STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment after a significant change in activities of daily living (ADLs) for 1 of (Resident #58) 3 residents review for ADLs. Findings included: Resident #58 was admitted 12/12/16 with cumulative diagnoses of depression, Post-Traumatic Stress Disorder (PTSD), anxiety, spinal stenosis and vascular dementia. Resident #58's admission Minimum Data Set (MDS) assessment dated 12/19/16 indicated the following regarding his ADL function: -limited assistance with bed mobility including one person physical assistance -limited assistance with transfers including two person physical assistance -supervision walking in his room with one person physical assistance	F 274	This corrective action plan will serve as Penick Village's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long-term care facilities as of November 19, 2009. F 274 Comprehensive Assessment After Significant Change 1. Minimum Data Set (MDS) Coordinator completed a new comprehensive assessment due to a significant change for resident # 58 on May 1, 2017. 2. All residents have the potential to be affected by this practice. The MDS Coordinator, Director of Nursing (DON) and Licensed Nursing Home Administrator (NHA) will review the comprehensive MDS assessments on all current residents to assure accuracy. Three potential residents were identified. None met the criteria for a significant change.	5/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/19/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 1 -walking in the corridor did not occur -locomotion on the unit required supervision of one person physical assistance -locomotion off the unit required supervision with no physician assistance -limited assistance dressing with one person physical assistance -eating was independent with no person physical assistance-set up only -limited assistance toileting with one person physical assistance -limited assistance personal hygiene with one person physical assistance -total dependent bathing with one person physical assistance -occasionally incontinent of bladder -always continent of bowel Resident #58's quarterly MDS assessment dated 3/21/17 indicated the following regarding his ADL function: -extensive assistance with bed mobility with two person physical assistance -extensive assistance with transfers including two person physical assistance -walking in the room did not occur -walking in the corridor did not occur -locomotion on the unit required extensive one person physical assistance -locomotion off the unit required limited assistance of with one person physical assistance -extensive assistive assistance dressing with two person physical assistance -limited assistance eating with one personal physical assistance -extensive assistance toileting with two persona physical assistance -extensive assistance personal hygiene with two	F 274	The update process will be complete before the end of the day on Thursday, May 25, 2017. 3. Our MDS Coordinator attended a regional Resident Assessment Instrument (RAI) training in Raleigh, NC on April 16-19. The training was presented by the American Association of Nurse Assessment Coordination. Our DON and MDS Coordinator led an in-service for the staff on Thursday, May 11, 2017. The in-service focused on documentation of the Activities of Daily Living (ADL) and the importance of clearly communicating any changes in resident behaviors or conditions to the MDS Coordinator. The following measure will be put in place to ensure that the deficient practice will not occur will be that Penick Village's Interdisciplinary Care Plan Team (ICPT) will meet weekly with the following materials: list of current residents, incident reports from last meeting, weight sheets, hospice admissions, new diagnoses, MDS Evaluation list from the last meeting and wound log. The following agenda will be used each week in this meeting: a review of all residents (utilizing the materials from above, a review of all current residents will be conducted to evaluate for significant changes, and any resident evaluated that has had a significant change will be documented in the Care Plan Meeting minutes by the DON and/or MDS Coordinator and a new comprehensive assessment will be completed); list of residents' assessment needs; a review of assessments completed; Care Plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 2 person physical assistance -total dependence bathing with two person physical assistance -always incontinent of bladder -frequently incontinent of bowel In an interview on 4/26/17 at 3:31 PM, the MDS nurse stated she began her job November 2016. Since that time she and attended the state training February 2017 and attending another training last week. Resident #58's quarterly MDS dated 3/21/17 was coded as reflected in his ADL charting for the seven day look back period. She stated as part of her MDS assessment, she reviewed the medical record and talked to staff. She stated the staff reported he was at his admission baseline. A review of Resident #58's medical record revealed he had not been treated for a urinary tract infection since admission. He had lost five pounds and developed a stage two pressure ulcer on 3/18/17 which healed on 4/18/17. In an interview on 4/27/17 at 9:53 AM, the Rehabilitation Manager stated Resident #58 had" really gone downhill" and had stopped walking with therapy in February at the time of discharge 2/9/17. In an interview on 4/27/17 at 10:45 AM, the Director of Nursing (DON) stated she did not feel Resident #58 had experienced an actual decline in his ADLs but rather the admission MDS dated 12/19/16 was coded inaccurately. She stated it was her expectation that a significant change MDS be completed if there was a decline in Resident #58 functional status that was not self-limiting after 14 days.	F 274	review and any updates will be documented by the MDS Coordinator; resident and family meetings to review Care Plans; review who will be assessed in the next weekly meeting; and ensure invitations have been sent to residents/families for upcoming meeting. 4. To monitor Penick Village's performance to assure that solutions are sustained, the following steps will occur: Weekly ICPT minutes, prepared by the DON or MDS Coordinator, will be reviewed by the Licensed Administrator to review for any significant changes; A weekly meeting will be held with the Licensed Administrator, DON, MDS Coordinator, Social Worker, a nurse and an Elder Assistant (Penick Village's Certified Nursing Assistant) to review any significant changes in the residents. Administrator will work with DON and MDS Coordinator to compare any residents identified with the ICPT to assure congruency. Using the audit tool created by the DON, there will be a weekly audit completed by the DON to assure compliance with any needs for a significant change that triggers a comprehensive Minimum Data Set assessment for 12 months and periodically thereafter. DON's results to be reviewed monthly by the Licensed NHA; A monthly and quarterly Quality Assurance (QA) Report will be created from the ICPT Meeting minutes by the NHA and will include the following: any ICPT meeting issues that needed to be addressed; results from the meetings with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 3	F 274	the Licensed Administrator, DON, MDS Coordinator, Social Worker, a nurse and an Elder Assistant that led to significant changes; number of Annual Assessments; number of Quarterly Assessments; number of Admission Assessments; number of Significant Change Assessments and why the significant change assessment was triggered, will be included; results from the DON's audit; any Plan of Care that includes Resident Choice of refusal of safety and medical interventions.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set Assessment in the areas of medication (Resident #39, #3, #20, #42), falls (Resident #46), diagnosis (Resident #3, #58) and hospice (Resident #65) for seven of fourteen sampled residents. The findings included: 1. Resident #39 was admitted to the facility 1/27/16. Cumulative diagnoses included: anxiety disorder, depression and insomnia. An Annual Minimum Data Set (MDS) assessment dated 2/3/17 indicated Resident #39 was cognitively intact. A review of the medications administered during the seven day look back period (1/28/17-2/3/17) indicated Resident #39 had not received any antianxiety medication during the seven day look back period. A review of physician orders revealed an order for Xanax (medication used for treatment of anxiety) 0.25 milligrams twice daily and Xanax 0.25 milligrams daily as needed for agitation/ anxiety. A review of the Medication Administration Record	F 278	F 278 Assessment Accuracy 1. Minimum Data Set Assessments for Residents #39, #3, #20, #42, #46, #3, #58, & #65 were all reviewed by the DON, MDS Coordinator, Clinical Manager, Staff Development Nurse and RN Supervisor by May 15, 2017. Corrections will be completed by May 25, 2017. 2. All residents have the potential to be affected by this practice. The Interdisciplinary Care Plan Team (ICPT) will audit all residents to assure that the most recent assessment (17 quarterly, 6 comprehensive and 3 PPS) reflects current condition and accurately reflects the lookback period for each resident. Of the 26 audited, 11 quarterly assessments and one comprehensive assessment required modifications were completed by the MDS Coordinator by May 25, 2017 by the MDS Coordinator. 3. The measures put into place to ensure that the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 (MAR) for the look back period of 1/28/17-2/3/17 revealed Resident #39 received Xanax on 1/28/17, 1/29/17, 1/30/17, 1/31/17, 2/1/17, 2/2/17 and 2/3/17. On 4/26/17 at 10:57AM, an interview was conducted with the MDS Coordinator who stated she began completing the MDS's in November 2016. She reviewed the MAR for the seven day look back period 1/28/17--2/3/17 and said she should have coded anxiety medication for 7 days. She stated she just overlooked it. On 4/26/2017 at 4:38PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate. 2. a. Resident #3 was admitted to the facility on 3/30/11. Cumulative diagnoses included impulse control disorder, depression and anxiety. A review of the Quarterly MDS dated 3/4/17 revealed section I for diagnosis did not indicated that Resident #3 had a diagnosis of depression or anxiety. Medications administered during the seven day look back period indicated Resident #3 received seven days of antianxiety medication. On 4/27/17 at 2:25PM, an interview was conducted with the Director of Nursing who stated she expected the diagnoses to be accurate on the MDS and depression, anxiety and impulse control disorder should have been documented in Section I. b. Resident #3 was admitted to the facility on 3/30/11. Cumulative diagnoses included impulse control disorder, depression and anxiety.	F 278	occur will be executed by Penick Village's ICPT during their weekly meeting led by the DON. In addition to the daily clinical and stand-up meetings, weekly ICPT minutes, prepared by the DON or MDS Coordinator, will be reviewed by the Licensed NHA. Any Care Plan updates will be completed by the MDS Coordinator. In addition to the MDS Coordinator attending the Resident Assessment training in Raleigh April 16-19, 2017, she also was educated by the Licensed NHA and Chief Executive Officer on Thursday, May 18, 2017. The MDS 3.0 RAI User's Manual was used as a teaching tool. The following materials will be utilized: List of all current residents; Incident reports from last meeting; Weight sheets; Hospice Admissions; New Diagnoses ; Medication changes from the last meeting and Wound report. The follow agenda will occur each week: A review of all residents (Utilizing the materials from above, a review of all current residents to evaluate for significant changes); List of Residents' assessment needs; A review of assessments completed; Plan of Care review and updates (Identify any residents/families who have made choices to refuse any safety or medical interventions and assure Plan of Care and progress notes reflect Resident/Family wishes); Resident and Family meetings to review Plan of Care; Review who will be assessed the next week and ensure Invitations sent to residents/families for upcoming meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 A Quarterly MDS dated 3/4/17 indicated Resident #3 was severely impaired in cognitio0n. A review of the medications administered during the seven day look back period (2/26/17-3/4/17) indicated Resident #3 had not received any antipsychotic or antidepressant medication during the seven day look back period. A review of physician orders revealed the following medications: Chlopromazine (antipsychotic medication) 100 milligrams by mouth every morning and Fluoxetine (antidepressant medication) 10 milligrams by mouth every bedtime. A review of the MAR for the look back period (2/26/17-3/4/17) revealed Resident #3 received Chlorpromazine and Fluoxetine on 2/26/17, 2/27/17, 2/28/17, 3/1/17, 3/2/17, 3/3/17 and 3/4/17. On 4/27/17 at 2:25PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate and the medications should have been documented on the MDS. 3. Resident #20 was admitted to the facility on 10/11/15 and readmitted 4/12/17 following a hospitalization for pneumonia. An Admission MDS dated 4/20/17 indicated Resident #20 was cognitively intact. A review of the medications administered during the seven day look back period (4/14/17-4/20/17) indicated Resident #20 did not receive any antibiotics during the seven day look back period. A review of physician orders dated 4/12/17	F 278	4. To monitor Penick Village's performance to assure that solutions are sustained the following steps will occur: A weekly audit, with the audit tool created by the Staff Development Nurse, will be completed by the Staff Development Nurse to assure compliance with any assessment inaccuracy for 12 months and periodically thereafter. A weekly meeting will be held with the Licensed NHA, DON, MDS Coordinator, Social Worker, nurse and Elder Assistants to review any concerns with assessment accuracy. The minutes will be taken by the Staff Development Nurse and will include: Meeting attendees; Residents reviewed and assessed and any new assessments completed and Families who attended. Administrator will work with DON and MDS Coordinator to compare any residents identified with the ICPT to assure congruency. Weekly ICPT minutes will be reviewed by the Licensed NHA to review for any assessment accuracy. Staff Development Nurse's results will be reviewed monthly with Licensed NHA and reviewed in QA meeting. A monthly and quarterly Quality Assurance Report will be created from the ICPT to include the following: Any ICPT meeting issues that needed to be addressed; Results from the meetings from the Licensed NHA, DON, MDS Coordinator, Social Worker, a nurse and an Elder Assistant that identify any concerns regarding assessment accuracy; Number of Annual Assessments; Number of Quarterly Assessments; Number of Admission Assessments; Results from the Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 revealed an order for Amoxicillin Clavulanate (antibiotic) 875-125 milligrams one tablet by mouth every 12 hours x 5 days. A review of the April MAR revealed Resident #20 received Amoxicillin Clavulanate on 4/14/17, 4/15, 17, 4/16/17 and 4/17/17 (four days). On 4//27/2017 at 9:50AM, an interview was conducted with the Director of Nursing. She reviewed the April MAR and stated the antibiotic should have been coded for 4 days during the seven day look back period. 4. Resident #58 was admitted 12/12/16 with cumulative diagnoses of depression, Post-Traumatic Stress Disorder (PTSD), anxiety, spinal stenosis and vascular dementia. A review of Resident #58's most recent psychiatric progress note dated 1/20/17 read to continue his Zoloft (antidepressant) for is depression and his Seroquel (antipsychotic) for PSTD. His quarterly Minimum Data Set (MDS) dated 3/21/17 indicated severe cognitive impairment with no behaviors. Resident #58 was coded as taking an antidepressant medication and an antipsychotic medication. He was not coded for depression or PTSD on his MDS dated 3/21/17. In an interview on 4/26/17 at 3:31 PM, the MDS nurse stated Resident #58's quarterly MDS dated 3/21/17 was coded inaccurately and should have included his diagnoses of depression and PTSD. In an interview on 4/26/17 at 3:45 PM, the Director of Nursing (DON) stated it was her	F 278	Development Nurse's audit; and Any Plan of Care that includes Resident Choice of refusal of safety and medical interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8	F 278		

