	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	06/02/201 <u>7</u>
PINEVILL	E REHABILITATION ANI	D LIVING CTR		010 LAKEVIEW DRIVE INEVILLE, NC 28134	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
F 242 SS=D	483.10(f)(1)-(3) SEL RIGHT TO MAKE CI	F-DETERMINATION - HOICES	F 242		6/19/17
	schedules (including health care and prov consistent with his o	as a right to choose activities, sleeping and waking times), iders of health care services r her interests, assessments, other applicable provisions			
		as a right to make choices or her life in the facility that resident.			
	members of the com community activities facility. This REQUIREMEN	as a right to interact with munity and participate in both inside and outside the T is not met as evidenced			
	interviews, and record	ons, resident and staff rd review, the facility failed to or 1 of 3 sampled residents d:		Resident # 67 food likes and dislikes were updated as of 6/5/17. All other resident⊡s food likes and dislikes were updated by the Dietary Manager or the Registered Dietician as 6/6/17 and tray card is updated to reflect	
		#67's quarterly Minimum 7/17 revealed an assessment		choices. 100% of Dietary staff have been re-educated by the Dietary Manager regarding the need to honor food	
	breakfast meal of 05 #67 was not to be se	#67's dietary slip on the /31/17 revealed Resident erved fried foods, fruit s, okra, peaches, squash, ni and tomatoes.		All newly hired Dietary staff will be educated at the time of hire on the importance of resident choices with regard to food choices.	
	AM revealed his mea	ent #67 on 05/31/17 at 8:59 als frequently contained lid not like. Resident #67		The Dietary Manager will audit 5 trays p week for accuracy to include food	ber
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				06/19/2017

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

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/20/20 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED	
	2636	345415	B. WING		06/02/201 <u>7</u>
IAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PINEVILLE REHABILITATION AND LIVING CTR					
				PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 242	Continued From pa	ae 1	F 242		
	· ·	ato slices on a napkin.		preferences honored with report on his	
		lined the tomatoes came from		findings weekly to the administrator x o	ne
		on 05/30/17. Resident #67		month	
		lained to the kitchen staff "4 or			
	•	tomatoes continued to be		The Dietary Manager will report these	
		#67 reported the continued indicated the facility did not		findings to the QA&A committee quarte x one year.	ny
				The QA&A committee will evaluate the	
	delivered by Nurse 12:51 PM revealed	ident #67's lunch meal, Aide (NA) #1, on 06/01/17 at Resident #67 received a		effectiveness of the plan and make changes to the plan as needed.	
	slices. Resident #6	idwich contained 2 tomato 7 explained he ordered ntly since he did not usually			
	like the main entrée	e. Resident #67 removed the hrew them into the trash can.			
		1 on 06/01/17 at 12:58 PM ot notice the tomato slices on			
		#1 explained the kitchen staff or honoring Resident #67's			
	06/01/17 at 6:26 PM received strawberri	ident #67's supper meal on I revealed Resident #67 es. Resident #67 reported he			
	did not like strawbe slip which listed a s	rries and pointed to the dietary trawberry dislike.			
	06/02/17 at 9:38 AM Resident #67 repor	lietary manager (DM) on M revealed he did not recall if ted the frequent serving of explained the cook should			
	follow the direction	on Resident #67's dietary slip toes and strawberries.			
		nterim Director of Nursing at 9:49 AM revealed she			

Facility ID: 923298

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CENTER	S FOR MEDICARE	AND HUMAN SERVICES		<u>(</u>	PRINTED: 06/20/20 FORM APPROVI 0MB NO: 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		06/02/201 <u>7</u>
NAME OF PF	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PINEVILLE	E REHABILITATION A	ND LIVING CTR		LAKEVIEW DRIVE EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 242	Continued From pa	ae 2	F 242		
	expected nursing s	taff to read the diet slip and hich contained a dislike.			
F 279 SS=D	483.20(d);483.21(b COMPREHENSIVE		F 279		6/19/17
	assessments comp months in the resid results of the asses	nust maintain all resident deted within the previous 15 ent's active record and use the asments to develop, review dent's comprehensive care			
	483.21 (b) Comprehensive	Care Plans			
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass	t develop and implement a rson-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive cribe the following -			
	or maintain the resi physical, mental, a	t are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and			
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not e resident's exercise of rights luding the right to refuse 83.10(c)(6).			

If continuation sheet Page 3 of 34

CENTER	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345415		B. WING	-EIN/	06/02/201 <u>7</u>
NAME OF PROVIDER OR SUPPLIER PINEVILLE REHABILITATION AND LIVING CTR		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			10 LAKEVIEW DRIVE NEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 279	Continued From	page 3	F 279		
	rehabilitative serv provide as a resu recommendations findings of the PA	ed services or specialized vices the nursing facility will lt of PASARR s. If a facility disagrees with the ASARR, it must indicate its esident's medical record.			
	(iv)In consultatior resident's represe	n with the resident and the entative (s)-			
	(A) The resident's desired outcomes	s goals for admission and s.			
	future discharge. whether the resid community was a	s preference and potential for Facilities must document lent's desire to return to the assessed and any referrals to ncies and/or other appropriate urpose.			
	plan, as appropria requirements set section.	ans in the comprehensive care ate, in accordance with the forth in paragraph (c) of this ENT is not met as evidenced			
	Based on observ record review the comprehensive c and individualized	vation, staff interviews, and e facility failed to develop a are plan which included specific d approaches for 1 of 4 sampled for weight loss (Resident #49).		The nutritional care plan for resident was evaluated and updated as of 6/5/ to reflect current interventions All care plans for residents at nutrition	/17
	The findings inclu			risk were reviewed by the Registered Dietician and interventions were evalu and updated by 6/6/17.	uated
		s admitted to the facility on gnoses which included dementia s.		The Dietary Manager or Registered Dietician will initiate a care plan for ar	-
	Review of Reside	ent #49's annual Minimum Data		resident who has been deemed to be nutritional risk including new admission	

Event ID: 9YRN11

Facility ID: 923298

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	-	ND HUMAN SERVICES			PRINTED: 06/20/20 FORM APPROV OMB NO. 0938-03
		(X2) MULTIPLE A. BUILDING _	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	201	345415	B. WING		06/02/201 <u>7</u>
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
INEVILLE	E REHABILITATION AN	ID LIVING CTR		010 LAKEVIEW DRIVE	
			P	INEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 279	Continued From page	ge 4	F 279		
	Set (MDS) dated 12	-		The Dietary Manager or Registered	
	. ,	erely impaired cognition. The		Dietician will update the care plan eac	h
		ident #49 ate independently		time a goal or intervention has change	ed
	after set up, receive with no significant w	ed a mechanically altered diet veight loss or gain.		with new goal or updated interventions	S.
				The Dietary Manager was re-educated	b
		#67's Nutritional Status Care		regarding the importance of an	
		CAA) dated 12/28/16 revealed		individualized and up-dated care plan	
		tian (RD) documented		residents at nutritional risk on 6/14/17	ру
		ght of 82 pounds on 12/13/16 oss of 5.7% in the past 6		the Nurse Manager.	
	•	(Body Mass Index) below			
		5. (BMI is a measure of body		The MDS Coordinator will audit five ca	are
		and height; under 18.5 is		plans for residents at nutritional risk p	-
		eight as defined by the		week for correct and relevant	-
	National Institute of	Health.) The RD		interventions x one month with report	to
	documented Reside	ent #49 received a frozen		the QA&A committee monthly x one	
		ent which provided an		month, then five care plans per month	1
		alories and 18 grams of		with report to the QA&A committee	
		The CAA indicated a gradual		quarterly x 4 quarters.	
	weight gain was des	siradie.		The QA&A committee will evaluate the	
	Review of a RD's no	ote dated 12/28/16 revealed		effectiveness of the plan and make	5
		ght, intake and acceptance of		changes as indicated.	
	supplement should	•			
		#49's care plan dated			
		a goal of weight maintenance.			
		ed delivery of diet with weight			
	and intake monitorin	-			
	uocumentation of hi	utritional supplements.			
	Review of Resident	#49's dietary slip revealed			
		grilled cheese sandwich and			
		pplement with lunch and			
		01/17 from 1:01 PM to 1:27			
		ent #49's lunch meal did not			

