51			MARs and ensure appropriate			
		of bed and was combative with			interventions are place. Documented findings and completion dates will be			
	_	haviors and refused			reported at the next QA meeting by D0	NC		
	treatment.	naviors and relased			The agenda and the attendance logs to			
					the in-services mentioned above will a			
	A physician's progre	ess note dated 10/28/16			be reported at the next QA meeting. A	And		
		#51 was combative,			In-services on refusal of medications a			
	non-compliant with	taking her medications and			or care, non-baseline behavior reporting	ng,		
		eek. She was combative with			and how care plans reflect baseline			
	_	had refused to get out of bed.			behaviors will be completed annually			
		ndicated to have dementia			moving forward by DON.			
	with behavioral issu	ies.						
	A review of the Nov	rember 2015 MAR revealed						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	1, ,	ATE SURVEY DMPLETED
		345111	B. WING_			05/05/2016
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	4 distinct calendar d for Ativan, 2 refusals for Seroquel. The medical record had no care plan in Nursing Assistant (N Resident #51 had ve behaviors, and had A NPN dated 11/10/ spit out medications had verbal behaviors. A NPN dated 11/11/ refused to get out of A physician's order of increase in Lexapro once daily. A NPN dated 11/13/ family was in the factory over her depressed A NPN dated 11/17/ refused medications. A NPN dated 11/17/ refused medications. A NPN dated 11/17/ refused medications.	d a total of 36 medications on ays. This included 3 refusals for Lexapro, and 3 refusals was reviewed. Resident #51 November 2015. IA) documentation indicated erbal behaviors, physical rejected care. 15 indicated Resident #51, refused each attempt, and s. 15 indicated Resident #51 bed. 20 11/13/15 indicated an from 5mg once daily to 10mg dated 11/13/15 indicated a rom 0.5mg twice daily to 15 indicated Resident #51's sillity and expressed concern and sleepy all of the time. 15 indicated Resident #51 on five attempts.	F3	309		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` ′	ATE SURVEY DMPLETED
		345111	B. WING _			05/05/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	refused medication NA documentation Resident #51 had v behaviors, and had A NPN dated 11/27 refused to get out o staff, and had verba A review of the Dec Resident #51 refus 9 distinct calendar of for Ativan, 6 refusa for Seroquel. The medical record had no care plan in A NPN dated 12/2/ refused medication A NPN dated 12/3/ refused all morning attempts.	/15 indicated Resident #51 s and her breathing treatment. dated 11/27/15 indicated verbal behaviors, physical rejected care. /15 indicated Resident #51 of bed, was combative with all behaviors. cember 2015 MAR revealed ed a total of 87 medications on days. This included 9 refusals is for Lexapro, and 9 refusals.	F3			
	NA documentation Resident #51 had v NA documentation Resident #51 had v	dated 12/12/15 indicated				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· /	OATE SURVEY OMPLETED
		345111	B. WING _			05/05/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	30.00.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	refused all medication A Social Service qualindicated no mood of #51 and no refusals look back period of the task period of the quarterly MDS of 12/23/15 indicated some mood or behaviors of assessment period, the assessment period antipsychotic medical antipsychotic medical antidepressant med. A NPN dated 12/28/requested staff walk there were refusals. NA documentation of Resident #51 had verigected care. A review of the Januare Resident #51 refuse on 9 distinct calendare fusals for Ativan, serfusals for Seroque. NA documentation of Resident #51 had veriged the serior serior was also for Seroque and Care Conference care conference was also for Seroque and Care Conference was also	arterly note dated 12/22/16 oncerns reported by Resident noted during the seven day he quarterly MDS. For Resident #51 dated he was cognitively intact. No were noted during the Medications received during od included seven days of an ation, seven days of an on, and six days of an on, and six days of an or cation. It indicated family had away from Resident #51 if of care or medication. In ated 12/29/15 indicated erbal behaviors and had ary 2016 MAR revealed days. This included 10 or refusals for Lexapro, and 10 l. ated 1/3/16 indicated	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE : COMPL	
		345111	B. WING _		05/0	05/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	1/8/16. There was no prior to 1/8/16. The psychotropic medical Lexapro) with behaving medication refusals. A physician's order of reduction in Ativan 0 0.25mg twice daily for A physician's order of discontinuation of Atifor Resident #51. A pharmacy note data Resident #51 had on medication refusals. request for a Gradual Seroquel 25mg twice. A NPN dated 1/24/16 refused medications. A physician's order of reduction of Seroquel 25mg once #51.	lated for Resident #51 on o care plan for Resident #51 care plan did not address tions (Seroquel, Ativan, and fors that included a pattern of lated 1/15/16 indicated a .5mg twice daily to Ativan or Resident #51. Idated 1/15/16 indicated a van 0.5mg prn every 6 hours lated 1/18/16 indicated a lated 1/18/16 indicated Academy of a lated 1/18/16 indicated a	F3			