expectation that the quarterly MDS dated 3/21/17 be coded to include Resident #58's diagnoses of depression and PTSD.

5. Resident #46 was admitted 10/10/16 with cumulative diagnoses of metabolic encephalopathy, dementia, cerebral vascular accident (CVA) with hemiplegia.

A review of the facility incident logs indicated Resident #46 sustained a fall on 2/6/17, 2/21/17, 2/28/17 and 4/6/17.

The quarterly MDS dated 4/19/17 indicated Resident #46 had severe cognitive impairment and was coded as have no falls since the last MDS assessment on 1/17/17.

In an interview on 4/26/17 at 3:31 PM, the MDS nurse stated Resident #46's quarterly MDS dated 4/9/17 was coded inaccurately and should have included the four falls that occurred since her last MDS assessment on 1/17/17.

In an interview on 4/26/17 at 3:45 PM, the DON stated it was her expectation that the quarterly MDS dated 4/19/17 would have been coded to include Resident #46's four falls since her last MDS assessment.

6. Resident #42 was admitted on 6/19/15. Cumulative diagnoses included: dementia with psychosis, depression, and agitation.

The comprehensive annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) 3/27/17 indicated Resident #42 had cognitive loss. A review of the medications administered during the seven day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9	F 278		

look back period (3/21/17 through 3/27/17) indicated Resident #42 had not received any antipsychotic medication during the seven day look back period.

A review of the physician orders for Resident #42 revealed an order for risperidone (an antipsychotic medication) 0.25 milligrams (mg) to be given orally daily for dementia with psychosis, dated 12/23/16.

A review of the Medication Administration Record (MAR) for the look back period of 3/21/17 through 3/27/17 revealed Resident #42 received risperidone on 3/21/17, 3/22/17, 3/23/17, 3/24/17, 3/25/27, 3/26/17, and 3/27/17.

On 4/26/17 at 11:12AM, an interview was conducted with the MDS Coordinator who stated she began completing the MDS's in November 2016. She reviewed the MAR for the seven day look back period of 3/21/17 through 3/27/17 and said she should have coded the antipsychotic medication for 7 days. She stated she overlooked coding it.

On 4/27/17 at 10:24 AM, an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the antipsychotic medication was not coded for the 3/27/17 MDS. The DON stated that it was her expectation that the MDS be coded accurately.

7. Resident #65 was admitted on 11/18/16. Cumulative diagnoses included: advanced kidney disease, diabetes, high blood pressure, heart disease, heart failure, and respiratory failure.