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEVILL	E REHABILITATION AND) LIVING CTR		1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 279	contain a frozen nutri #49 consumed 100% sandwich. Interview with Nurse 1:31 PM revealed Res sandwiches frequent assigned monitoring did not notice if Resid nutritional supplement Interview with the die 06/02/17 at 9:31 AM should receive a froz with the lunch and su explained the grilled after a meeting with F member. The DM re care plan was shared dietician. The DM re the frozen nutritional cheese should be list Interview with the inter (DON) on 06/02/17 a expected Resident # for weight loss to be Interview with MDS r PM revealed either th nutritional care plans Telephone interview 9 2:20 PM revealed Res should include the int nutritional supplement	Aide (NA) #3 on 06/01/17 at esident #49 ate grilled cheese ly. NA #3 explained she was of the main dining room and dent #49 received a frozen nt. etary manager (DM) on revealed Resident #49 ren nutritional supplement upper meals. The DM cheese sandwich was added Resident #49's family ported development of the d with the registered ported the interventions of supplements and grilled ted on the care plan. erim Director of Nursing it 9:50 AM revealed she 49's care plan interventions specific and individualized. hurse #1 on 06/02/17 at 2:03 he DM or RD developed	F 21		

Facility ID: 923298

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/20/20 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING	- $ +$ $N/2$	06/02/201 <u>7</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
	E REHABILITATION ANI		1010	LAKEVIEW DRIVE	
FINEVILLI	E REHABILITATION AND		PINE	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309	Continued From pag	e 6	F 309		
F 309 SS=G	483.24, 483.25(k)(l) FOR HIGHEST WEL	PROVIDE CARE/SERVICES LL BEING	F 309		6/19/17
	applies to all care an residents. Each resi facility must provide services to attain or practicable physical, well-being, consister comprehensive asse 483.25 Quality of care Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resi that residents receive accordance with pro-	adamental principle that ad services provided to facility dent must receive and the the necessary care and maintain the highest mental, and psychosocial at with the resident's assment and plan of care. The undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure the treatment and care in fessional standards of hensive person-centered asidents' choices, including			
	provided to residents consistent with profe the comprehensive p and the residents' go	ure that pain management is who require such services, essional standards of practice, person-centered care plan, pals and preferences.			
	services, consistent of practice, the comp care plan, and the re preferences.	e dialysis receive such with professional standards prehensive person-centered			

If continuation sheet Page 7 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
345415		B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE	06/02/201 <u>7</u>	
PINEVILL	E REHABILITATION AN	D LIVING CTR		010 LAKEVIEW DRIVE INEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 309	Based on observati resident/staff/pharm interviews and medi failed to administer p sampled residents re #96) The findings include Resident #96 was at with diagnoses whice affecting right domin right shoulder repain The quarterly Minim assessed Resident at impairment and takin medication. The current care plat problem area initiate #96 has limited physic weakness. Approact included physical the referrals as ordered. Physician/nurse prat- medical record of Ref following: 04/27/17-The physic and noted a history of physician noted Res right shoulder with d the right shoulder as motion. The physici consistent with impir cuff pinched betwee scapula.) The physic	on, acist/nurse practitioner cal record review the facility pain medication to 1 of 3 eviewed for pain. (Resident d: dmitted to the facility 07/31/16 h included hemiplegia tant side, muscle spasms and um Data Set dated 05/04/17 #96 with mild cognitive ng scheduled pain n for Resident #96 included a ed 06/01/17 noting, Resident sical mobility related to stroke, thes to this problem area erapy, occupational therapy ctitioner progress notes in the esident #96 included the tan assessed Resident #96 of right shoulder repair. The sident #96 reported pain in his liscomfort with palpation of a well as decreased range of	F 309	Resident #96's tramadol was obtained and resident was medicated per physician's order as of 5/31/17 with resident stating "The pain is gone". An audit of all pain medications was completed as of 5/31/17 to ensure that prescribed pain medications were available. An Audit of 100% of residents was completed by the West Unit Nursing Coordinator, the East Unit Nursing Coordinator, the Nurse Manager and th Second Shift Supervisor to ensure that pain management was effective as of 5/31/17. 100% of scheduled nurses were re-educated as of 6/19/17 by the Pharmacy Manager related to the importance of the following: Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are no available, such as Pixis machine, back pharmacy Steps to take when the Pixis machine i not in working order or the medication in not in the Pixis, utilization of back up pharmacy Nurses that were unavailable for re-education will not allowed to pass medications or work at facility until the education is completed. All newly hired nurses will be educated	all ne stup sis