	Resident #51 refuse 8 distinct calendar da for Ativan, 8 refusals for Seroquel.	d a total of 93 medications on ays. This included 8 refusals for Lexapro, and 8 refusals was reviewed. The care plan				

PRINTED: 06/14/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/	05/2016
PENICK V	ROVIDER OR SUPPLIER		•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE COUTHERN PINES, NC 28387	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE
F 309	A NPN dated 2/4/16 it to the nurse that Resist to care on their last rown NA documentation da Resident #51 had verbehaviors. NA documentation da Resident #51 had rejumentation da Resident #51 had rejumentation da Resident #51's family at activities. NA documentation da Resident #51 had verrejected care. A review of the March Resident #51 refused on 10 distinct calendarefusals for Ativan, 7 refusals for Seroquel. The medical record was not updated in Managementation da Resident #51 had verbehaviors, and had resident #51 had verbehaviors.	ated 2/3/16 indicated that behaviors, physical ejected care. Indicated NAs had reported dent #51 became resistant bunds. Inted 2/10/16 indicated that behaviors and physical detected care. Inted 2/13/16 indicated etected care. Inted 2/19/16 indicated etected care. Inted 2/19/16 indicated etected care are a total of 108 medications are days. This included 11 refusals for Lexapro, and 7 Inted 3/6/16 indicated etected 3/6/16 indicated etected care.	F	309			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED
		345111	B. WING _			05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, 500 EAST RHODE ISLAND AVE SOUTHERN PINES, NC 283	NUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 309	Continued From page	e 60	F3	09		
	refused NA care, had	ndicated Resident #51 I verbal behaviors, and at included scratching. o refused morning				
	NA documentation da Resident #51 had ver behaviors.	ated 3/8/16 indicated rbal behaviors and physical				
	verbal behaviors and included kicking. Re	ndicated Resident #51 had physical behaviors that sident #51 also refused and morning care from the				
	A NPN dated 3/10/16 refused medications.	indicated Resident #51				
		ote indicated a phone call nt #51's family to schedule a				
	NA documentation da Resident #51 had ve	ated 3/12/16 indicated rbal behaviors.				
		indicated Resident #51 had physical behaviors that behaviors that behaviors that				
	NA documentation da Resident #51 had ve	ated 3/15/16 indicated rbal behaviors.				
		ated 3/23/16 indicated rbal behaviors, physical ejected care.				
	A MDS quarterly note	e dated 3/24/16 indicated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		ONSTRUCTION		ATE SURVEY OMPLETED	
		345111	B. WING _				05/05/2016
NAME OF PE	ROVIDER OR SUPPLIER		•	500	EET ADDRESS, CITY, STATE, ZIP CODE EAST RHODE ISLAND AVENUE UTHERN PINES, NC 28387	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pag	e 61	F3	809			
		nysical and verbal behaviors ily during the MDS review					
	3/24/16 indicated shimpairment. She was behaviors, verbal be one to three days du Medications received period included six dimedication, seven days and included six dimedication.	or Resident #51 dated e had moderate cognitive s indicated to have physical haviors, and rejection of care ring the assessment period. d during the assessment ays of an antipsychotic ays of an antianxiety days of an antidepressant					
	A NPN dated 3/26/16 refused care.	3 indicated Resident #51					
	A review of the April 2016 MAR revealed Resident #51 refused a total of 128 medications on 15 distinct calendar days. This included 16 refusals for Ativan, 8 refusals for Lexapro, and 9 refusals for Seroquel.						
	The medical record was not updated in A	was reviewed. The care plan April 2016.					
		ated 4/5/16 indicated sysical behaviors and had					
		ated 4/7/16 indicated hysical behaviors and other					
		ated 4/9/16 indicated orbal behaviors, physical rejected care.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		345111	B. WING _			05/05/2016
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	agitated, combative of medications. NA documentation do Resident #51 had vere behaviors. NA documentation do Resident #51 had vere rejected care. NA documentation do Resident #51 had vere rejected care. A physician's order do 0.5mg prn every 6 hours at bedtime for Four A physician's order donce at bedtime for Four A physician's order donc	indicated Resident #51 was with staff, and refused all ated 4/10/16 indicated rbal behaviors and physical ated 4/11/16 indicated rbal behaviors and had ated 4/12/16 indicated rbal behaviors and had ated 4/12/16 indicated Ativan burs for Resident #51. ated 4/12/16 indicated an from 5mg once daily to 10mg Resident #51. ated 4/12/16 indicated a on was ordered for Resident #51 had a physical behaviors toward administered. A psychiatric ered. 6 indicated Resident #51 oward staff and refused care	F3	309		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION		SURVEY PLETED
		345111	B. WING _			05	/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			500	EET ADDRESS, CITY, STATE, ZIP CODE EAST RHODE ISLAND AVENUE UTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pag	e 63	F:	309			
		e dated 4/13/16 indicated the spoke with Resident #51's ed to a psychiatric					
	A NPN dated 4/14/16 was administered to	indicated Ativan 0.5mg prn Resident #51.					