The quarterly Minimum Data Set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10 assessment with an Assessment Reference Date (ARD) 3/29/17 indicated Resident #65 was coded as having had a condition or chronic disease that may have resulted in a life expectancy of less than six months. A review of the Special Treatments and Programs revealed that the resident was not coded as having had received Hospice care during the seven day look back period (3/23/17 through 3/29/17). A review of the physician orders for Resident #65 revealed an order for Hospice Services dated 12/19/16. A further review of the medical record revealed that the resident was admitted to Hospice Services on 12/19/17 and was receiving Hospice Services up to and after the ARD of 3/29/19. On 4/27/17 at 2:15 PM, an interview was conducted with the Director of Nursing (DON). The DON acknowledged that Resident #65 was not coded for coded for Hospice Services. The DON stated that it was her expectation that the MDS be coded accurately.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11	F 280		

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to review and revise the care plan following a fall on 4/3/7 by not removing the bed and chair alarm intervention when the resident refused alarms for one of four residents reviewed for falls (Resident #39). The findings included: Resident #39 was admitted to the facility 1/27/16. Cumulative diagnoses included chronic systolic heart failure and cerebrovascular accident.	F 280	F 280 Right to Participate Planning Care 1. Care Plan for Resident #39 was reviewed and updated by the Minimum Data Set (MDS) Coordinator to reflect Resident's choice/refusal to utilize a bed and chair alarm intervention on May 1, 2017. 2. Residents who are potentially affected by this practice are identified as those	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 An Annual Minimum Data Set (MDS) dated 2/3/17 indicated Resident #39 was cognitively intact. Limited assistance was needed with transfers and ambulation in the room and corridor. No falls occurred during the assessment period. A Care Area Assessment (CAA) for falls dated 2/9/17 stated Resident #39 was at risk for falls related to legal blindness, need for assistance with ADL's, and use of mobility device for ambulation, She was ambulatory with the use of a walker and 1 person limited assist and required limited one person assist for transfers and toileting needs. There were no noted falls during the observation period. Proceed to care plan to keep bed in lowest position when unattended by staff and visitors, keep call light within reach, encourage her to call for assistance, provide proper lighting for tasks, keep floor in resident's room clutter free and ensure oxygen tubing and equipment was free from resident's path during ambulation. An incident report dated 4/3/17 at 1:20AM stated Resident #39 was observed by a passing elder assistant (nursing assistant) sliding to the floor from her recliner seat. The elder assistant was unable to reach resident #39 before she ended up on the floor in an upright sitting position on her buttocks with her legs extended outward in front of her and her back against the bottom--front of the recliner. The investigation/ follow up dated 4/3//17 at 8:44AM by the MDS nurse stated the interdisciplinary team met to review the incident and the care plan was updated. A review of Resident #39 ' s care plan revealed Resident #39 was at risk for potential falls and	F 280	who are at risk for falls and have no cognitive impairments and have been identified by the Interdisciplinary Care Plan Team's (ICPT) Assessment. Two residents were found to be potentially affected by this practice. The Care Plan for each resident identified has been reviewed and modified by May 25, 2017. 3. The measures put into place to ensure that the deficient practice will not occur is that Penick Village's ICPT will meet weekly to review any residents who could be affected by this practice and will update Care Plans, as necessary. The agenda items to be covered relevant to the Care Plan are: List of Residents' assessment needs; A review of assessments completed; Care Plan review and updates (Identify any residents/families who have made choices to refuse any safety or medical interventions and assure care plan and progress notes reflect Resident/Family wishes); Resident and Family meetings to review Care Plan. 4. To monitor Penick Village's performance to assure that solutions are sustained the following steps will occur: Weekly Interdisciplinary Care Plan Team minutes will be reviewed by the Licensed Administrator to review for any resident/family choice that includes refusal of safety/medical interventions. A weekly meeting will be had with the Licensed Administrator, DON, MDS Coordinator, Social Worker, nurses and Elder Assistants to review any significant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 had been last reviewed and revised on 4/3/17 for an observed fall on 4/3/17. Interventions added on 4/3/17 to start 4/4/17 included that Resident #39 be reminded to call for assistance with ambulation and staff to apply bed/ chair alarms per physician order with resident's/ family permission. A review of the medical record revealed a nursing note dated 4/3/17 at 10:22AM that stated Resident #39 declined a bed/ chair alarm at that time. On 4/24/17 at 3:33PM, an interview was conducted with Resident #39. She stated she had recently fallen when she went to sit in her recliner and missed the seat of the chair landing on her bottom. Resident #39 was not observed to have a bed or chair alarm in place at the time of the interview. On 4/26/17 at 10:57AM, an interview was conducted with the MDS Coordinator and the Director of Nursing. The MDS Coordinator stated the alarm intervention was added to the care plan on 4/3/17. The Director of Nursing was also present during the interview and stated resident #39 refused the alarms. When asked why the intervention for the alarms was still on the care plan and not discontinued, the MDS Coordinator stated she did not go back and change the care plan after resident refused the alarms.	F 280	changes in the residents. Administrator will work with DON and MDS Coordinator to compare any residents identified with the Interdisciplinary Care Plan Team to assure congruency. A weekly audit tool was created by the DON and will be completed by the DON to assure compliance with any Care Plan revisions to reflect resident's right to participate for 12 months and periodically thereafter. DON's results to be reviewed monthly with Licensed NHA. A monthly and quarterly Quality Assurance Report will be created from the ICPT to include the following: Any ICPT meeting issues that needed to be addressed; Results from the meetings that led to significant changes; Number of Annual Assessments; Number of Quarterly Assessments; Number of Admission Assessments; Number of Significant Change Assessments and why the significant change assessment was triggered, will be included; Results from the DON's audit; and any Care Plan that includes Resident Choice of refusal of safety and medical interventions.	
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his	F 311		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 15 or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide services to maintain a resident ' s functional status in the absence of justification for a functional decline for 1 of (Resident #58) of 3 residents reviewed for activities of daily living (ADLs). Findings included: Resident #58 was admitted 12/12/16 with cumulative diagnoses of depression, Post-Traumatic Stress Disorder (PTSD), anxiety, spinal stenosis and vascular dementia. Resident #58's admission Minimum Data Set (MDS) assessment dated 12/19/16 indicated the following regarding his ADL function: -limited assistance with bed mobility including one person physical assistance -limited assistance with transfers including two person physical assistance -supervision walking in his room with one person physical assistance -walking in the corridor did not occur -locomotion on the unit required supervision of one person physical assistance -locomotion off the unit required supervision with no physician assistance -limited assistance of one staff with dressing -eating was independent with no person physical assistance-set up only -limited assistance toileting with one person physical assistance -limited assistance personal hygiene with one	F 311	F311 Treatment/Services to Improve/Maintain ADLs 1. Resident #58 was assessed by the Interdisciplinary Care Plan Team (ICPT). The following actions were implemented: A new care plan was developed on May 1, 2017; Pharmacist Review of all medications on May 22, 2017; PT referral and screen on April 20, 2017; Physician orders reviewed on May 22, 2017; and Resident had physician visit and any new orders were implemented on May 22, 2017. 2. All residents have the potential to be affected by this practice. The ICPT will review and identify any residents who may have experienced a functional decline. Any resident identified will have: A new care plan developed; Pharmacist Review of all medications; PT referral and screen; Physician orders reviewed; Resident will have physician visit and any new orders will be implemented by May 25, 2017. 3. The Monday-Friday Interdisciplinary Team (IDT) comprised of the Director of Nursing, Social Worker, Minimum Data Set Coordinator, Infection Control Nurse, Clinical Manager and Rehab Director identify residents who are at risk for active, potential decline will be added to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 16 person physical assistance -total dependent bathing with one person physical assistance -occasionally incontinent of bladder -always continent of bowel Resident #58 ' s quarterly MDS assessment dated 3/21/17 indicated severe cognitive impairment and the following regarding his ADL function: -extensive assistance with bed mobility including two person physical assistance -extensive assistance with transfers including two person physical assistance -extensive assistive of two staff with dressing -limited assistance eating with one person physical assistance -extensive assistance toileting with two person physical assistance -extensive assistance personal hygiene with two person physical assistance -total dependence bathing with two person physical assistance -always incontinent of bladder -frequently incontinent of bowel Resident #58 was care planned on 3/29/17 for a risk for ADL decline related to his dementia, lumbar stenosis and need for assistance with ambulating and ADLs. The goal was for Resident #58 to maintain his ability to perform his ADLs with assistance from staff. Interventions included staff setting up his bathing supplies as needed, setting up his meal tray as needed, transfer assistance as needed and therapy as ordered. Resident #58 was also care planned on 3/29/17 for his risk on incontinence of bladder and bowel secondary to his dementia and need for ADL	F 311	the existing agenda of: Falls, Behaviors; Wounds; Antibiotics; Incident reports and Other areas of concern. “Identifying Residents who are in Decline” Philosophy and Process (Penick Village’s version of Policy and Procedure) that assists in identifying residents who are in decline was created on May 23, 2017. This Philosophy and Process will include the following: Residents identified by the IDT; All three shifts’ nurses processes on identifying and reporting potential decline; All three shifts’ Elder Assistants processes on identifying and reporting potential decline; IDT responsibility on reporting back to the person(s) identifying the decline to be shared at change of shift(s); and the ICPT’s responsibility in addressing the decline. In-servicing of all healthcare staff was held to review the Philosophy and Process by May 25, 2017 for all staff who were scheduled. All others will be in-serviced upon next scheduled report time with a maximum of three shifts allowed before they are removed from the schedule. In the event they are removed from the schedule, they will be required to complete the in-service before being placed back on the schedule. Annual education will be included in Penick Village’s annual in-service requirements. 4. To monitor Penick Village’s performance to assure that solutions are sustained the following steps will occur: Weekly ICPT minutes will be reviewed by the Licensed NHA to review any residents who have been identified for decline and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 17 assistance. The goal was for Resident #58 to remain free of complications secondary to incontinence. Interventions included staff to monitor for incontinence and provide care as needed and to monitor his skin for breakdown related to incontinence. In an observation on 4/25/17 at 3:50 PM, Resident #58 was self-propelling in his wheelchair down the hallway. He was clean, groomed and dressed for season. He was pleasantly confused and did not engaged in meaningful conversation. In an observation on 4/26/17 at 8:30 AM, Nursing Assistant (NA) #1 and NA #2 dressed Resident #58. He appeared cooperative. He was then transferred using the standing lift to his wheelchair and pushed down the hall into the dining room. He was cooperative and able to follow directives during the transfer. There were no identified concerns. Resident #58 was cooperative and able to follow direction. NA #1 stated she had only worked at the facility for one month and she was not familiar with Resident #58 ' s admission functional status but since she had worked with him, he always required two people helping him with his ADLs. NA #1 stated he needed a standing lift for transfers and she did not know if Resident #58 was able to ambulate. NA #1 stated he wore a brief for incontinence. In an observation on 4/26/17 at 11:45 AM Resident #58 was in the dining room eating his lunch. NA #2 set up his tray after which he proceeded to fed himself without difficulty. NA #2 stated she had worked at the facility for approximately five years. NA #2 stated some days Resident #58 needed redirection to stay at	F 311	the actions taken to prevent the decline; A weekly meeting will be held with the Licensed Administrator, DON, MDS Coordinator, Social Worker, a nurse and an Elder Assistant to review any declines in the residents. Administrator will work with Clinical Manager and MDS Coordinator to compare any residents identified with the ICPT to assure congruency. A weekly audit will be completed by the DON to assure declines for 12 months and periodically thereafter. DON's results to be reviewed monthly with Licensed NHA. A monthly and quarterly Quality Assurance Report will be created from the ICPT meeting to include the following: Any ICPT meeting issues that needed to be addressed; Results from the meetings from the Licensed NHA, DON, MDS Coordinator, Social Worker, nurses and Elder Assistants that led to active or potential decline; Number of Annual Assessments ; Number of Quarterly Assessments; Number of Admission Assessments; Number of Significant Change Assessments and why the significant change assessment was triggered will be included; Results from the DON's audit (Any Care Plan that includes Resident Choice of refusal of safety and medical interventions and reviews of resident declines that triggered actions).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 18	F 311		