Facility ID: 923298

FOR MEDICARE & DEFICIENCIES		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	345415	B. WING		06/02/201 <u>7</u>	
VIDER OR SUPPLIER					
REHABILITATION AND	LIVING CTR				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
Continued From page 8 contracture of the right upper extremity. The physician assessed Resident #96 as able to voice/express concerns though there was evidence of cognitive impairment. Due to the right shoulder pain on 04/27/17 the physician ordered Lidoderm patch and an X-ray of the right shoulder. 05/30/17-The nurse practitioner assessed Resident #96 for right shoulder pain. The nurse practitioner noted Resident #96 was seen for evaluation of pain to the right side; noting he had issues with osteoarthritis of the right joint and generalized discomfort to the right side since his stroke. The nurse practitioner assessed Resident #96 as alert and oriented X 2. Review of current physician orders in the medical record of Resident #96 noted the following medications were ordered: -Tramadol HCL 50 milligrams every 8 hours for moderate to moderately severe pain. Tramadol was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM. -Baclofen 5 milligrams as needed twice a day for		F 309	regarding the following at the time of h Pain assessments Availability of pain medications System for reordering pain medication Steps to take when medications are n available, such as Pixis machine, back pharmacy Steps to take when the Pixis machine not in working order or the medication was not in the Pixis, utilization of back pharmacy The Director of Nursing, West Unit Nursing Coordinator, the East Unit Nur Coordinator or the Second Shift Supervisor will report on new pain medication orders daily and validate th the medications are available during the facilities morning meeting. The Director of Nursing or the East Unit Nursing Coordinator or the West Unit Nursing Coordinator or the West Unit Nursing Coordinator or the Second Sh Nursing supervisor will audit 5 resider per week to ensure the availability of p	ne time of hire. ions medications tions are not ichine, back up is machine is medication ion of back up est Unit st Unit Nursing Shift w pain d validate that ble during the the East Unit West Unit Second Shift it 5 residents	
nours on, 12 hours o n addition, Resident occupational therapy 01/31/17-04/05/17. Review of the X-ray r Resident #96 noted a degenerative joint dis	ff. #96 had physician orders for to evaluate and treat from results from 04/28/17 for a humeral prosthesis, mild sease of the right shoulder;		medications including new admissions well as the effectiveness of the pain management regime. These audits wi performed weekly x one month with re to the QA&A committee monthly x 1 y The QA&A committee will evaluate the findings to determine the effectiveness the plan and make changes as needed	ll be eport ear. ese s of	
	FOR MEDICARE & DEFICIENCIES CORRECTION DVIDER OR SUPPLIER REHABILITATION AND SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page contracture of the righ obysician assessed F voice/express concer evidence of cognitive right shoulder pain or ordered Lidoderm pa shoulder. D5/30/17-The nurse p Resident #96 for righ practitioner noted Re evaluation of pain to ssues with osteoarth generalized discomfo stroke. The nurse pr #96 as alert and orien Review of current phy record of Resident #95 medications were or Tramadol HCL 50 m moderate to moderat was scheduled to be and 4:00 PM. Baclofen 5 milligram nuscle spasticity. Lidoderm patch right hours on, 12 hours of n addition, Resident portional therapy D1/31/17-04/05/17.	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION AND LIVING CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 contracture of the right upper extremity. The ohysician assessed Resident #96 as able to voice/express concerns though there was evidence of cognitive impairment. Due to the right shoulder pain on 04/27/17 the physician ordered Lidoderm patch and an X-ray of the right shoulder. D5/30/17-The nurse practitioner assessed Resident #96 for right shoulder pain. The nurse oractitioner noted Resident #96 was seen for evaluation of pain to the right side; noting he had ssues with osteoarthritis of the right joint and generalized discomfort to the right side since his stroke. The nurse practitioner assessed Resident #96 as alert and oriented X 2. Review of current physician orders in the medical record of Resident #96 noted the following medications were ordered: Tramadol HCL 50 milligrams every 8 hours for moderate to moderately severe pain. Tramadol was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM. Baclofen 5 milligrams as needed twice a day for muscle spasticity. Lidoderm patch right shoulder every day,12 hours on, 12 hours off. n addition, Resident #96 had physician orders for procupational therapy to evaluate and treat from	DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ A. BUILDING_ WIDER OR SUPPLIER 345415 B. WING	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES GREECTON (X1) PROVIDERSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A BUILDING GREECTON (X2) MULTIPLE CONSTRUCTION A BUILDING ABULDING CREATION AND LIVING CTR INVIDE STREET ADDRESS, CITY, STATE, ZP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 WIND REABILITATION AND LIVING CTR ID PROVIDER OF NUM OF CORRECTION (EACH DER/CENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER OF NUM OF CORRECTION (EACH DER/CENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER OF NUM OF CORRECTION (EACH DER/CENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER OF NUM OF CORRECTION (EACH DER/CENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 contracture of the right upper extremity. The Drivector of the right side a ble to opic/express concerns though three was evidence of cognitive impairment. Due to the sight shoulder pain on du/27/17 the physician ordered Liddoem patch and an X-ray of the right shoulder. DS/30/17-The nurse practitioner assessed Resident #96 for right shoulder pain. The nurse practitioner noted Resident #96 inded the following nedications were ordered! Tramadol HCL 50 milligrams as needed twice a day for nuscle spasticity. Liddoem patch right shoulder every day, 12 nours on, 12 hours off. n addition, Resident #96 had physician orders for pocupational therapy to evaluate and treat from 1/13/1/7-04/05/17. The DA&A committee will evaluate the findinges to determine the Refere Vieness of the pain management regime. These audits win performed weeky x one month with re to the CA&A committee will evaluate the fin	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORI	D: 06/20/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345415	B. WING		06	/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
PINEVILL	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE :D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 309	occupational therapis complaints of pain in rated as an 8 on a so severe pain). The O he had the pain for a and the OT felt it was and range of motion OT noted the pain im to perform mobility ta necessary to improve set by the OT include -Resident #96 will rep shoulder with a goal perform transfers. At the end of therapy progress as follows: -At the start of therapy reported his right sho end of therapy Resid shoulder pain as a 4 being severe pain.) On 05/31/17 at 9:11 / observed laying in be was in a lot of pain an received his morning addition, Resident #97 Tramadol the day prio out of Tramadol. Review of the May 207 Administration Recorn noted the 8:00 AM do been documented as 4:00 PM dose of Tran documented as "not	26 was screened by the st (OT) and noted with his right shoulder which was vale of 1-10 (with 10 being T noted Resident #96 stated in extended period of time is due to impaired strength related to the stroke. The paired Resident #96's ability usks and skilled therapy was in functional abilities. Goals ed: bort decreased pain in right for no pain at rest in order to if on 04/05/17 the OT noted by on 01/31/17 Resident #96 bulder pain as severe. At the ent #96 reported his right on a scale of 1-10 (with 10 AM Resident #96 was ed. Resident #96 stated he nd stated he had not dose of Tramadol. In 16 stated he missed his or and was told they were	F 3	09		

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ENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/20/20 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345415	B. WING		06/02/201 <u>7</u>
IAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
	REHABILITATION AN		1010	LAKEVIEW DRIVE	
	E REHADILITATION AND	DEIVINGETR	PINE	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309	Continued From pag	ue 10	F 309		
		cumented as administered to	1 000		
	Resident #96 by Nur				
	On 05/31/17 at 9:26	AM Nurse #3 (assigned to			
	work with Resident #	#96 on 05/31/17 from 7:00			
		she had not given morning			
	-	lesident #96. Nurse #3 was			
		bout the availability of the			
		ent #96. Nurse #3 opened the			
		and stated there was no			
		o give to Resident #96.			
		would ask another staff			
		amadol for Resident #96 from			
	-	n (an automated medication			
	dispensing system).				
	On 05/31/17 at 10:1	5 AM Nurse #4 (the unit			
		e Pyxis MedStation was not			
	. ,	result, Tramadol was not			
		administer to Resident #96.			
	•	ause Tramadol was a			
		written prescription for			
		#4 stated each nurse was			
		king when a residents			
	•	was "getting low" so the			
		ractitioner could be notified			
		ritten. Nurse #4 stated if the			
		vailable staff should obtain it			
	from the Pyxis MedS	Station. Nurse #4 stated she			
	•	ng the Pyxis MedStation had			
		The Nurse Practitioner (NP)			
	•	me of the interview and			
	-	t assessed Resident #96 for			
	•	e Tramadol and written a			
	prescription. The NI	P looked at her notes and			
	verified she had see	n Resident #96 on 05/30/17			
		ription for the Tramadol. The			
	-	have expected the Tramadol			
		the pharmacy on 05/30/17			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 345415 B. WING	938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
	201 <u>7</u>
PINEVILLE REHABILITATION AND LIVING CTR 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) DMPLETION DATE
F 309 Continued From page 11 for administration to Resident #96. F 309 On 05/31/17 at 10:40 AM the Controlled Drug Record for the Tramadol for Resident #96 was requested from Nurse #3. At the time of the request the NP was overheard talking to Nurse #3 about her (the NPs) assessment of Resident #96's pain that morning and the NP recommended giving the Bacloten for muscle spasms until the Tramadol arrived at the facility for administration. Review of the Controlled Drug Record for Resident #96 on 06/31/17 at 10:43 AM noted the last dose of Tramadol was documented and signed as given on 05/30/17 at 9:00 AM. On 05/31/17 at 10:45 AM aphone interview was done with Nurse #6. Nurse #6 reported she had worked with Resident #96 on 06/30/17 from 11:00 PM until 05/31/17 at 7:00 AM. Nurse #6 stated she recalled giving several residents Tramadol during her shift but couldn't recall any specifics regarding Resident #96 be nore: #6 stated if she gave Tramadol to Resident #96 she would have recorded it on the Controlled Drug Record. Nurse #6 stated she would not have borrowed the Tramadol for Resident #96 she would have recorded it on the Controlled Drug Record. Nurse #6 stated she would not have borrowed the Tramadol for Resident #96 she would have free of Tramadol signed out for Resident #96 was 05/30/17 at 9:00 AM. Nurse #6 reported she was having a lot of computer issues during her shift and stated there was a possibility she signed off for the medication but did not give it. On 05/311/17 at 10:59 AM Resident #96 stated he still had not received the Tramadol and he fett like his am was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.). On	