	Resident #51 had ref recent increase in be physical, and refusal	note dated 4/15/16 indicated fusals of medications and a chaviors that included verbal, s of care. Resident #51's eduction in Lexapro from aily.					
		ated 4/15/16 indicated a from 10mg at bedtime to tesident #51.					
	A NPN dated 4/17/16 was administered to	indicated Ativan 0.5mg prn Resident #51.					
		ated 4/18/16 indicated rbal behaviors and had					
	A psychiatric consult 4/20/16 for Resident	ation was completed on #51.					
		ated 4/22/16 indicated rbal behaviors and had					
		ated 4/23/16 indicated rbal behaviors and physical					
		indicated nursing staff #51's responsible party (RP)					

NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE	5/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE	
SOUTHERN PINES, NC 28387	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 Continued From page 64 regarding the psychiatric consultation. The RP requested contact with the psychiatric provider. A NPN dated 4/28/16 indicated nursing staff spoke with Resident #51's RP regarding the psychiatric consultation and she agreed to an increase in Lexapro from 5mg to 10mg. A physician's order dated 4/28/16 indicated an increase in Lexapro from 5mg at bedtime to 10mg once daily for Resident #51. NA documentation dated 4/28/16 indicated Resident #51 had verbal behaviors. A NPN dated 4/30/16 Ativan 0.5mg prn was administered to Resident #51. An interview was conducted with the Social Worker (SW) on 5/5/16 at 10:30 AM. The SW indicated that ideally she was informed of residents with behaviors by nursing staff verbally. She stated that sometimes she was informed and sometimes she was not. She stated that if nursing staff reported behaviors to her it was then discussed in the morning meeting. She indicated she had not routinely reviewed behavior documentation. She stated that if a resident was having repetitive behaviors and/or medication refusals she expected to be informed. She indicated that multiple medication refusals were a concern to her. The interview with the SW continued. She stated she was familiar with Resident #51. She indicated staff had informed her of a behavioral incident that occurred with Resident #51 in April. She stated she then completed a referral for a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345111	B. WING			05/	05/2016
NAME OF PR				50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE OUTHERN PINES, NC 28387		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	#51 had a psychiatric weeks ago. She reverse Resident #51 having She indicated she was Resident #51's family medication refusals. aware of medication informed by Resident record of Resident #5 SW. She revealed she the behaviors and medication in October 2011 through April 2016. Shave discussed a psycon with Resident #51 informed of the behaviorals. An interview was con Nursing (DON) on 5/5 indicated that behavior be reported in the dain nursing staff. She state were not reported in the indicated she expected in the stated she was familiar revealed she became behavioral issues and refusals in April. She aware of the behavior medication refusals pshe should have been	ars. She indicated Resident consultation a couple of caled she was unaware of had behaviors prior to April. Is informed in April by that she had some She revealed she was not refusals prior to being the she had not been informed of calcation refusals that initially its and had continued the indicated she would rehiatric consultation early its family had she been viors and medication refusals that initially its family had she been viors and medication ducted with the Director of 6/16 at 10:45 AM. She oral issues were expected to ly morning meeting by ated that medication refusals the morning meeting. She are do not be informed verbally by expetitive medication refusals. The DON continued. She are with Resident #51. She aware of Resident #51's do repetitive medication indicated she was not ral issues and repetitive rior to April. She stated that in informed by nursing staff ssues and medication	F	309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345111	B. WING		05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 312 F 312 SS=D	483.25(a)(3) ADL C DEPENDENT RES A resident who is ur daily living receives	ARE PROVIDED FOR	F 31		6/2/16
	by: Based on record re resident and staff in feed 3 (Residents # residents who need	eview, observation and terview, the facility failed to 18, 11 & 45) of 3 sampled ed extensive assistance or in the staff with eating.		Resident #11 is being fed when the is received. Resident #45 passed away on May 2016. The care plan of resident #18 care has been updated to reflect how the resident prefers to have her meals	23,
	11/19/12 with multip Multiple Sclerosis a Minimum Data Set 2/13/16 indicated th was moderately imp extensive assistance	-		delivered and served by MDS Coordinator. Staff educated on resi preferences on 5-26-16 Dining Service process has been observed by DON several times du different meals. Residents who nee assistance with dining have potentia	ring ed al to be
	of the care plan pro required total or ext	d 3/8/16 was reviewed. One blems was Resident #18 ensive assistance with eating sincluded to assist her with all		affected by this process. The Dinin process for residents who need assistance will be assessed in partr with the nursing team and dining se team. The new process will consist dining services staff member will rep	nership rvice of