the table and continue to eat his food, but he was capable of feeding himself. NA #2 stated when Resident #58 was initially admitted, he was able to ambulate with staff assistance to the bathroom, but he would have episodes of combativeness and refusal. NA #2 stated the Director of Nursing (DON) told the aides on 4/25/17 to toilet Resident #58 after meals in an effort to reduce his falls. NA #2 stated so far, Resident #58 had been cooperative. NA #2 stated this information was communicated to the rest of the aides through shift report, a communication sheet left for the aides to read and lastly, by looking at the Resident Care Guide in the computer. NA #2 stated she did not rely on the Resident Care Guide in the Computer because it was rarely updated.

In an interview on 4/26/17 at 4:25 PM, NA #6 stated on occasion, Resident #58 would become combative with his ADLs and toileting. She stated she was new to the facility and had worked with Resident #58 for about one month. She stated Resident #58 was incontinent most of the time and she had not noted any changes in his function status since she began working with him.

In an interview on 4/26/17 at 5:40 PM, the Administrator stated the facility did not have a restorative program. He stated the facility was undergoing some system issues and restorative nursing was one of those things that was still on the agenda. The Administrator stated Resident #58 had been a challenge due to his functional status and impaired cognition.
In an interview on 4/27/17 at 9:25 AM, NA #1 stated Resident #58 was able to urinate in the toilet this morning but his bladder continence would vary. He wore a brief that was frequently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 19	F 311		

damp but not saturated and she confirmed recent in-servicing regarding toileting Resident #58 before and after meals as of 4/25/17.

A review of Resident #58's medical record revealed he had not been treated for any urinary tract infections since admission. He had lost five pounds and developed a stage two pressure ulcer on 3/18/17 which healed on 4/18/17.
In an interview on 4/27/17 at 9:29 AM, NA #2 stated Resident #58 had experienced a decline in his ADLs since admission. NA #2 stated he was participating with therapy when he first came in but he now requires more supervision and assistance.

In an interview on 4/27/17 at 9:40 AM, Nurse #1 stated she had worked at the facility since August 2016. She stated Resident #58 had an overall ADL decline since he was admitted.