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DEPART	MENT OF HEALTH A	ND HUMAN SERVICES			Fr		PPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			ON	<u>/IB NO. 0</u>	938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION (X:	3) DATE SUF COMPLET	
		345415	B. WING			06/02/	2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	E REHABILITATION AN			10	10 LAKEVIEW DRIVE		
FINEVILLI	E REHADILITATION AN	DEIVING CTR		PI	NEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	05/31/17 at 12:00 Pl still had not received On 05/31/17 at 12:1 had not given Resid Tramadol or the Bac NP at 10:40 AM). N understanding from wasn't in pain but ha #3 offered to go to th verify this. Nurse #3 Resident #96 and as get out of bed to eat he was hurting too n and was waiting for stated to Resident # him that morning an tightness, not pain. I am hurting. Nurse his pain level was ar Nurse #3 returned to produced a paper w report from the NP (which noted no pain Baclofen. Nurse #3 the Baclofen to Resi no, she was plannin On 05/31/17 at 12:1 Nursing was asked if operating and she re AM. The interim Dir the Tramadol had be administration to Re responded, not yet. approximately 12:20	M Resident #96 reported he d his Tramadol. 3 PM Nurse #3 stated she lent #96 the 8:00 AM dose of clofen (as suggested by the lurse #3 stated it was her the NP that Resident #96 ad muscle tightness. Nurse he room of Resident #96 to 3 entered the room of sked him if he was going to t lunch. Resident #96 stated much to get out of bed or eat his medication. Nurse #3 496 that the NP had assessed id he was having muscle Resident #96 responded, no, #3 asked Resident #96 what nd Resident #96 replied "10". o her medication cart and there she documented the fat approximately 10:40 AM) h, muscle tightness and given was asked if she had given ident #96 and she reported g on doing that. 5 PM the interim Director of if the Pyxis MedStation was eported it "went up" at 11:24 rector of Nursing was asked if een taken out of the Pyxis for esident #96 and she	F 3	09			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		06/02/201 <u>7</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE	
PINEVILL	E REHABILITATION AND	LIVING CTR		PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 309	she was aware Resid doses of Tramadol au The administrator sta all narcotics for resid was available to be g On 05/31/17 at 12:45 done with the NP. TH Resident #96 on 05/3 prescription for the TH felt the Tramadol was #96. The NP stated that morning (around to describe his pain. reported his right arm she felt the right bice his right calf and note The NP stated she m right calf of Resident reported a little relief she told Resident #90 give him the Baclofer to see if it would relie stated she discussed her to give the Baclof Tramadol. The NP s expected the Baclofer minutes of their discu On 05/31/17 at 2:20 Nurse #3 stated she things" that morning was not given to Res until brought to her a #3 stated she later w Resident #96 after he	PM the administrator stated dent #96 had missed several and agreed it was a concern. ted they were going to audit ents to ensure medication given to residents as ordered. PM a phone interview was ne NP stated she assessed 30/17 prior to writing the ramadol. The NP stated she is warranted for Resident she did assess Resident #96 10:40 AM) and asked him The NP stated Resident #96 in felt "tight." The NP stated p of Resident #96 as well as ed his muscles were tight. assaged the right bicep and #96 and Resident #96 from pain. The NP stated 6 she would have Nurse #3 in until the Tramadol arrived eve his muscle pain. The NP this with Nurse #3 and told fen while awaiting the tated she would have in to be given within 30	F 30		

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CENTER	-	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		PRINTED: 06/20/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345415	B. WING		06/02/2017
NAME OF PR	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			101	0 LAKEVIEW DRIVE	
PINEVILLE	E REHABILITATION ANI	D LIVING CTR	PIN	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 309	Continued From pag	je 14	F 309		
	Nurse #5 verified shi on 05/30/17 from 3:0 stated she recalled t available to be given stated she asked an rights to the Pyxis M Tramadol for Reside nurse told her the Py working which was v dose of Tramadol wa Resident #96 on 05/ On 06/01/17 at 1:25 Resident #96 from 0 interviewed. The OT screened Resident # complained of right s she felt the pain was immobility of his righ Resident #96 unders was able to report hi OT explained that th always give the exact questions appropriat in pain. The OT stat therapy on 01/31/17 pain level as severe. modalities were user #96 which included H electrical stimulation of treatment on 04/0 his pain as a 4 out o knew nursing staff w medication and there	nt #96. Nurse #5 stated this (xis MedStation wasn't vhy she charted the 4:00 asn't available on the MAR of 30/17. PM the OT that treated 1/31/17-04/05/17 was Treported when she 496 on 01/31/17 he shoulder pain. The OT stated arelated to his stroke and tt side. The OT stated stood the 1-10 pain scale and s pain using this scale. The ough Resident #96 could not ct date she felt he answered tely, including whether he was ted at the beginning of Resident #96 described his . The OT stated various d to treat the pain of Resident heat packs, exercise and . The OT stated at the end 5/17 Resident #96 described f 10. The OT stated she rere providing pain e were no OT			
	end of his therapy or	or pain management at the n 04/05/17. The OT stated scharged from therapy on			

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If continuation sheet Page 15 of 34

CENTER	-	AND HUMAN SERVICES <u>A MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		(PRINTED: 06/20/20 FORM APPROV 0MB NO: 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		COMPLETED
_		345415	B. WING		06/02/201 <u>7</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			1010	LAKEVIEW DRIVE	
INEVILLI	E REHABILITATION AN	ID LIVING CTR	PINE	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 309	Continued From pa	ae 15	F 309		
1 000	I '	-	F 309		
		bal for no pain in the right			
		met due to Resident's #96's			
	report of a 4 out of	i u pain ievei.			
	On 06/02/17 at 1:25	5 PM the consultant			
		is expectation was for			
		medications as ordered by			
	the physician, espe	cially medications for pain			
	management. The	consultant pharmacist stated			
		any issues with medications			
		to be administered to			
		lity. When asked specifically			
		consultant pharmacist stated			
		arcotic it was a little more			
	obtaining from the F	ring process as well as ² yxis MedStation.			
		BPM a pharmacist at the			
		cy pulled up the records of			
		oted the 05/30/17 prescription			
		sident #96 had not been			
		acy until 05/31/17 at 9:34 AM.			
		ted the prescription had been f 05/31/17 and sent to the			
	facility on the 12:30				
		-			
		:15 PM-4:00 PM the interim			
		(DON) was interviewed about amadol for Resident #96. The			
	-	the facility had a form called			
		ay form which staff utilized to			
		lents in need of a prescription			
		he interim DON stated all			
		sible for looking at the			
		ons left for residents and			
	either informing the				
	-	menting on the Narcotic			
		resident needs for narcotic			
	refills. The interim I	DON stated typically nurses			

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If continuation sheet Page 16 of 34