	conducted on the si dietary aide was ob to the room of Resid	AM, a dining observation was ration 2 hall. At 11:40, a served to bring the lunch tray dent #18. A continuous and ucted from 11:40 AM until		nursing floor with meals to be delived and a designated nursing assistant assist with the tray delivery ensuring all trays are set up appropriately and residents that need assistance with	will g that d

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED		
		345111	B. WING _		_	05/05/2016
NAME OF P	ROVIDER OR SUPPLIER	_		STREET ADDRESS, CITY, STA	•	0.00.2010
				500 EAST RHODE ISLAND	AVENUE	
PENICK V	ILLAGE			SOUTHERN PINES, NC	28387	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	12:25 PM. There were to enter the room to were 3 nurse's aided (nurse aides) were was helping station PM, 2 NAs were obwhen NA #1 was in were just finished for room. NA #1 stated assistance with eat short 1 NA and that was no staff member rooms. On 5/3/16 at 5:00 udining observation whall. At 5:15 PM, the Resident #18 by a staff member observation what was no staff member observation which was not not not not not not not not not no	was no staff member observed of feed Resident #18. There is working on the hall, 2 NAs in the dining room and 1 NA in 1 to feed residents. At 12:20 observed collecting trays and terviewed, she stated that they reeding residents in the dining in that Resident #18 needed ing. She added that they were it was the reason why there is er feeding residents in their was conducted on station 2 in the dining in the	F3	of resident. Dining sideliver any tray with member present to up. The updated produced and the in-serviced on updated (nursing) and Dietitical After implementing 6-2-16 it will be obsubasis for next 90 dates by DON and the protect the staff at monthly systemic improvem with the dining serve monitor how long it begin eating meal at a ln-services was contained and delivery personnel thas a clear understated.	assist with meal set rocess will be set staff will be ates on 6-2-16 by DON ian (dining services). Ithe new process on served on a regular ays including weekends ocess will be reviewed nursing meetings for ents in partnership rices team. DON will takes for residents to after food is provided. In pleted on 6-2-16 for I Dining Services tray to be sure each person anding of our process and assistance during rector of Nursing ager will observe as several times per	
	She stated that she residents as soon a indicated that they	AM, the DON was interviewed. e expected staff to feed as the tray was served. She were not short of staff. The system in feeding residents.		in a timely fashion. The Penick Village	g followed and that assisted properly and	
	9/24/07 with multipl	s admitted to the facility on le diagnoses including arterly MDS assessment dated		the next 90 days to observation results.	will meet weekly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		-	(X3) DATE SURVEY COMPLETED			
		345111	B. WING _		_	05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S 500 EAST RHODE ISLAND SOUTHERN PINES, NC	D AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)	
F 312	and decision makin extensive assistance. The care plan dated of the care plan progrequired total care wapproaches was to meals. On 5/2/16 at 11:35 conducted on the sidetary aide was obto the room of Resi observation was conducted on the room of Resi o	anat Resident #11 had memory g problems and needed be with eating. d 2/26/16 was reviewed. One oblems was Resident #11 with eating. One of the feed the resident with all AM, a dining observation was tation 2 hall. At 11:40, a observed to bring the lunch tray dent #11. A continuous of the feed Resident #11. There are sworking on the hall, 1 NA from with a trainee and 2 NAs 2) were on the hall feeding	F3	the next QA meeti agenda and the at	ng by DON. The ttendance logs from th oned above will also be	
	On 5/5/16 at 8:30 A She stated that she residents as soon a indicated that they	erified that Resident #11 with eating. MM, the DON was interviewed. e expected staff to feed as the tray was served. She were not short of staff. The system in feeding residents.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COMPLETED
		345111	B. WING		05/05/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	, 00000000
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 312	Continued From pa	ge 69	F 3	12	
	12/17/13 with multip Vascular Dementia assessment dated of Resident #45 had r problems and was with eating. The care plan dated	s admitted to the facility on ple diagnoses including . The quarterly MDS 3/11/16 indicated that nemory and decision making totally dependent on the staff			
	required total care	oblems was Resident #45 with eating. One of the feed the resident with all			
	conducted on the s dietary aide was ob to the room of Resi observation was co 12:25 PM. There w to enter the room to were 2 nurse's aide was in the dining ro	AM, a dining observation was tation 2 hall. At 11:40, a served to bring the lunch tray dent #45. A continuous inducted from 11:40 AM until was no staff member observed of feed Resident #45. There is working on the hall, 1 NA som with a trainee and 2 NAs 2) were on the hall feeding			
	supposed to have 4 1 NA from station 2 On 5/2/16 at 12:26	#3 stated that they were NAs but they were short 2 so came to help feed residents. PM, NA # 4 was interviewed.			