In an interview on 4/27/17 at 9:53 AM, the Rehabilitation Manager stated Resident #58 lived at home prior to his admission to the facility. He received therapy while he was in the hospital. Resident #58 was able to progress from one personal physical assistance to needing light contact guard assistance with cueing for his transfers from the bed to his wheelchair. Resident still had the issue on impulsiveness and a lack of his own limitations when it came to standing and transferring unassisted. The Rehabilitation Manager stated in the last few months, Resident #58 had "really gone downhill" and at the time of discharge from therapy on 2/9/17, he was still ambulating approximately 200 feet with contact guard assistance. He stated therapy made no recommendations to the nursing staff at the time of therapy discharge, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 20 facility did not provide restorative services but he was uncertain it would have prevented his decline since it appeared to be related to his impulsiveness. In an interview on 4/27/17 at 10:45 AM, the Director of Nursing (DON) stated she did not feel Resident #58 had experienced an actual decline in his ADLs but rather he was at his admission baseline. The DON stated it was her expectation that no resident have a functional decline as it related to the facility provision of care and services.	F 311		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to investigate and implement effective interventions to address multiple falls for 2 of (Resident #58 and #46) 4 residents reviewed for accidents. The facility also failed to supervise and provide direction to nurse aides who transferred Resident #46 in a manner the staff independently deemed appropriate because there was no information on how to transfer the resident. The method of transfer resulted in skin tears for 1 of (Resident #46) 4 residents reviewed for accidents. Findings included: 1. Resident #58 was admitted 12/12/16 with cumulative diagnoses of depression, Post-Traumatic Stress Disorder (PTSD), anxiety, spinal stenosis and vascular dementia. According to the facility policy, titled "Resident Falls" revised September 2012, the Quality Assurance team reviewed any resident who had two or more falls or any injury from a fall during the previous quarter. The electronic Resident Care Guide for Resident #5 included the following interventions dated 12/12/16: *Resident #58 can be aggressive. Staff will assist with mobility needs as tolerated. (There were no indicated methods for transfers or mobility) *Responsible Party (RP) wanted Resident #58	F 323	F 323 Free of Accident Hazards/Supervision – failed to prevent multiple falls 1. Resident #58 was evaluated by Director of Nursing (DON), Clinical Manager, Minimum Data Set (MDS) Coordinator and Rehab Director on April 20, 2017. The following interventions are in place: MDS Coordinator and Interdisciplinary Care Plan Team completed a Comprehensive Assessment on May 1, 2017 and a new care plan was developed, Pharmacist Consultant reviewed medications on May 22, 2017 recommended that BP medication parameters be changed. Physician to review on 5/26/17 scheduled visit. PT referral and screen on April 20, 2017 occurred and Resident is currently receiving PT three times per week. On May 22, 2017, physician orders were reviewed by physician and no new orders. Proper direction on addressing resident needs were shared with Elder Assistants (Nursing Assistants) on April 25, 2017 and May 25, 2017 verbally, in-service, and through Care Plan by the Director of Nursing and Staff Development Nurse. Resident #46 was evaluated and the following interventions are in place: Pharmacist Consultant completed a medication review on May 4, 2017 and recommended discontinuing Remeron.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 to be toileted every two hours. The RP requested he not be left alone in the bathroom and assisted back to his chair. Staff were to toilet Resident #58 after meals as needed. *Resident #58 was to have a bed and chair alarm. Secure alarms in place per RP request. Monitor the function of the alarms with each interaction. A fall mat was to be placed at the bedside when Resident #58 was in bed. Resident #58's admission Minimum Data Set (MDS) assessment dated 12/19/16 indicated severe cognitive impairment with wandering behaviors. He required limited assistance with bed mobility and transfers. Resident #58 was coded with no impairments to his upper or lower extremities and as unsteady with transfers, walking and transfers to the toilet but able to stabilize himself without physical assistance. He was coded as having no fall history. The Care Area Assessment (CAA) portion of Resident #58's admission MDS triggered the following areas and were care planned: cognition, ADLs, urinary incontinence, behaviors, falls, pressure ulcers and psychotropic medications. A review of the facility incident logs from 12/1/16 to present included 19 falls occurred involving Resident #58. There were no falls with injury. The incident reports and Interdisciplinary Team (IDT) notes read as follows: *12/20/16 at 8:45 PM, Resident #58 was found on	F 323	Remeron was discontinued on May 5, 2017. The Interdisciplinary Care Plan Team reviewed fall prevention tactics on February 7, 2017 and she received the wheelchair on February 20, 2017. The Fall Risk assessments were completed on May 13, 2017 and intervention included the addition of non-slip socks. Physician visit on April 24, 2017 and no new orders received. 2. Residents who have potential to be affected by the same practice were identified as experiencing more than one fall in a two month period. Five residents were identified for this potential on May 18, 2017. One Fall Risk Assessment was completed on 5/20/17 – orthostatic Blood Pressures for three days implemented and a blood pressure medication was discontinued, and four were completed on 5/25/17. No new interventions were determined at this time. Clinical Manager taught in-services which began on May 16 and were completed on May 22, 2017 for the Root Cause Analysis Tool (Fall Scene Investigation) for all nurses and implemented on May 22, 2017. On May 22, 2017, Pharmacist Consultant reviewed all five residents and one recommendation was made for one of the residents to decrease Seroquel dose. Physician to review recommendation from Pharmacist at next visit on 5/26/2017. 3. Measures put into place to ensure that the practice will not occur again included a review and update of the Incident and Accident Philosophy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 the floor in the dining room. The nurse documented she heard something and she saw Resident #58 going down. The intervention at this time was hourly checks and neurological (neuro) checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *12/31/16 at 4:55 AM, staff heard a loud noise from Resident #58's room. He was sitting on the floor with his shirt lying on the seat of his wheelchair. The alarm tab was still attached to his shirt with the alarm device on the seat of the chair under his shirt. The intervention read neuro checks, hourly checks and one-on-one staff with Resident #58. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/8/17 at 1:00 AM, Resident #58 was found on the floor in the dining room. The nurse heard his alarm and observed him in the supine position on floor in front of his wheelchair. Interventions included neurological checks and hourly checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/14/17 at 11:15 PM, Resident #58 was in the dining room eating a sandwich. The nurse was completing shift change when she heard an alarm and observed Resident #58 leaning over in his wheelchair reaching toward the floor. Before the nurse could get to Resident #58, he fell hitting his head and mouth. The interventions as this was an ice pack to his lip, neuro checks and 30	F 323	Process (P&P) on May 23, 2017. Changes in P&P included the Implemented Root Cause Analysis tool to create a greater understanding of why the fall occurred and to increase success of fall prevention. For all incidents and accidents that include Falls, the Fall Scene Investigation was included as part of a Root Cause Analysis for each fall. If a resident hits his or her head, the protocol was clarified for head injury: resident to be sent to hospital for evaluation. Further clarification included if a fall was not witnessed, neurological assessments protocol were to be followed: In the event that an incident occurred and unwitnessed, a neurological assessment schedule should be initiated as follows: Every 15 minutes for 1 hour, Every 30 minutes for 2 hours, Every hour for 8 hours, Every 8 hours for 72 hours and if any signs and symptoms of an head injury are observed, the resident is to be sent to the emergency room. Nurses and nursing aides were in-serviced on Incident and Accident P&P on 5/24/17 and as they report to duty on all shifts including nights and weekends with a maximum of three shifts worked before they are removed from the schedule. They must complete the in-service to get back on the schedule. To ensure proper supervision and direction for Elder Assistants, the Care Guide was replaced with access to Plan of Care on electronic medical records. On May 11, 2017, the Care Guide was replaced with the Care Plan. On May 11, 2017, in-servicing of nursing aides began and part-time and as needed nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 minutes checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/17/17 at 7:10 PM, Resident #58 was found on the floor in the therapy room. The intervention as this time was hourly checks and neuro checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/23/17 at 9:15 PM, the aide heard Resident #58's alarm sounding. Resident #58 was found lying on his back by the bathroom door. The interventions included hourly checks for eight hours, neurological checks and staff were to ensure bed alarm were on and functioning properly. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/25/17 at 6:30 PM, Resident #58 was in the dining room trying to get out of his wheelchair to get into another chair. His wheelchair rolled and he landed on the floor. The interventions included staff to monitoring Resident #58 closely after meals and to continue his chair alarm and ensure it was operational. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *1/26/17at 4:40 PM, Resident #58 was observed lying on the floor in the doorway of the nurses break room. His alarm was sounding. It was documented that all the staff were down the hall	F 323	assistants are being in-serviced as they report to duty on all scheduled shifts including nights and weekends with a maximum of three shifts worked before they are removed from the schedule. They must complete the in-service to get back on the schedule. The MDS Coordinator updates the Care Plan as changes occurs. The Licensed Administrator, Director of Nurses, Charge Nurses, Staff Development Nurse and Clinical Manager will all help with in-servicing all Elder Assistants (Nursing Assistants) will be in-serviced on Fall Preventions and Interventions which was included in the Incident and Accident P&P (number 8 in the policy) and in-service. 4. To monitor Penick Village's performance to assure that solutions are sustained the following steps will occur: All incidents and accidents will continue to be reviewed at the Monday through Friday, IDT meetings. Charge nurses have the authority during the weekends and off business hours to contact Licensed Administrator and Director of Nursing for further interventions and support for any incident or accident. Patterns/symptoms that are identified through the incident and accident reports will be evaluated by the Licensed Administrator, DON, MDS Coordinator and Clinical Manager to assure appropriate interventions have been implemented. Any resident who has multiple incidents/accidents, will have their interventions brought to the QA meetings by the Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 in rooms assisting other residents. The interventions included neuro checks, hourly checks and the cord to the chair alarm was changed. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *2/6/17 at 6:15 PM, Resident #58 was observed standing up from his wheelchair in front of the nurses station when he lost his balance and fell. The interventions included neuro checks and hourly checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. *2/8/17at 6:40 PM, the nurse heard the alarm sounding in the hallway. Resident #58 was found sitting on his buttocks in front of his wheelchair. The interventions included hourly checks, one-on-one staff and neuro checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. A review of Resident #58's Physical Therapy Discharge Summary dated 2/9/17 indicated he was able to ambulate 250 feet with contact guard assistance, improved safety awareness with ambulation and able to transfer from his wheelchair to a recliner with contact guard assistance. The summary indicated the staff received training on Resident #58's transfer status and gait. The Summary also noted Resident #58 was impulsive and wanting to stand with impairment cognition. *2/9/17 at 6:00 PM, the nurse heard Resident	F 323	Each health care staff member will be required to complete an annual in-service on falls and fall prevention. The Staff Development Nurse will report the results to of the Annual Fall and Fall Prevention In-service attendance records to the QA Committee. For the next 12 months, at monthly healthcare team staff meetings, Plan of Care effectiveness in providing direction to address resident care needs will be reviewed by the Licensed Administrator or Director of Nursing with the staff. Staff feedback and recommendation will be reviewed and necessary action steps will be reported to QA committee by the Licensed Administrator and Director of Nursing. In addition, the Director of Nursing, Clinical Manager, MDS Coordinator will meet a sampling of staff to get feedback and recommendations will be reviewed and necessary action steps will be report to QA committee by the Licensed Administrator and Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26	F 323		

#58's wheelchair alarm. He was on floor in the dining room. The intervention included placing Resident #58 at the nurses station, providing a snack, one-on-one supervision and his tab alarm was placed out of his reach. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

*2/11/17 at 12:30 PM, another resident's sitter summoned the nurse to the dining room stating Resident #58 was on the floor. His alarm was still attached to his shirt and the alarm box. The alarm apparently did not sound. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

*2/17/17 at 2:50 AM, the aide had assisted Resident #58 to the bathroom. He wanted the door shut and refused further assistance. The aide shut the bathroom door and Resident #58 slid from the toilet to the floor. The intervention included staff educated to keep Resident #58 in eyesight at all times. Staff were not to leave Resident #58 unattended and continue to one-on-one supervision. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

* 2/24/17 at 6:10 AM, the aide heard Resident #58's alarm. Upon entry, Resident #58 was observed sliding out of the bed onto the floor. The interventions included taking Resident #58 to the common area for closer observation and hourly checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

interventions revision.

*2/27/17 at 11:00 PM, Resident #58 was at the nurses station when he stood unassisted and was unable to bear his weight. He began to lower himself to the floor with staff assistance. The intervention included assisting Resident #58 to his wheelchair and hourly checks for the remainder of the shift. The IDT met on 3/1/17 to review the incident. The investigation/follow-up read the same immediate interventions initiated at the time of the fall.