	-	ND HUMAN SERVICES			PRINTED: 06/20/201 FORM APPROVE OMB NO: 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
	\mathbf{D}	345415	B. WING		06/02/201 <u>7</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
	E REHABILITATION AND		1010	LAKEVIEW DRIVE	
			PINE	EVILLE, NC 28134	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309	or nurse practitioner building. The interim would document nee sheet if the physiciar not in the building for were present. The ir were no set paramet certain number of me when the need was s explained the name of Tuesday) had nothin prescription would be verified it appeared F AM on 05/30/17 until without Tramadol. T appeared Resident # on 05/30/17, the 12:0 the 8:00 AM dose on hours late. The inter why the prescription Fax'd to the pharmado facility's attention. The did not know who Fa pharmacy on 05/31/1 DON stated if the me nursing staff should a the Pyxis MedStation she did not know the	e 16 brt the need to the physician if they were present in the DON stated the nurses ds on the Narcotic Tuesday or nurse practitioner were them to address when they neers for staff to go by (like a edications remaining), just seen. The interim DON of the sheet (Narcotic g to do when the need for a e written. The interim DON Resident #96 went from 9:00 12:20 PM on 05/31/17 he interim DON stated it 496 missed the 4:00 PM dose 00 AM dose on 05/31/17 and 05/31/17 was over four im DON could not explain for Tramadol had not been cy until it was brought to the he interim DON stated she x'd the prescription to the 17 at 9:34 AM. The interim edication was not available access the medication from h. The interim DON stated Pyxis was down the evening n't aware it was down the	F 309		
	access it for the Tran interim DON stated to second shift nursing available 24 hours an 05/30/17. The interim was available 24/7 for DON stated if a med	until Nurse #4 attempted to nadol for Resident #96. The hey currently did not have a supervisor but she was nd could have been called on n DON stated the pharmacy or Pyxis support. The interim ication was not available she ess the Pyxis MedStation.			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/20/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/201 <u>7</u>
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PINEVILL	E REHABILITATION AN	ID LIVING CTR		LAKEVIEW DRIVE EVILLE, NC 28134	
04015	SUMMA DV S	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 309	Continued From pa	ge 17	F 309		
F 325 SS=D	was down she expe be notified. The intr pharmacy was also 9:00 PM. The interi- not borrow narcotic: of the approximate Baclofen to Resider awaiting the Tramace would have expected On 06/02/17 at 4:16 she expected medic given as ordered by administrator stated that resulted in Tran Resident #96 as or 483.25(g)(1)(3) MA UNLESS UNAVOID (g) Assisted nutritio (Includes naso-gast both percutaneous percutaneous endo enteral fluids). Base comprehensive ass ensure that a reside (1) Maintains accep status, such as usu body weight range a the resident's clinica this is not possible o indicate otherwise; (3) Is offered a there	INTAIN NUTRITION STATUS DABLE n and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must	F 325		6/19/17

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CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/20/20 FORM APPROVI OMB NO. 0938-03 (X3) DATE SURVEY	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345415	B. WING		06/02/201 <u>7</u>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	E REHABILITATION AN			1010 LAKEVIEW DRIVE		
				PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	
F 325	Continued From pa	ae 18	F 32	5		
		NT is not met as evidenced	1 02			
	by:					
		ions, staff and nurse		Resident # 49 was given the ordered	1	
	practitioner interview facility failed to prov	ws, and record review, the vide a nutritional supplement		supplement as of 6/2/17.		
		esidents at risk for weight loss		An audit of all residents with ordered		
	(Resident #49).			nutritional supplements was complete	-	
	The findings include	- d.		the Registered Dietician as of 6/6/17		
	The findings include	ed:		ensure that they are receiving nutritio supplements per physician's order.	nai	
	Resident #49 was a	admitted to the facility on		supplements per physician's order.		
		oses which included dementia		The Dietary Manager will review new		
	and osteoarthritis.			supplement orders daily to ensure that		
				they are reflected on the MAR or tray		
	Review of physiciar	n's orders dated 12/12/16		and report on new supplements, inclu	ıding	
		#49 should receive a frozen		new admissions during the facility		
	nutritional suppleme and dinner meals.	ent twice daily with the lunch		morning meeting.		
				All Dietary and Nursing staff were		
		#49's annual Minimum Data		re-educated regarding the importance) of	
	Set (MDS) dated 12	erely impaired cognition. The		providing nutritional supplements as ordered as of 6/19/17.		
		ident #49 ate independently				
		eived a mechanically altered		Dietary and Nursing staff who were		
		ant weight loss or gain.		unavailable for the re-education will n	ot be	
	-			allowed to work until the education is		
		#67's Nutritional Status Care		complete.		
		CAA) dated 12/28/16 revealed				
		cian (RD) documented		Newly hired Dietary and Nursing staff		
		ght of 82 pounds on 12/13/16		be educated regarding the importance		
		oss of 5.7% in the past 6		receiving nutritional supplements at the time of hire.	ie	
		(Body Mass Index) below 5. (BMI is a measure of body				
		and height; under 18.5 is		The DON, The West Unit Nursing		
		eight as defined by the		Coordinator or the East Unit Nursing		
	National Institute of			Coordinator will audit 5 residents per		
		ent #49 received a frozen		week on the administration of nutrition		
		ent which provided an		supplements x one month with report		
		alories and 18 grams of		the administrator weekly.		

Facility ID: 923298

	-	ND HUMAN SERVICES			PRINTED: 06/20/201 FORM APPROVE DMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	345415 D LIVING CTR	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		06/02/201 <u>7</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 325	weight gain was des Review of a RD's no Resident #49's weig supplement should Review of Resident 12/28/16 revealed a Interventions include and intake monitorin Review of Resident 02/20/17 revealed a impaired cognition. #49 ate independen significant weight lo Review of Resident revealed the followin 01/04/17, 83 lbs. on 03/07/17, 04/08/17 Review of Resident Administration Reco documentation of fro the lunch and dinne 06/01/17. Observation on 05/3 PM revealed Reside contain a frozen nut #49's dietary slip on frozen nutritional su with the lunch meal. 75% of the lunch meal.	The CAA indicated a gradual sirable. The CAA indicated a gradual sirable. the dated 12/28/16 revealed (ht, intake and acceptance of be monitored. #49's care plan dated goal of weight maintenance. ed delivery of diet with weight ng. #49's quarterly MDS dated n assessment of severely The MDS indicated Resident tly after set-up with no ss. #49's weight measurements ng: 83 pounds (lbs.) on 02/03/17, 81 lbs. on and on 05/05/17. #49's electronic Medication ord (eMAR) revealed ozen nutritional acceptance at r meals from 05/30/17 to 80/17 from 1:05 PM to 1:40 ent #49's lunch meal did not ritional supplement. Resident the meal tray indicated a pplement should be served Resident #49 consumed eal. At 1:41 PM, Resident toom without receipt of a	F 325	The DON will report monthly on the results of these audits once per month a one month, once per quarter x 11 month. The QA&A committee will evaluate the findings of these audits and evaluate the effectiveness of the plan and make changes as indicated.	าร.	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/20/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	
		345415	B. WING _			06/	02/201 <u>7</u>
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND) LIVING CTR			INEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	Observation on 06/0 PM revealed Resider contain a frozen nutr #49's dietary slip on frozen nutritional sup with the lunch meal. left the dining room v nutritional supplement Interview with Nurse 1:31 PM revealed the provided frozen nutri meal trays. NA #3 et monitoring of the manotice if Resident #4 nutritional supplement Interview with Nurse revealed she relied of the dining room to re and frozen nutritional could not recall if Resident if Resident if nurse #2 explained simeals taken in the manotice if revealed she docume frozen nutritional sup did not verify receipt Observation on 06/0 Resident #49's dinner frozen nutritional sup dietary slip on the me nutritional sweet sup with the dinner meal. Interview on 06/02/1	 1/17 from 1:01 PM to 1:27 ht #49's lunch meal did not itional supplement. Resident the meal tray indicated a plement should be served Resident #49 consumed 50 At 1:30 PM, Resident #49 without receipt of a frozen nt. Aide (NA) #3 on 06/01/17 at e dietary department tional supplements on the xplained she was assigned in dining room and did not 9 received a frozen nt. #2 on 06/01/17 at 4:21 PM on nursing staff assigned to port consumption of meals I supplements. Nurse #2 sident #49 received or nutritional supplement. She did not routinely monitor ain dining room. Nurse #2 ented acceptance of the plement on the eMAR but of the supplement. 1/17 at 6:24 PM revealed ar meal did not contain a plement. Resident #49's eal tray indicated a frozen plement should be served 	F3	325			