	She stated that the	y have 4-5 feeders on the hall. y tried their best to feed erified that Resident #45 with eating.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345111	B. WING		05/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 312	Continued From page	2 70	F 312	2	
F 323 SS=D	She stated that she e residents as soon as indicated that they we NAs did not have a sy 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensuenvironment remains as is possible; and ear	the tray was served. She ere not short of staff. The ystem in feeding residents. ACCIDENT SION/DEVICES are that the resident as free of accident hazards	F 323		6/2/16
	by: Based on record revi interview, the facility f effective intervention (Resident #44) of 3 sa accidents. Findings in Resident #44 was add 5/18/15 with multiple Vascular Dementia. Set (MDS) assessme that Resident #44 had making problems and	mitted to the facility on diagnoses including The quarterly Minimum Data nt dated 2/17/16 indicated memory and decision had one fall with injury. indicated that Resident #44		Fall risk assessment for resident #4 completed by DON on 61-16. Interventions will be updated on care Care plan was updated to address fa prevention protocols by 6-2-16. A care plan conference with the fami responsible party was scheduled by coordinator For residents who may have been affected by this deficient practice, residents who are at risk for falls were identified, interventions were reviewed and care plans were updated as necessary. DON will perform audit or residents at risk for falls by 6-2-16 are	e plan all ly / MDS re ed
	The care plan dated 2	2/17/16 was reviewed. One		ensure interventions are in place on	iu

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345111	B. WING		05/	05/2016
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY)	BE	(X5) COMPLETION DATE
F 323	of the care plan prob The approaches incluses assessment quarterly total assist with trans lowest position, pad a frequently. The incident reports a reviewed. The report indicated that the resign front of the wheeld were ensure chair ala and pommel cushion report dated 1/12/16 Resident #44's alarm on the floor. A skin to forearm. The correct the alarm and monitor dated 2/29/16 at 6:40 resident was found on the corrective action alarm and monitoring at 6:50 PM indicated wheelchair to the floor were continue with cloom pommel cushion. The 6:00 PM revealed that the floor mat. The continue bed alarm and dated 4/10/16 at 4:00 resident was on the floor was sent for the sent assessed, the leg so she was sent for the sent assessed, the leg so she was sent for the sent assessed action were precaution.	lems was potential for falls. Unded to complete a fall risk y and after any fall, needed ifer using a Hoyer lift, bed in at bedside and to check for the last six months were t dated 11/5/15 at 5:45 PM ident was found on the floor hair. The corrective action arm in place and functioning was properly placed. The at 5:30 PM indicated that a went off and found resident ear was noted to the left tive action were to continue oring of resident. The report at AM indicated that the an the floor beside the bed. were continue bed/chair by. The report dated 3/12/16 that the resident slid out of or. The corrective actions thair alarm, monitoring and the report dated 3/31/16 at the tresident was found on corrective actions were and monitoring. The report to PM revealed that the floor next to her wheelchair. The with no fracture. The	F 323	resident and on care plan DON and MDS coordinator will review residents who are at risk for falls daily and update interventions and care plates as necessary on an on-going basis. The Penick Village Nursing Home Administrator (NHA), Director of Nurse (DON) and Minimum Data Set Coordinator (MDS) will meet weekly the next 90 days to review residents are at risk for falls documented findin will be reported at the next QA meetin DON.	/ for ans ing for who gs	

			· ,	(X3) DATE SURVEY COMPLETED		
		345111	B. WING _		0;	5/05/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
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F 323	On 5/4/16 at 9:45 AM Nurse #2 indicated the risk for falls. She trie unassisted. She had alert the staff that she bed/chair. On 5/3/16 at 2:50 PM The DON indicated the reviewed in the stand had to write the correct report and the MDS Nervise the care plan to actions/interventions. Resident #44 were becushion. 483.25(n) INFLUENZ IMMUNIZATIONS The facility must deverthat ensure that (i) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is of immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the resident or the immunized of the immuniced of the i	It the DON was interviewed. If the DON was i		334		6/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345111	B. WING		,	05/05/2016
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	•	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			SHOULD BE	(X5) COMPLETION DATE	
F 334	documentation that following: (A) That the reside representative was the benefits and pot immunization; and (B) That the reside influenza immunizati influenza immunizati contraindications or The facility must der that ensure that — (i) Before offering th immunization, each legal representative the benefits and pot immunization; (ii) Each resident is immunization, unless medically contraindial already been immunication; and (iv) The resident or trepresentative has the immunization that following: (A) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) That the reside representative was the benefits and pot pneumococcal immunication; and (iv) The resident in the re	nedical record includes indicates, at a minimum, the ont or resident's legal provided education regarding ential side effects of influenza on the either received the ion or did not receive the ion due to medical refusal. In the either received the ion or did not receive the ion due to medical refusal. In the either received the ion or did not receive the ion due to medical refusal. In the ion or did not receive the ion due to medical resident, or the resident's receives education regarding ential side effects of the ion offered a pneumococcal so the immunization is cated or the resident has nized; the resident's legal the opportunity to refuse the indicated, at a minimum, the interesident's legal provided education regarding ential side effects of unization; and intelether received the unization or did not receive mmunization due to medical	F 33	34		