*3/15/17 at 9:55 AM, the staff heard Resident #58 yelling. He was found on the edge of his bed with his elbows on the bed his buttocks in the air with his feet extended. Resident #58 was assisted to the fall mat at his bed side. The interventions included assisting Resident #58 to his wheelchair and providing his morning care then placing him in the common area for closer observation. The IDT investigation/follow-up met on 3/16/17. The bed alarm was replaced due to low volume.

Resident #58's quarterly Minimum Data Set (MDS) assessment dated 3/21/17 indicated severe cognitive impairment with no behaviors and extensive assistance with bed mobility and transfers. Resident #58 was coded with no impairments to his upper or lower extremities and as unsteady with transfers, walking and transfers to the toilet requiring physical assistance to stabilize. He was coded for two or more falls since the last assessment without injury.

*3/27/17 at 5:55 AM, Resident #58's alarm was sounding. He was found on the floor beside his bed on his knees. The intervention included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

hourly checks and neurological checks for 24 hours. The aide got Resident #58 up and dressed him for the day. He was placed at the nurses' station for one-on-one with the nurse. A review of the medical record revealed evidence of the neurological checks but no documented root cause analysis, investigation or follow up. The IDT met to review the incident on 3/27/17. There was no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

Resident #58 was care planned on 3/29/17 for a risk for falls secondary to his limitations related to dementia, difficulty walking, decreased safety awareness and increased need for assistance. The goal was for Resident #58 to remain free from injury secondary to falls. Interventions included staff completing a fall risk assessment after each fall, assisting Resident #58 during transfers, and ensuring adaptive devices such as his walker/cane/wheelchair were in reach and in good repair. Other interventions included non-skid socks, reminding Resident #58 to lock his wheelchair brakes and reminding Resident #58 to use his call bell for assistance prior to getting up. Staff was to assist with ambulation as needed, a bed and chair alarm to alert staff of unsafe movement and a fall mat to floor at bedside. Resident #58's was also to have psychiatric, physician and pharmacy services to monitor his medication therapy for possible contributing factors to falls and adjust as needed.

*4/16/17 at 10:00 AM, Resident #58 was at the nurses station. He attempted to get into a rolling chair while writer was unable to get him to sit in him wheelchair. He was assisted to the floor. The intervention included staff adjusting the alarm and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

wheelchair cushion. He was removed from behind the nurses station into the hallway to be more visible to staff. The IDT met to discuss the assisted fall on 4/17/17 but there was no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

*4/24/17 at 1:30 PM, Resident #58 was heard yelling out while in the dining room. He was found on sitting on the floor. His wheelchair alarm did not sound. The intervention included placing Resident #58 back into his wheelchair and replacing the batteries to his chair alarm. The IDT met on 4/25/17 to review the incident. The aides were to toilet Resident #58 after meals.

In an observation on 4/25/17 at 3:50 PM, Resident #58 was self-propelling his wheelchair in the hallway. A clamp was observed attached to his sweater extending to an alarm box attached to his wheelchair. The cord length was such that if he leaned forward to reach down to the floor or attempt to stand unassisted, the alarm would sound if it was in proper working order.

In an observation of Resident #58's room on 4/25/17 at 3:55 PM, there was a floor mat folded and placed in between his recliner and his closet. His bed was in the lowest position. There was an alarm pad under his fitted sheet and another alarm bed in the seat of his recliner. There was ½ length side rails to bed.

In an interview on 4/25/17 at 5:10 PM, the Director of Nursing (DON) stated there was a clinical meeting every morning at 8:30 AM to discuss falls and other incidents that may have occurred overnight. She stated last week during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

one of the clinical meetings, they decided to start writing down the contents of the meeting and any interventions they were implementing but because the survey team entered 4/25/17 at 10:45 AM, they had not had an opportunity to start that new process.

In an observation on 4/26/17 at 8:30 AM, NA #1 and NA #2 were observed transferring Resident #58 using the standing lift. He was cooperative and able to follow directives during the transfer. There were no identified concerns. Resident #58 was cooperative and able to follow direction.

In an interview on 4/26/17 at 11:45 AM, NA #2 stated she was educated 4/25/17 to toilet Resident #58 after meals to hopefully reduce his falls. NA #2 stated when Resident #58 was taken to activities, he would frequently leave on his own. NA #2 stated anytime a new intervention is added to any resident, a mini in-service was held informing the staff. NA #2 stated this information was communicated to the rest of the aides through shift report, or through a communication sheet left for the aides to read at the nurses' station or by looking at the Resident Care Guide in the computer. NA #2 stated she did not rely on the Resident Care Guide because it was rarely updated.

In an interview on 4/26/17 at 3:31 PM, the Rehabilitation Manager stated Resident #58 was on his case load during most of his falls but he was discharged from therapy due to a lack of progress. He verified he was part of the IDT and met each morning to discuss the falls on Resident #58. He stated the IDT consisted of himself representing therapy, the DON, the MDS nurse and the clinical managers. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31	F 323		

Rehabilitation Manager stated he did not recommend any restorative therapy on discharge due to Resident #58 poor cognition and impulsiveness. The MDS nurse stated when the care plan was created and interventions were implanted, the interventions did not amend or auto-populate the Resident Care Guide in the computer. She stated management was aware of the issue and had been working with the computer technical services but the issue was on-going. The MDS nurse stated she would have to go into each Resident Care Guide and update them individually in order for the Resident Care Guide to be accurate. She stated she was new in her position as of November 2016 and was still learning her role.

In an interview on 4/26/17 at 4:25 PM, NA #6 stated on occasion, Resident #58 would become combative with his activities of daily living (ADLs) and toileting. She stated she was new to the facility and had worked with Resident #58's for about one month. She stated she was told Resident #58 fell a lot in the dining room and to keep a close eye on him. NA #6 stated she did not rely on the Resident Care Guide in the computer but rather on what was reported to her and if she was uncertain about anything, she asked a peer.

In an interview on 4/26/17 at 5:40 PM, the Administrator stated the facility did not have restorative program and Resident #58 had been a challenge due to his functional status and impaired cognition.

In an interview on 4/27/17 at 10:45 AM, the DON stated it was her expectation that the IDT and along with the floor staff investigate the root

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32	F 323		

cause for Resident #58's repeated falls and provide effective interventions to reduce his falls.

2. a. Resident #46 was admitted 10/10/16 with cumulative diagnoses of metabolic encephalopathy, dementia and cerebral vascular accident (CVA) with left sided hemiplegia (weakness).

According to the facility policy, titled "Resident Falls" revised September 2012, the Quality Assurance team reviewed any resident who had two or more falls or any injury from a fall during the previous quarter.

The electronic Resident Care Guide for Resident #46 included the following interventions dated 10/10/16:

*Resident #46 was confused and only oriented to self. She was very active in bed and required monitoring for positioning.
*Resident #46 was total care for her ADLs. She was to be toileted every 2 hours and when she was screaming or crying since this was her way of communicating she needed to have a bowel movement. (There were no indicated methods that were to use for transfers or mobility)
*Resident #46 was to have a bed and chair alarm. There were to be no under pad in her wheelchair seat and she had a concave mattress to her bed. There was also a fall mat to be at the bedside when she was in the bed.

Resident #46 admission MDS assessment dated 10/17/16 indicated severe cognitive impairment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 33	F 323		

with no behaviors. She required total assistance with med mobility, extensive assistance with transfers and she was non-ambulatory. She was coded as unsteady with transfers requiring physical assistance and impairment to one side both upper and lower.
Resident #46 was coded with one fall without injury.

The Care Area Assessment (CAA) portion of Resident #46's admission MDS triggered the following areas and were care planned: cognition, communication, ADLs, urinary incontinence, nutrition, dehydration, falls, pressure ulcers and psychotropic medications.

Resident #46 was care planned on 12/1/16 for falls. Interventions included repositioning when she was up in her wheelchair, ensuring her alarms were in place, incontinence round and the IDT was to evaluate the new non-slip wheelchair cushion for Resident #46.

A review of the facility incident logs from 12/1/16 to present included 11 falls involving Resident #46. There were falls with minor injury.

The incident reports and Interdisciplinary Team (IDT) notes read as follows:

*12/1/16 at 7:01 AM, the nurse heard Resident #46's wheelchair alarm sound in the dining room. Resident #46 was sitting on the floor in front of her wheelchair. The wheelchair cushion and the chair alarm were only half way on the wheelchair. The intervention included repositioning of the wheelchair cushion and alarm. The IDT note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 34	F 323		

dated 12/2/16 at 8:56 AM read Resident #46 was to be repositioned in the wheelchair and the wheelchair cushion was repositioned.

*12/4/16 at 1:30 PM, Resident #46 was observed on the floor in the hallway. Her alarm was operational and alerted staff of the fall. Neurological checks were initiated and the family wanted to discuss with therapy if a different wheelchair would benefit Resident #46. The IDT team note dated 12/5/16 at 8:55 AM read Resident #46 was having increased anxiety and yelling when not in her wheelchair. Staff were to continue to encourage Resident #46 to have periods out of the wheelchair.