Facility ID: 923298

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED 50RM 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE	
PINEVILLI	E REHABILITATION AND	LIVING CTR		PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 325	Resident #49 during staff in the dining roo consumption of meal Interview with the die 06/02/17 at 9:31 AM should receive a froz with the lunch and su explained staff should dietary slip and check delivery. Interview with the nur at 9:47 AM revealed to receive a frozen nut daily as ordered. Interview with the inter (DON) on 06/02/17 at expected Resident #4 frozen nutritional sup reported she expected frozen nutritional sup dietary department. A second interview w at 11:21 AM revealed lbs. on 06/02/17 at 2 #49 should be offered supplement with the	reported she did not observe lunch meal and relied on m to monitor receipt and s. tary manager (DM) on revealed Resident #49 en nutritional supplement pper meals. The DM d follow the guidance on the k compliance prior to meal rse practitioner on 06/02/17 she expected Resident #49 utritional supplement twice erim Director of Nursing t 9:50 AM revealed she 49 to receive the ordered plements. The interim DON ed nursing staff to obtain the plement if omitted by the ith interim DON on 06/02/17 I Resident #49 weighed 82 with the registered dietician 2:20 PM revealed Resident	F 32		
F 333		important intervention in and nutritional status. NTS FREE OF	F 33	3	6/19/17

Facility ID: 923298

If continuation sheet Page 22 of 34

		ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/201 <u>7</u>
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
		D LINING CTR	1	010 LAKEVIEW DRIVE	
PINEVILL	E REHABILITATION AN	DEIVINGETR	F	PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 333 SS=G	SIGNIFICANT MED 483.45(f) Medication The facility must ens	ERRORS Errors.	F 333		
	This REQUIREMEN by: Based on observation resident/staff/pharma interviews and media failed to administer p the physician for 1 of reviewed for pain ma The findings include Resident #96 was and with diagnoses which affecting right domin right shoulder repain The quarterly Minima assessed Resident # impairment and takin medication. Physician/nurse prace medical record of Res following: 04/27/17-The physic and noted a history of physician noted Res right shoulder with d the right shoulder as motion. The physici	acist/nurse practitioner cal record review the facility pain medication as ordered by f 3 sampled residents anagement. (Resident #96) d: dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/17 f muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d d dmitted to the facility 07/31/16 h included hemiplegia ant side, muscle spasms and d d d d d d d d d d d d d d d d d d		Resident #96's tramadol was obtained and resident was medicated per physician's order as of An audit of all residents with ordered p medications was completed by the We Unit Nursing Coordinator, East Unit Nursing Coordinator and the Second S Supervisor as of 5/31/17 to ensure that prescribed pain medications were available. All available nurses were re-educated related to the importance of the followin Pain assessments Availability of pain medications System for reordering pain medications Steps to take when medications are no available, such as Pixis machine, back pharmacy Steps to take if the Pixis machine is no working order or the medication is not the Pixis, utilization of back up pharma Nurses that were unavailable for re-education will not be allowed to pass medications or work at facility until the education is completed.	ain st hift tall ng: st up t in n cy

Facility ID: 923298

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CENTERS	FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	PRINTED: 06/20/201 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN OF CO	DRRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	VIDER OR SUPPLIER	345415	B. WING	IREET ADDRESS, CITY, STATE, ZIP CODE	06/02/201 <u>7</u>
				10 LAKEVIEW DRIVE	
PINEVILLE R	REHABILITATION AND	D LIVING CTR	PI	INEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
Cisi Si Oa ORpeisgs# Rrem-Triwa-Em-L h RRdow Cowrea T	capula.) Due to the 4/27/17 the physicia nd an X-ray of the r 5/30/17-The nurse p Resident #96 for righ ractitioner noted Reveluation of pain to sues with osteoarth eneralized discomfor troke. The nurse pr 96 as alert and orie Review of current ph ecord of Resident #9 hedications were or Tramadol HCL 50 m noderate to moderat vas scheduled to be nd 4:00 PM. Baclofen 5 milligram huscle spasticity. Lidoderm patch righ ours on, 12 hours o Review of the X-ray r Resident #96 noted a egenerative joint dis therwise, no fracture vas seen.	a the humerus and the right shoulder pain on an ordered Lidoderm patch ight shoulder. oractitioner assessed t shoulder pain. The nurse sident #96 was seen for the right side; noting he had writis of the right joint and ort to the right side since his actitioner assessed Resident inted X 2. ysician orders in the medical 26 noted the following dered: illigrams every 8 hours for tely severe pain. Tramadol given at 12:00 AM, 8:00 AM as as needed twice a day for t shoulder every day,12	F 333	All newly hired nurses will be educate regarding the following at the time of the Pain assessments Availability of pain medications System for reordering pain medications available, such as Pixis machine, back pharmacy Steps to take if the Pixis machine is new working order or the medication is not the Pixis, utilization of back up pharmat The Director of Nursing or the East Un Nursing Coordinator or the West Unit Nursing Coordinator or the Second St Nursing supervisor will audit 5 resider per week to ensure the availability of p medications. These audits will be performed weekly x one month with re to the QA&A committee will evaluate the findings to determine the effectiveness the plan and make changes as needed	nire.

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NDD PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING A BUILDING NAME OF PROVIDER OR SUPPLIER 345415 B. WING PINEVILLE REHABILITATION AND LIVING CTR STREET ADDRESS, CITY, STATE, ZIP CODE (M) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EXCH OPERCENCY MUST EP PRECEDED BY PLL) (EXCH OPERCENCY MUST EP PRECEDED BY PLL) TAG D PREVILLE, NC 28134 F 333 Continued From page 24 Review of the May 2017 Medication Administration Record (MAR) for Resident #96 noted the 8:00 AM dose of Tramadol had not been documented as given that moming. The 4:00 PM dose of Tramadol no 05/30/17 was documented as for given" by Nurse #5 due to no5/31/17 at 9:26 AM Nurse #3 (assigned to work with Resident #96 on 05/31/17 from 7:00 AM-3:00 PM) stated she had not given moming medication not available." The 12:00 AM dose on 05/31/17 at 9:26 AM Nurse #3 (assigned to work with Resident #96. Nurse #3 quench there was no Tramadol available to give to Resident #96. Nurse #3 stated she would ask another staff nurse to obtain a Tramadol for Resident #96. Nurse #3 stated she would ask another staff nurse to obtain a Tramadol for Resident #96. Nurse #4 stated because Tramadol was not operating and, as a result, Tramadol was a no tramadol available to dive to Resident #96. Nurse #4 stated because Tramadol was not operating and, as a result, Tramadol was not neading accessible to definiter to Resident #96. Nurse #4 stated because Tramadol was a narcofic it required a written prescription for re-ordering. Nurse #4 stated each nurse was responsible for checking when a residents narcofic medication was "getting low" so the IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	TED: 06/20/2 DRM APPRO\ <u>NO. 0938-0</u> 3
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responsible for checking when a residents narcotic medication was "getting low" so the	
narcotic medication was "getting low" so the	
I shusision or nurse prestitioner equilable patified	
physician or nurse practitioner could be notified	
and a prescription written. Nurse #4 stated if the medication wasn't available staff should obtain it	
from the Pyxis MedStation. Nurse #4 stated she	
did not know how long the Pyxis MedStation had	
not been working. The Nurse Practitioner (NP)	
was present at the time of the interview and	

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/20/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
PINEVILL	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE	
				PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 333	recalled she had just continued need of the prescription. The NF verified she had seer and wrote the prescr NP stated she would to be delivered from for administration to 1 On 05/31/17 at 10:40 Record for the Trama requested from Nurs request the NP was of #3 about her (the NP #96's pain that morni recommended giving spasms until the Tran for administration. Review of the Contro Resident #96 on 05/3 last dose of Tramado signed as given on 0 On 05/31/17 at 10:45 done with Nurse #6. worked with Residen PM until 05/31/17 at she recalled giving se during her shift but of regarding Resident # gave Tramadol to Re recorded it on the Co #6 stated she would Tramadol for Residen never borrow a narco the last dose of Tram #96 was 05/30/17 at	assessed Resident #96 for e Tramadol and written a P looked at her notes and a Resident #96 on 05/30/17 iption for the Tramadol. The have expected the Tramadol the pharmacy on 05/30/17 Resident #96. • AM the Controlled Drug adol for Resident #96 was e #3. At the time of the overheard talking to Nurse 's) assessment of Resident ng and the NP the Baclofen for muscle madol arrived at the facility	F 3	333	