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/05/2016	
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP COI 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	CODE		
(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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 334	and practitioner recording pneumococcal immury years following the fir immunization, unless the resident or the refuses the second in	based on an assessment mmendation, a second nization may be given after 5 st pneumococcal medically contraindicated or sident's legal representative	F 3:	34			
	by: Based on record rev facility failed to offer a and pneumococcal v 49, #77 & #56) of 5 s Findings included: The facility's policy of Pneumococcal Vacci 2013 were reviewed. policy read in part "I received the influenze in the last 12 months year's flu season and to the eggs, Gentamy Polymyxin, Thimeros immunization shall be along with education potential side effects immunization shall th resident and docume form on the resident's charting system. " The Pneumococcal In part " prior to offering immunization, each r legal representative s	iew and staff interview, the and to administer influenza accines to 3 (Residents # ampled residents reviewed. In Influenza and nation dated November, The Influenza Vaccination of the resident had not a immunization/vaccination and or during the current the resident was not allergic vain Sulfate, Neomycin, of or Sodium Bisulfate, the e offered to the resident regarding the benefits and of the immunization. The en be provided to the neted on the immunization is record and in the electronic immunization policy read in		The charts of residents #49, were audited to ensure that a vaccines were offered, given already received by DON Ad ensuring that residents who is refused vaccination at Penicitheir loved ones were educated vaccine safety and efficacy. The residents were offered vaccine documented in AOD Our DON and Admissions Complete an audit of all exist to ensure that appropriate vaccines and information doctors and information doctors. AOD in Residents who received by 6-8-16. All residents have not had vaccines have vaccine and information doctors. Residents who received vaccination at Penicitheir loved ones were educated vaccine safety and efficacy. Will be documented in AOD monitor and audit to ensure vacfiered and documented in AOD monitor and audit to ensure vacfiered and documented in AOD.	appropriate a, refused, or ditionally received or k Village and ted on The above nes. Results coordinator will ing residents accines were ready ents who been offered umented in ived or k Village and ted on Information DON will vaccines are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
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Littore	TELAGE			S	OUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pag	e 75	F3	334			
F 334	of the immunization. pneumococcal immu immunization was m the resident had alre medical record shall resident's legal repreducation regarding side effects of pneum that the resident eith pneumococcal immudue to medical control. Resident # 49 was 1/15/16. The immun medical record and to Resident #49 were reform both on the medical records we and pneumococcal versident had not record on 5/5/16 at 8:30 AM (DON) was interviewed the infection control interview. She state infection control nursimmunization form borecords and on the elimmunizations were refused. The DON finot find documentation influenza and pneumodministered to Resident #49 was nursing facility and the administered the immunitation that the indicated the immunication indicated the indicated that the resident had the indicated the immunication indicated the indicated that the resident had the indicated the immunication indicated the indicated the indicated that the resident had a the resident was not shown in the records and on the eliministered to Resident had the records and pneumodministered to Resident had the indicated the immunication in the records and pneumodministered the immunication in the records and pneumodministered the immunication in the records and pneumodministered the immunication in the records and the records	Residents shall be offered a nization, unless the edically contraindicated or ady been immunized. The reflect that the resident or esentative was provided the benefits and potential nococcal immunization and er received the nization or did not receive it aindication or refusal. " Is admitted to the facility on ization form on the resident's he electronic records for eviewed. The immunization dical record and the ere blank for the influenzal faccine indicating that the eleved both immunizations. If, the Director of Nursing ed. The DON indicated that nurse was not available for did that she expected the electronic records the date the administered or had been curther stated that she could on that the immunizations for nococcal vaccines had been dent #49. The DON added as admitted from other ne facility might have nunizations to the resident at the infection control nurse ne facility on admission to		334	Our Admissions Coordinator will revie new admission paperwork for vaccine information. Consent will obtained an education provided for residents choot to receive a vaccine at Penick Village Residents deciding to refuse the vaccivill sign a refusal form which will be documented. Vaccines will be administered and data on vaccine administration or refusal will be documented in AOD. Our Admissions Coordinator will perform monthly audiensure all residents have current flu apneumococcal vaccines or a refusal document on file. Infection Control Nuwill offer and administer vaccines yearly. DON will monitor to ensure vaccines are given with a weekly audithe next 90 days. The Penick Village Nursing Home Administrator (NHA), Director of Nursi(DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review vaccine day and ensure vaccines are up to date.	d sing	