In an IDT note dated 12/8/16 at 8:41 AM, the team stated a new wheelchair cushion had been applied to Resident #46's wheelchair and the staff were to monitor for effectiveness.

*12/10/16 at 10:26 AM, Resident #46 was observed sliding from her wheelchair. The nurse was unable to slide her back into the wheelchair so Resident #46 was assisted to the floor. The intervention was a physical therapy consult and a chair alarm pad that functioned properly. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. There was also no evidence of a therapy consult or screen.

*12/31/16 at 12:30 PM, Resident #46 slid from her wheelchair in the hallway in front of the nurses station. A "green pad" (under pad) was under Resident #46 which made the wheelchair seat slippery. The intervention included replacing the chair alarm and removing the green pad. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 35	F 323		

review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

Resident #46's fall care plan was revised on 1/3/17 to include the intervention of staff not placing an under pad in her wheelchair and monitoring for her need to reposition.

*1/5/17 at 3:59 PM, Resident #46 was observed sitting on the floor in the hallway. Resident #46 noted scooting out of the wheelchair when staff were unable to get to her before she fell. There was no documented root cause analysis, investigation or follow up.

In a nursing note dated 1/6/17 at 10:56 AM, the DON contacted an outside provider for recommendation for seating/positioning of Resident #46. Resident #46 was to be trial-tested using a reclining wheelchair to reduce her fall risk.

Resident #46's fall care plan was revised 1/6/17. Interventions included reminding Resident #46 to lock her wheelchair brakes and call for assistance prior to getting up. Staff were to ensure her adaptive devices were in good repair and she wore proper non-skid footwear. Staff were to evaluate for proper fit and function of her wheelchair.

*1/13/17 at 9:05 AM, Resident #46 was found on the floor in the hallway. Staff heard the wheelchair alarm sounding. She was found sitting on top of the wheelchair cushion as if she just slid off the chair. A review of the medical record revealed no documented evidence of root cause analysis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 36	F 323		

investigation or follow up for possible interventions revision.

*1/13/17 at 9:30 PM, staff heard Resident #46's alarm sound from her room. She was found on floor beside her bed. Interventions included hourly checks, a concave mattress, and fall mat beside bed. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

In an IDT note dated 1/16/17 at 2:22 PM, the team discussed two recent falls. There was no documented evidence of root cause analysis, investigation or follow up for possible interventions revision. It was noted that Resident had been noted to slouch in the wheelchair.

Resident #46's fall care plan was revised on 1/16/17. Interventions included the securement of the wheelchair cushion, proper placement of the wheelchair cushion, chair alarm and bed alarm. Resident #46 was also to have a fall mat at her bedside when she was in bed and an outside vender was consulted for cushion alternatives.

In an IDT note dated 1/25/17 at 11:37 AM, a referral was made to another outside positioning provider who was scheduled to see Resident #46 on 2/1/17.

Resident #46 was care planned on 2/1/17 for falls. Interventions included a fall risk assessment after each fall, staff assistance with transfers, bed and chair alarms and staff were to ensure proper alarm function.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 37	F 323		

In an IDT note dated 2/2/17 at 10:00 AM, the new recommendation was an incline cushion for Resident #46's wheelchair. The plan was to proceed with obtaining the recommended device.

*2/6/17 at 9:00 AM, Resident #46's wheelchair alarm sounded in the hallway. She yelled for help when a member of the housekeeping department found her. Resident #46 had slid from her wheelchair. Interventions included hourly checks and activities were encouraged. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

*2/21/17 at 2:15 PM, Resident #46 was found on the floor in her room. Interventions included hourly checks and neuro checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

*2/28/17 at 5:50 AM, Resident #46's alarm sounded. She was found lying prone in her room on the floor on the bedside floor mat. She sustained a skin tear to her right elbow. The only intervention documented was for neuro checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

Resident #46's fall care plan was revised on 2/28/17 to include a concave mattress.

In an IDT note dated 3/6/17 at 3:31 PM, the team noted Resident #46 was doing well with the new incline wheelchair cushion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 38	F 323		

*4/6/17 at 1:30 PM, Resident #46 was found lying on floor on her back with the sheet and blanket under her. Her bed alarm pad was replaced and described as non-working. Interventions included staff to ensuring alarms were in place and working properly, a concave mattress and hourly checks. A review of the medical record revealed no documented evidence of root cause analysis, investigation or follow up for possible interventions revision.

Resident #46's quarterly MDS dated 4/19/17 indicated severe cognitive impairment with rejection of care. She was coded for extensive assistance with bed mobility, transfers, and non-ambulatory. She was coded as unsteady with transfers requiring physical assistance and impairment to one side both upper and lower.

Resident #46's fall care plan was reviewed on 4/7/17 but no new interventions were initiated.

In an interview on 4/25/17 at 5:10 PM, the Director of Nursing (DON) stated there was a clinical meeting every morning at 8:30 AM to discuss falls and other incidents that may have occurred overnight. She stated last week during one of the clinical meetings, they decided to start writing down the contents of the meeting and any interventions they were implementing but because the survey team entered 4/25/17 at 10:45 AM, they had not had an opportunity to start that new process.

In an observation on 4/26/17 11:45 AM, Resident #46 was observed self-propelling her wheelchair out of the dining room. She was using her left had to propel the left wheel of her wheelchair and her right foot to control her direction. There were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 39	F 323		

observed leg rest on her wheelchair. She was well-groomed and dressed for the season.

In another observation on 4/26/17 at 2:55 PM, NA #3 was propelling Resident #46 down the hallway. Resident #46's right foot was dragging under her wheelchair with her left leg extended forward and outward. There were no observed leg rest on her wheelchair. NA #3 stated Resident #46 had a history of falling from her wheelchair in the past. She thought the problem was with her wheelchair cushion. While interviewing NA #3, Resident #46 proceeded for self-propel down the hallway the in same fashion has observed earlier in the day.

In an interview on 4/26/17 at 3:31 PM, the Rehabilitation Manager stated he did not evaluate Resident #46 in December for a different wheelchair because he felt the wheelchair was the right size for her. He stated he had no documentation of screens or evaluations on Resident #46. He verified he was part of the IDT and met each morning to discuss the falls on Resident #46. He stated the IDT consisted of himself representing therapy, the DON, the MDS and the clinical managers. The Rehabilitation Manager recalled the DON contacted a positioning specialist but she was having difficulty getting him to come and assist her. The Rehabilitation Manager provided an email dated 2/23/17 approving the ordering of a wedge cushion for Resident #46's wheelchair. He was uncertain when it was ordered and placed in Resident #46's wheelchair.

In an interview on 4/26/17 at 3:45 PM, the DON stated she did not keep notes about her consulting the positioning specialist and she was unsure when Resident #46's wheelchair cushion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40	F 323		

was replaced.

In an interview on 4/27/17 at 9:40 AM, Nurse #2 stated Resident #46 was bad about scooting out of her wheelchair but one they got the new cushion for her wheelchair, the falls decreased drastically.

In an interview on 4/27/17 at 10:45 AM, the DON stated it was her expectation that the IDT and along with the floor staff investigate the root cause for Resident #46's repeated falls and provide effective interventions to reduce her falls.

2. b. Resident #46 was admitted 10/10/16 with cumulative diagnoses of metabolic encephalopathy, dementia and cerebral vascular accident (CVA) with left sided hemiplegia.

Resident #46 was care planned on 4/15/17 for a skin tear to her left lower leg during a wheelchair transfer with interventions to include padding the wheelchair, treatment as ordered and to monitor for signs of infection. She was also care planned to be transferred with staff assistance but there was no documented directive on how to transfer Resident #46.

Resident #46's quarterly MDS dated 4/19/17 indicated severe cognitive impairment with rejection of care. She was coded for extensive assistance with bed mobility, transfers, and non-ambulatory. She was coded as unsteady with transfers requiring physical assistance and impairment to one side both upper and lower.

A review of the facility incidents logs indicated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41	F 323		

*4/15/17 at 9:10 PM, Resident #46 sustained a skin tear to her left lower leg while two aides were transferring her to her wheelchair. The interventions indicated the wheelchair was assessed for sharp edges and none were noted. The IDT note dated 4/17/17 at 1:17 PM noted to continue the wound care as ordered and monitor for infection.

*4/18/17 at 9:30 PM, two aides were transferring Resident #46 from her bed to her wheelchair causing a skin tear to her right lower leg. NA #3's statement read Resident #46 bumped her leg on the wheelchair during a transfer. The IDT note dated 4/24/17 at 8:45 AM read staff were to pad the wheelchair, monitor for infection, and provide wound care as ordered.