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	MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
	345415	B. WING		06/02/201 <u>7</u>
OVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
REHABILITATION AN		1010		
		PINE	EVILLE, NC 28134	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG		DATE
Continued From page	ie 26	F 333		
her shift and stated t	here was a possibility she			
still had not received	the Tramadol and he felt like			
scale of 1-10 (with 1 05/31/17 at 12:00 Pt	0 being severe pain.)On M Resident #96 reported he			
still had not received	I his Tramadol.			
had not given Reside	ent #96 the 8:00 AM dose of			
NP at 10:40 AM). N	urse #3 stated it was her			
wasn't in pain but ha	d muscle tightness. Nurse			
verify this. Nurse #3	entered the room of			
-				
-	-			
•	• • •			
•				
•	•			
produced a paper wi	here she documented the			
	6			
	•			
	OVIDER OR SUPPLIER REHABILITATION AND SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From pag her shift and stated t signed off for the me On 05/31/17 at 10:59 still had not received his arm was pulling a scale of 1-10 (with 1 05/31/17 at 12:00 PP still had not received No 05/31/17 at 12:11 had not given Reside Tramadol or the Bac NP at 10:40 AM). N understanding from 1 wasn't in pain but ha #3 offered to go to th verify this. Nurse #3 Resident #96 and as get out of bed to eat he was hurting too m and was waiting for l stated to Resident # him that morning and tightness, not pain. I am hurting. Nurse his pain level was ar Nurse #3 returned to produced a paper wil report from the NP (i which noted no pain Baclofen. Nurse #3 the Baclofen to Resi no, she was planning On 05/31/17 at 12:11 Nursing was asked i operating and she re-	A 345415 OVIDER OR SUPPLIER REHABILITATION AND LIVING CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 her shift and stated there was a possibility she signed off for the medication but did not give it. On 05/31/17 at 10:59 AM Resident #96 stated he still had not received the Tramadol and he felt like his arm was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.) On 05/31/17 at 12:13 PM Nurse #3 stated she had not received his Tramadol. On 05/31/17 at 12:13 PM Nurse #3 stated she had not given Resident #96 the 8:00 AM dose of Tramadol or the Baclofen (as suggested by the NP at 10:40 AM). Nurse #3 stated it was her understanding from the NP that Resident #96 to verify this. Nurse #3 entered the room of Resident #96 and asked him if he was going to get out of bed to eat lunch. Resident #96 stated he was hurting too much to get out of bed or eat and was waiting for his medication. Nurse #3 stated to Resident #96 that the NP had assessed him that morning and he was having muscle tightness, not pain. Resident #96 repponded, no, I am hurting. Nurse #3 asked Resident #96 what his pain level was and Resident #96 replied "10". Nurse #3 returned to her medication cart and produced a paper where she documented the report from the NP (at approximately 10:40 AM) which noted no pain, muscle tightness and given Baclofen. Nurse #3 was asked if she had given the Baclofen to Resident #96 and she reported no, she was planning on doing that. On 05/31/17 at 12:15 PM the interim Director of Nursing was asked if the Pyxis MedStation was operating and she reported it "went up" at 11:24 AM. The interim Director of Nursing was asked if the interim Director of Nursing was asked if	OVIDER OR SUPPLIER 345415 B. WING REHABILITATION AND LIVING CTR ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 26 F 333 her shift and stated there was a possibility she signed off for the medication but did not give it. F 333 On 05/31/17 at 10:59 AM Resident #96 stated he still had not received the Tramadol and he felt like his arm was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.) On 05/31/17 at 12:00 PM Resident #96 reported he still had not received his Tramadol. On 05/31/17 at 12:13 PM Nurse #3 stated she had not given Resident #96 the 8:00 AM dose of Tramadol or the Baclofen (as suggested by the NP at 10:40 AM). Nurse #3 stated it was her understanding from the NP that Resident #96 wasn't in pain but had muscle tightness. Nurse #3 offered to go to the room of Resident #96 and asked him if he was going to get out of bed to eat lunch. Resident #96 to eat and was waiting for his medication. Nurse #3 stated to Resident #96 that the NP had assessed him that morning and he was having muscle tightness, not pain. Resident #96 reported, no, I am hurting. Nurse #3 asked Resident #96 what his pain level was and Resident #96 replied "10". Nurse #3 returned to her medication cart and produced a paper where she documented the report from the NP (at approximately 10.40 AM) which noted no pain, muscle tightness and given Baclofen. Nurse #3 was asked if she had given the Baclofen. Nurse #3 was asked if she had given the Baclofen. Nurse #3 was asked if the Pyxis MedStation was operating and she reported it "went up" at 11:24 AM. The interim Director of Nursing was asked if	345415 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION AND LIVING CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST PRECEDED BY FULL REGULATORY OR LIC DEMIFITING INFORMATION) REFINATION INFORMATION) REFINATION OF DEFICIENCIES (EACH DEFICIENCY MIST PRECEDED BY FULL REGULATORY OR LIC DEMIFITING INFORMATION) REFINATION OF DEFICIENCIES (EACH DEFICIENCY MIST PRECEDED BY FULL REGULATORY OR LIC DEMIFITING INFORMATION) TAGE Continued From page 26 her shift and stated there was a possibility she signed off for the medication but did not give it. On 05/31/17 at 10:59 AM Resident #96 stated he still had not received his Tramadol and he felt like his arm was pulling and his pain was a 10 on a scale of 1-10 (with 10 being severe pain.) On 05/31/17 at 12:13 PM Nurse #3 stated thes still had not received his Tramadol. On 05/31/17 at 12:13 PM Nurse #3 stated thes still had not received his Tramadol. On 05/31/17 at 12:13 PM Nurse #3 stated thes still had not received his Tramadol. On 06/31/17 at 12:13 PM Nurse #3 stated thes state to Resident #96 for the room of Resident #96 fand asked him if he was going to get out of bed to eat lunch. Resident #96 to verify this. Nurse #3 attest the Resident #96 for pointed him that murcing and he was having muscle tightness, not pain. Resident #96 responded, no, lam nuring, Nurse #3 atked Resident #96 had by him that murcing to much to get out of bed or eat and was waiting for his medication. Nurse #3 stated to Resident #96 responded, no, lam nuring, Nurse #3 atked Res

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEVILLE REHABILITATION AND LIVING CTR			1010 LAKEVIEW DRIVE		
				PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 333	administration to Res responded, not yet. approximately 12:20 gave Resident #96 th Tramadol. On 05/31/17 at 12:30 she was aware Resid doses of Tramadol a The administrator sta all narcotics for resid was available to be g On 05/31/17 at 12:48 done with the NP. T Resident #96 on 05/3 prescription for the T Tramadol was warra NP stated she did as morning (around 10: describe his pain. Th reported his right arm right bicep of Reside calf and noted his mu of the tightness, the the right bicep and ri Resident #96 reported The NP stated she to have Nurse #3 give I Tramadol arrived to s muscle pain. The NI with Nurse #3 and to while awaiting the Tr expected the Baclofe minutes of their discu	 ben taken out of the Pyxis for sident #96 and she On 05/31/17 at PM Nurse #3 reported she he (8:00 AM scheduled) O PM the administrator stated dent #96 had missed several nd agreed it was a concern. ated they were going to audit lents to ensure medication given to residents as ordered. 5 PM a phone interview was he NP stated she assessed 30/17 prior to writing the framadol and felt the nted for Resident #96 that 40 AM) and asked him to he NP stated Resident #96 an felt "tight" and she felt the nt #96 as well as his right uscles were tight. Because NP reported she massaged ght calf of Resident #96 and ed a little relief from pain. Old Resident #96 she would him the Baclofen until the see if it would relieve his P stated she discussed this old her to give the Baclofen amadol and she would have en to be given within 30 ussion. 	F 33	3	
		PM in a follow-up interview got "caught up in a lot of			