PRINTED: 06/14/2016 FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE Descriptor SUMMARY STATEMENT OF DEPCISICIES SUMMARY STATEMENT OF DEPCISION SUMMARY STATEM	` '		IDENTIFICATION NUMBER:				l' '	
PENICK VILLAGE (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG)			345111	B. WING			05/	05/2016
Continued From page 76 Continued From page	NAME OF PI	ROVIDER OR SUPPLIER		•			-	
FREETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 334 Continued From page 76 2. Resident #77 was admitted to the facility on 2/9/16. The immunization form on the resident's medical record and the electronic records for Resident was interviewed. The immunizations or interview. She stated that she expected the infection control nurse was not available for influenza and pneumococcal vaccines influence that the immunizations were administered or had been administered to Resident #77. The DON added that Resident #77.	PENICK V	ILLAGE						
2. Resident #77 was admitted to the facility on 2/9/16. The immunization form on the resident's medical record and the electronic records for Resident #77 were reviewed. The immunization form both on the medical record and the electronic records were blank for the influenza and pneumococcal vaccines indicating that the resident had not received both immunizations. On 5/5/16 at 5:30 AM, the Director of Nursing was interviewed. The DON indicated that the infection control nurse was not available for interview. She stated that she expected the infection control nurse was not available for interview. She stated that she expected the infection control nurse was not available for interview. She stated that she expected the immunization form both on the resident's medical records and on the electronic records the date the immunizations were administered or had been refused. The DON further stated that she could not find documentation that the immunizations for influenza and pneumococcal vaccines had been administered to Resident #77. The DON added that Resident #77 was admitted from other nursing facility and the facility might have administered the immunizations to the resident but she indicated that the infection control nurse should have called the facility on admission to verify this information. 3. Resident #56 was admitted to the facility on 9/14/15. The immunization form on the resident's medical record and the electronic records for Resident #56 were reviewed. The immunization form both on the medical record and the electronic records for Resident #56 were reviewed. The immunization form both on the medical record and the electronic records were blank for the pneumococcal vaccine indicating that the resident had not received the immunization. On 5/5/16 at 8:30 AM, the Director of Nursing	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
infection control nurse was not available for	F 334	2. Resident #77 was 2/9/16. The immunized medical record and the Resident #77 were reform both on the medical pneumococcal varies dent had not receous on 5/5/16 at 8:30 Alwas interviewed. The infection control nurs interview. She stated infection control nurs immunization form both records and on the elimmunizations were a refused. The DON funct find documentation influenza and pneum administered to Resident #77 was nursing facility and the administered the immunitation of the indicated that should have called the verify this information. 3. Resident #56 was 9/14/15. The immunimedical record and the Resident #56 were reform both on the medical record we pneumococcal vaccin had not received the On 5/5/16 at 8:30 Alwas interviewed. The	admitted to the facility on ration form on the resident's ne electronic records for eviewed. The immunization dical record and the ere blank for the influenza recines indicating that the evived both immunizations. If the Director of Nursing the DON indicated that the ere was not available for dict that she expected the ere to document on the oth on the resident's medical electronic records the date the readministered or had been for that the immunizations for records admitted from other refacility might have the infection control nurse refacility on admission to the resident's ne electronic records for eviewed. The immunization dical record and the record and the record indicating that the resident immunization. If, the Director of Nursing the DON indicated that the	F	334			

interview. She stated that she expected the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/	05/2016
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	-		
PREFIX (EACH DE	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
immunization records and or immunizations refused. The not find docum pneumococca administered to	ol nurse form bo n the el s were a DON fu nentation I vaccin so Resio	e to document on the ofth on the resident's medical ectronic records the date the administered or had been of the stated that she could on that the immunization for the had been offered or dent #56.		334			
SS=E SPREAD, LIN The facility mu Infection Cont safe, sanitary to help preven of disease and (a) Infection C The facility mu Program unde (1) Investigate in the facility; (2) Decides wi should be app (3) Maintains a actions related (b) Preventing (1) When the l determines the prevent the sp isolate the res (2) The facility communicable from direct con direct contact	ens ust esta rol Progrand cor it the ded infection ontrol Fust esta er which is, continued to infection in the infection of t	Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions.	F	441			6/2/16