On 4/25/16 at 10:45 AM, Resident #46 was observed with a dressing to her left shin dated 4/24/17.

In an interview on 4/25/17 at 5:10 PM, the Director of Nursing (DON) stated there was a clinical meeting every morning at 8:30 AM to discuss falls and other incidents that may have occurred overnight. She stated last week during one of the clinical meetings, they decided to start writing down the contents of the meeting and any interventions they were implementing but because the survey team entered 4/25/17 at 10:45 AM, they had not had an opportunity to start that new process.

In another observation on 4/26/17 at 11:45 AM, Resident #46 was observed self-propelling her wheelchair out of the dining room. There were no rest leg attached to the wheelchair and no padding of the lower front legs of the wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 42	F 323		

where the leg rest attached to the frame.

In another observation and interview on 4/26/17 at 2:55 PM, NA #3 was propelling Resident #46 down the hallway. NA #3 stated Resident #46 was transferred using a standing lift.

In an interview on 4/26/17 at 3:31 PM with the DON, the MDS nurse and the Rehabilitation Manager stated they held clinical meeting daily to discuss incidents and interventions. The incident report on 4/18/17 was reviewed with the DON, MDS nurse and Rehabilitation Manager. The DON stated she was unsure who was asked to pad to Resident #46's wheelchair as stated in their IDT meeting on 4/24/17.

In an observation on 4/27/17 at 9:44 AM, Resident #46 was observed being propelled down the hallway by the Rehabilitation Manager. The wheelchair front lower legs where the leg rest attached to the frame were observed as padded and covered with black tape.

In a telephone interview on 4/27/17 at 11:40 AM, NA #3 recalled entering Resident #46's room, she was sitting up on the side of the bed trying to get up. NA #3 stated she picked her up and transferred her to the wheelchair. She just lifted Resident #46 and pivoted her into her wheelchair. When she did, Resident #46 hit her leg on the wheelchair where the leg rest fits.

In a telephone interview on 4/27/17 at 11:47 AM, NA # 4 stated she was with NA #3 on 4/15/17. Resident #46 was trying to get up out of the bed. NA #4 stated Resident #46 incapable of using a standing lift because she could not follow instructions. NA #4 stated NA #3 lifted Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43 #46 and put her in the wheelchair. Resident #46 hit her leg on the part of the wheelchair that holds the leg rest. In a telephone interview on 4/27/17 at 12:23 PM, NA #5 stated she was told to use the Resident Care Guide to find information about each resident but it did not say how to lift Resident #46. She stated on 4/18/17 she and NA #3 were getting Resident #46 up out of the bed when she became combative. NA #3 picked Resident #46 up to put her into the wheelchair when causing Resident #46 to hit her leg where leg rest attached to wheelchair. In an interview on 4/27/17 at 2:40 PM, the DON stated it was her expectation that when the IDT met, each person who attended had a responsibility to ensure the interventions initiated would be implemented properly and communication to the floor staff. It was also her expectation the staff transfer each resident in the safest manner possible.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 44 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard expired milk in one of two kitchen refrigerators (refrigerator that contained milk that would be placed on residents ' food trays). The findings included: On 4/24/17 at 10:30AM, an initial tour of the kitchen was conducted with the kitchen supervisor. An observation of the kitchen refrigerator that contained milk that would be placed on residents tray), there were 6 cartons of whole milk with an expiration date of 4/22/17, 2 cartons of whole milk with an expiration date of 4/22/17 and 19 cartons of fat free skim milk with an expiration date of 4/23/17. On 4/24/17 at 10:30AM, an interview was conducted with the kitchen supervisor. He stated it was the responsibility of the tray line person to check for expiration dates of the food/ milk items. On 4/24/17 at 10:40AM, an interview was conducted with dietary staff #1. She stated she checked for expired items after lunch. Dietary staff #1 said the milk items for breakfast and	F 371	F 371 Store, Prepare and Serve Food Safely 1. The six cartons of whole milk with the expiration date of April 22, 2017, the two cartons of whole milk with an expiration date of April 22, 2017, and the 19 cartons of fat free skim milk with an expiration date of April 23, 2017 were disposed of immediately by the morning supervisor, after they were identified on the morning of Monday April 24, 2017. 2. All residents have the potential for being affected by this practice. 3. The following Philosophy and Processes (Penick Village's version of Policy and Procedure) were reviewed by the Director of Dining Services on 5/23/2017: Storage of Food and Supplies which includes eliminating the holding of foods too long through disposal; The 12 Fundamental Rules of Food Safety which includes labeling and dating. And, a Tray	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 45 lunch were already in the cooler when she came on shift. She said the refrigerator was stocked by the evening staff Sunday evening. Dietary staff #1 said she had not checked for expired items this morning. On 4/25/17 at 10:20AM, an interview was conducted with the general manager. He stated all staff were supposed to check all food items, including milk products, prior to placing them on the tray and the evening staff should have checked the milk for the expiration date before they put it in the refrigerator for the staff to use the next day. He stated the milk products should have been removed.	F 371	Line Philosophy and Process (Penick Village's version of Policy and Procedures) was created and implemented on 5/25/2017. Healthcare dining services staff were in-serviced on May 23rd and May 25th by the Dining Service Director and will continue to be or by the Supervisor as they report if they were not scheduled before May 25th (Such as a part time employee or an employee on Family Medical Leave). 4. The Health Care Kitchen refrigerators and freezers will audited several times a week on different shifts and weekends to assure compliance by the Dining Services Director, Supervisor, and Licensed Administrator utilizing a weekly checklist that began May 25, 2017. The checklist was created by the Dining Service Director and implemented by the Director of Dining services beginning May 25, 2017. Results of the audits to date have shown no out of date food products. Audit checklist will be reviewed with Licensed Administrator or Chief Executive Officer on a weekly basis. The Licensed Administrator will bring results of audits and copy of the checklist for the Quality Assurance meeting.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 46 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 520	F 520 QA Committee (repeated findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 47 facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and to monitor the interventions the committee put into place following the recertification survey 5/5/16. This was for three deficiencies which was recited during the recertification survey of 4/27/17 in the area of Resident Assessment at F278 and F280. The third recited area was in the area of Quality of Care and Treatment at F323. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tags is cross referenced to: F278-E: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set Assessment in the areas of medication (Resident #39, #3, #20, #42), falls (Resident #46), diagnosis (Resident #3, #58) and hospice (Resident #65) for seven of fourteen sampled residents. F280-D: Based on observation, medical record review and staff interview, the facility failed to review and revise the care plan following a fall on 4/3/7 by not removing the bed and chair alarm intervention when the resident refused alarms for one of four residents reviewed for falls (Resident #39).	F 520	for F 278, F 280, F323) All residents have the potential to have been affected by the practice. Effective May 24, 2017, the plan to assure substantial compliance on findings of the requirements for F274, F278, F280, F311, F323, F371, and F520 is the following: Penick Village has a monthly Quality Assurance (QA) Meeting in which the Chief Executive Officer (CEO) will participate until the next survey, the Licensed Administrator and Director of Nursing (DON) will meet weekly for six months with CEO to review quality assurance the actions determined in F274, F278, F280, F311, F323, F371, and F520's Plan of Correction, the CEO will keep minutes using an action grid format – any action items that are needed to address continued compliance will have a personal responsible assigned, due date, and specific action steps to be taken to assure compliance. If CEO is unavailable, the Chief Financial Officer will be assigned in place for the week. The CEO will review current Action Grid with of the Penick Village's Board of Director's Healthcare Committee at its June 2, 2017 meeting and its quarterly meetings thereafter. The Healthcare Committee will evaluate plan for continued effectiveness. A QA meeting summary of results and actions, will be reported to Penick Village's Board of Directors Healthcare Committee by the Chief Executive Officer. The Plan of Correction will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 48 F323-E: Based on observations, staff interviews and record review, the facility failed to investigate and implement effective interventions to address multiple falls for 2 of (Resident #58 and #46) 4 residents reviewed for accidents. The facility also failed to supervise and provide direction to nurse aides who transferred Resident #46 in a manner the staff independently deemed appropriate because there was no information on how to transfer the resident. The method of transfer resulted in skin tears for 1 of (Resident #46) 4 residents reviewed for accidents. In an interview on 4/27/17 at 2:52 PM, the Administrator acknowledged understanding of reciting of F278, F280 and F323 during the recertification survey of 4/27/17. The Administrator stated the facility had made great strides but the change in MDS staff may have contributed to the repeat citations in the area of F278 and F280.	F 520	monthly during the QA meeting by the Licensed Administrator and minutes/actions will be signed off by the Chief Executive Officer. The Licensed Administrator will monitor through next standard survey inspection to ensure continued compliance.	