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		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/201 <u>7</u>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
			1	010 LAKEVIEW DRIVE	
PINEVILL	E REHABILITATION AN		P	PINEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 333	was not given to Result of the second states and the second states and the second states are second states and the second states are stated she recalled the states are stated she second and states are states and she second are states and she second are states and she second are states are states and for Reside nurse told her the Py working which was we dose of Tramadol for Reside nurse told her the Py working which was we dose of Tramadol are states and and the second are states are states and the second states are states and the second are states are states and the second are states are states and the second are states are states are states and the second are states are states and the second are states are states are states and the second are states are and the second are are states are and the second are are and the second are are and the second are and the second are are are and the are are are are are are are are are ar	which was why the Baclofen sident #96 from 10:40 AM ittention at 12:13 PM. Nurse vent back and checked on e received the Tramadol and orted his pain had gone from 5 AM in a phone interview e worked with Resident #96 00 PM-11:00 PM. Nurse #5 he Tramadol was not to Resident #96. Nurse #5 other nurse with access edStation to obtain a nt #96. Nurse #5 stated this vxis MedStation wasn't vhy she charted the 4:00 asn't available on the MAR of 30/17. PM the consultant s expectation was for medications as ordered by ially medications for pain consultant pharmacist stated iny issues with medications o be administered to ity. When asked specifically consultant pharmacist stated rootic it was a little more ing process as well as	F 333		

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		ND HUMAN SERVICES			PRINTED: 06/20/20 FORM APPROVE OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		06/02/201 <u>7</u>
	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE LAKEVIEW DRIVE	
			PINI	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 333	Continued From pag	je 29	F 333		
	The pharmacist state	ed the prescription had been 05/31/17 and sent to the			
		15 PM-4:00 PM the interim			
	Director of Nursing (DON) was interviewed about amadol for Resident #96. The			
	interim DON stated t	he facility had a form called			
		y form which staff utilized to ents in need of a prescription			
	•	e interim DON stated all			
		sible for looking at the			
	quantity of medicatio	ons left for residents and			
	either informing the				
	-	nenting on the Narcotic			
		esident needs for narcotic			
		ON indicated typically nurses			
		ort the need to the physician if they were present in the			
	•	n DON stated the nurses			
		eds on the Narcotic Tuesday			
	sheet if the physiciar	n or nurse practitioner were			
	÷	r them to address when they			
		nterim DON reported there			
		ters for staff to go by (like a			
		edications remaining), just seen. The interim DON			
		of the sheet (Narcotic			
	•	ig to do when the need for a			
		e written. The interim DON			
		Resident #96 went from 9:00			
		I 12:20 PM on 05/31/17			
		he interim DON stated it			
		#96 missed the 4:00 PM dose			
		00 AM dose on 05/31/17 and n 05/31/17 was over four			
		rim DON could not explain			
		for Tramadol had not been			
		cy until it was brought to the			
	7(02-99) Previous Versions Ob		<u> </u>	/ ID: 923298 If continu	ation sheet Page .30 c

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/20/2 FORM APPRO\ OMB NO. 0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
	$2 \cap ($	345415	B. WING		06/02/201 <u>7</u>
ME OF PF	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
INEVILLE REHABILITATION AND LIVING CTR					
			PINI	EVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 333	Continued From pa	ae 30	F 333		
	-	The interim DON stated she	1 000		
	•	ax'd the prescription to the			
		/17 at 9:34 AM. The interim			
		nedication was not available			
	nursing staff should	l access the medication from			
		on. The interim DON reported			
		e Pyxis was down the evening			
		sn't aware it was down the			
	•	7 until Nurse #4 attempted to			
		amadol for Resident #96. The			
		they currently did not have a g supervisor but she was			
		and could have been called on			
		rim DON stated the pharmacy			
		for Pyxis support. The interim			
		dication was not available she			
	expected staff to ac	ccess the Pyxis MedStation.			
	The interim DON st	ated if the Pyxis MedStation			
	was down she expe	ected a supervisor or herself to			
		tion, the interim DON stated			
		acy was also available until			
		PM. The interim DON stated			
		row narcotics. The interim			
		e approximate 1 1/2 hour			
		lofen to Resident #96 on aiting the Tramadol) and the			
		build have expected it to be			
	given sooner.				
	On 06/02/17 at 4:18	5 PM the administrator stated			
		cations to be available and			
	• •	y the physician. The			
		there was a system failure			
		madol not being given to			
	Resident #96 as or				
F 500	483.70(g)(1)(2)(i)(ii) RESOURCES-ARF) OUTSIDE PROFESSIONAL	F 500		6/19/17
SS=D	NLOUNOLO-ANN				

	MENT OF HEALTH AND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
	345415	B. WING		06/02/201 <u>7</u>
NAME OF PI	ROVIDER OR SUPPLIER	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	E REHABILITATION AND LIVING CTR	1	010 LAKEVIEW DRIVE	
		P	PINEVILLE, NC 28134	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 500	Continued From page 31 (g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g) (2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain written agreements for services provided by two outside providers for 2 of 2 residents (Resident #52, Resident #19) receiving dialysis services. The residents	F 500	Current contracts are in place for all active Dialysis residents as of 6/2/17 An audit of all contracts was completed of 6/19/17 to ensure that the facility has	
	received dialysis without a contract in place. Findings included: 1. A review of the list of residents who received dialysis and the dialysis centers where they		contracts for all vendors. The Administrator was re-educated by Regional Director of Operations as of 6/2/17 regarding the importance of hav contracts with all outside vendors	
	received their dialysis was provided by the Director of Nursing (DON) revealed Resident #52 received dialysis at Dialysis Center #1.		The Administrator will audit all new vendors as they are contracted with to	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 06/20/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345415	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	02/201 <u>7</u>
PINEVILL	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 500	(MDS) dated 05/16/2 resident was receivin An interview on 06/02 Registered Dietician with the dialysis cented diet orders from the of and entered by the mile 2. A review of the list dialysis and the dialy received their dialysis Director of Nursing (Director of	 #52's Minimum Data Set 017 documented the g dialysis. 2/2017 at 2:16 PM with the revealed she communicated er dietician. She stated any lialysis center were received urses. of residents who received sis centers where they s was provided by the DON) revealed Resident #19 vices at Dialysis Center #19's MDS dated 	F 50	0 ensure that there is a signed contract w all outside vendors with report to the QA&A committee monthly x 1 year. The QA&A committee will evaluate the effectiveness of the plan and make changes as indicated.	<i>i</i> ith	

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		AND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345415	B. WING		06/02/201 <u>7</u>
NAME OF PI	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
	E REHABILITATION			0 LAKEVIEW DRIVE	
			PIN	IEVILLE, NC 28134	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 500	aware that they d contracts for Dialy contacted the dia dialysis contracts A review 06/02/20 Center #1 and #2 facility had obtain Dialysis Centers a dialysis facility's r facilities responsi management of th	e vendor. She was new and not id not have copies of current ysis Centers #1 and #2. She lysis centers and obtained with dialysis Centers #1 and #2. 017 of the contracts for Dialysis with the facility indicated the ed a written agreement with #1 and #2 which included the esponsibilities, the nursing bilities, the medical ne residents, transportation and g and communication between	F 500		
FORM CMS-256	7(02-99) Previous Version	s Obsolete Event ID:9YRt	N11 Facili	ty ID: 923298 If continu	uation sheet Page 34 of 34