	ID DI AN DE COPPECTION IDENTIFICATION NI IMPED		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		0	5/05/2016	
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 4-	DEFICIENCY)	f the skin e s will be sylactically staff, completed esidents, ucated on inpleted by nave been 2-16 1		
	dated 1/22/16 and the dated 4/23/16 indicate short term memory primpairment in decision assessments also incompasses as receiving oint methan to feet under the The facility's policy or	dicated that Resident #49 Ints and medications other Skin/ulcer treatment. In infection control dated In the policy did not address		treated. no reported symptoms onset of scabies reported by st We have developed a new active a scabies outbreak response to treatment of new outbreaks and by staff. All staff members and will be prophylactically treated education on care of linen and family members. Staff educated importance of reporting any new to MD immediately. All staff members.	aff. on plan for or include d response residents with exposed d on w symptom		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345111	B. WING			05/	/05/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				50	00 EAST RHODE ISLAND AVENUE		
PENICK V	ILLAGE			s	OUTHERN PINES, NC 28387		
(V4) ID	QUMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
F 441	Continued From page	e 79	F	441			
		dated 4/21/16 at 1:43 PM			including part-time and PRN staff will	he	
	indicated that the res				in-serviced on the new action plan and		
		th new orders for (brand			necessary procedures and precaution		
		ream to the body twice a day			6-2-16. All infections will be tracked a		
		ntment (topical corticosteroid			they are discovered by infection nurse		
	I .	nation) twice a day for 14			Current Infection Control policies will be		
	I .	r day at bedtime to red and			reviewed and updated by 6-2-16 by D		
	itchy rash. The notes	s dated 4/27/16 at 9:16 PM			Staff will be in-serviced on any change	es	
	indicated that the der	matology clinic had called			by 6-2-16.		
	the facility and notifie	d the nurse that Resident					
	T	scabies. The attending			The Penick Village Nursing Home		
	physician was notified			Administrator (NHA), Director of Nursi	-		
	1	cabicidal agent), apply from			(DON) will meet weekly until at least 6		
	I .	for 10 hours and wash off,			months after the last confirmed case to		
	'	Ivermectin (anti parasite			review each and every potential case	and	
		gs), take 3 tablets by mouth.			treatment plan.		
	#49 on contact isolati	dered also to put Resident			All infections and infectations along wi	th.	
		topathology report revealed			All infections and infestations along with the corresponding treatment plans and		
		s obtained from the left palm			any outbreak prevention measures take		
		lder of Resident #49 on			will be reported in the QA meetings by		
		of the biopsy was reported to			DON.		
		and the diagnosis was			20.11		
	scabies.	3					
	On 5/2/16 at 10:30 A	M, Resident #49 was					
	observed. She was s	sitting in a wheelchair in her					
	room. There was a co	ontact precaution sign on the					
	door and an isolation	cart outside the door.					
	On 5/2/16 at 10:35 A						
		ted that the facility had one					
		She indicated that Resident					
	1	precaution due to scabies.					
		M, NA #1 was interviewed.					
		sident #49 was taken off					
		nd 2 other residents (rooms					
	,	oted to have rashes and					
	1	tion on 5/3/16. NA #1 further					
		members had developed					
	Trasnes just before the	e resident was diagnosed					

NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	(X5) COMPLETION
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with scables. All staff members who worked on the hall where Resident #49 had resided were treated with Elimite cream on 4/29/16, 2 days after Resident #49 was diagnosed with scables. On 5/3/16 at 10:35 AM, Nurse #2 was interviewed. He stated that he worked 7A-7P on the hall where Resident #49 had resided. He indicated that the resident had the rashes for months and was treated with cream. The resident had been to the dermatology clinic in the past and on 4/21/16, the clinic did the scraping and the result was scables. He confirmed that he developed rashes right after the resident was diagnosed with scables and he received Elimite cream on 4/29/16. On 5/3/16 at 10:36 AM, NA #2 was interviewed. She stated that she worked on the hall where Resident #49 had resided. She confirmed that she developed rashes just before the resident was diagnosed with scables and she was treated with Elimite cream on 4/29/16. On 5/4/16 at 8:30 AM and at 2:55 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the infection control nurse was not available for interview. She indicated that the facility had no policy that was specific for scables. She stated that after Resident #49 was diagnosed with scables, the attending physician and the health department were notified. The attending physician had ordered Elimite cream and Ivermectin for the resident. The health department advised them to disinfect the room and to wash all clothing and linens in the room. The physician ordered not to treat other residents unless they were symptomatic. The DON indicated that she did not do an investigation on how the resident acquired the scables. The DON also indicated that she did not do an investigation on how the resident acquired the scables. The DON also indicated that she did not do an investigation on how the resident acquired the scables. The DON also indicated that she did not do an investigation on how the resident acquired the scables. The DON also indicated that she did not do an investigation on how the resident acq	

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F 441	Continued From page	e 81	F 44	41		
	spread of scables to	other residents and staff. taff members were treated	F 44	1 1		