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 _____	05/10/2018

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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interview, the facility failed to honor resident's activities of interest and choice by limiting his ability to go to out of room/floor activities independently for 1 of 1 sampled resident reviewed for choices (Resident #1). Findings included:	F 561	F561 Self-determination 1. A reassessment was completed on 5/31/18 by the MDS Coordinator, Social Worker, and Life Enrichment Associate with Resident #1 and a care plan was held with resident and responsible party on 6/6/18 to address resident's ability,	6/7/18

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

Electronically Signed | 05/26/2018

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 _____	05/10/2018

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 561	Continued From page 1 Resident #1 was admitted to the facility on 7/29/15 with multiple diagnoses including Bipolar disorder. The annual Minimum Data Set (MDS) assessment dated 7/25/17 indicated that Resident #1's activity preferences that were very important to him included going outside to get fresh air when the weather was good, going to his favorite activities and doing things with group of people. The quarterly MDS assessment dated 4/18/18 indicated that Resident #1 had moderate cognitive impairment and needed supervision with ambulation and transfer. The assessment also indicated that he had clear speech and he was able to understand others and able to make self-understood. The Interdisciplinary (ID) notes were reviewed. The notes dated 3/2/18 revealed that Resident #1 enjoyed going to the Village House (separate building) for meals. The notes dated 4/17/18 indicated that Resident #1 would continue to make his own choices with daily routine. The activity notes dated 4/18/18 indicated that Resident #1 was alert and he enjoyed watching television, reading in the library (second floor), going to the Village House activities, and special events. The resident had walked to activities with his walker. The team would encourage out of room activities of interest and choice. The notes dated 4/25/18 indicated that the first responder was called out because Resident #1 was found off campus. He was returned back into his room and he stated that he was trying to	F 561	opportunities and choices in regard to routines and activities to maintain highest level of independence. The resident was interviewed by Social Worker and Life Enrichment Associate to develop a self-determined plan of activities and routines by 6/5/18. Deficient practice for the resident was corrected on 6/6/18 placing the facility in compliance on 6/6/18. 2. A review of all residents who are alert and oriented will be completed by 6/5/18 to determine if activities of interest and choice are being honored. This review will be completed by Penick Village Life Enrichment Associate. Results will be used to further individualize the resident life enrichment plan of care. Any necessary updates will be documented with an Activities Daily Note in Matrixcare following any noted change in interest and choice. 3. With any change in resident behavior and condition that limits individuals' ability to self-determination of activities of choice; an assessment and care plan will be completed by the Interdisciplinary Care Team, to reflect opportunities to maximize resident activities and interest of choice. Monitoring in this way will ensure that residents' right to self-determination is being met. Clinical staff in-service on self-determination, resident rights, communication and documentation was held on 5/31/18. This in-service was led by the Healthcare Administrator and Director of Nursing. Any clinical staff not in-serviced will be removed from the schedule until in-servicing has taken	

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 _____	05/10/2018

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 561	Continued From page 2 leave (name of facility) to see what it was like outside. A secure alarm (device that will immediately alarm and automatically lock the door) was placed on his right ankle. On 5/9/18 at 2:50 PM, Resident #1 was observed in his room watching television. He was wearing a secure alarm on his right ankle. He stated that he would love to eat at the Village House and to go to the gym upstairs but he could not go by himself any time anymore because of the secure alarm (pointing to his right ankle). On 5/9/18 at 3:05 PM, Nurse #3 was interviewed. She stated that she had assessed Resident #1 when he was returned back into his room on 5/25/18. He was alert and oriented, knew her name (name of the Nurse), where he went and the time of the day. Nurse #3 stated that when he came back, a secure alarm was placed on his leg. She added that Resident #1 was no longer able to go to the Village House to eat and to the gym when he wanted to go, "I hate it for him, he is very independent" the Nurse stated. On 5/9/18 at 3:08 PM, the Activity Director was interviewed. She stated that Resident #1 would like to attend activities at the Village House, to go to the library and gym upstairs and to attend special events. She indicated that Resident #1 had to go to these activities with assistance now, he could not go by himself because he had a secure alarm. On 5/10/18 at 10:22 AM, Elderly Assistant (EA) # 1 was interviewed. EA #1 stated that she was assigned to Resident #1. She stated that Residents #1 used to eat at the Village House	F 561	place. All full-time skilled nursing staff must be in-serviced no later than 6/7/18 to ensure complete compliance. 4. Over the next three months, monitoring will be conducted through the following steps: - Weekly Interdisciplinary Care Team meetings which will include discussion of any resident who has indicated a limitation in ability to have access to activities of interest and choice will be ongoing. - This information will be collected by the Life Enrichment Associate through weekly Interest Interviews with each resident for the first month, - Findings will be audited by Social Worker through month two, and - Results will be reported in monthly QA by Social Worker/MDS Coordinator to track patterns and trends until the end of the third month.	

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 _____	05/10/2018

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 561	Continued From page 3 and now he had to eat in his room all meals. On 5/10/18 at 10:45 AM, the Administrator was interviewed. She stated that Resident #1 was still able to go upstairs for activities and to the Village House for meals but he had not asked the staff to take him.	F 561		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their written policy and procedure for investigating and reporting of an injury of unknown origin (UKO) for one of one sampled residents reviewed for injuries of UKO (Resident #24). The findings included: Review of the facility policy titled "Resident Abuse and Neglect" last revised December 2017 stated, in part, "L. Injuries of Unknown Source are classified as such when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident:	F 607	F607 Develop and Implement Abuse, Neglect and Exploitation of Residents and Misappropriation of Resident Property Policy 1. An investigation was started on 5/8/18 by the Director of Nursing (DON) on Resident #24 for Injury of Unknown Origin (IUO) and completed on 5/11/18. Resident is not alert and oriented and was unable to participate in investigation. DON unable to determine cause of bruising from investigation findings. The resident was seen by the psychotherapy nurse	6/7/18

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 _____	05/10/2018

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 607	Continued From page 4 and b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. E. Reporting/Response 1. The Healthcare Administrator or his/her designee will notify the State Agency of alleged violations involving abuse, neglect, misappropriation of resident property and injuries of unknown source as soon as possible but in no event later than 24 hours from the time the incident/allegation was made known to them." Resident #24 was admitted to the facility 1/19/15 with cumulative diagnoses of dementia with behavioral disturbance, atrial fibrillation and advanced dementia. A quarterly Minimum Data Set (MDS) dated 3/28/18 indicated Resident #24 had short and long-term memory impairment and was moderately impaired in decision-making skills. Resident #24 displayed physical behavior directed towards others 1-3 days during the assessment period. She required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, personal hygiene and bathing. Total assistance was required for toilet use. A care plan dated 4/7/18 stated Resident #24 was at risk for altered skin integrity related to need for extensive assistance with bed mobility, transfers, toileting, incontinence, fragile skin. Interventions noted: Staff to assist with repositioning while in bed or wheelchair during care rounds and as needed. Staff to assist with incontinent care	F 607	practitioner on 5/25/18 and routine visits will be ongoing. The clinical team will work with psychotherapy nurse practitioner and private sitters to document agitation, combativeness or other potential causes of injury. Staff is to report any combative or aggressive behaviors to charge nurse in order to document behaviors. A 24-hour and 5-day report were submitted on 6/8/18, however, the investigation regarding the deficient practice was completed on 5/11/18, placing Penick Village in compliance on 5/11/18. 2. An additional review of all incident reports from 3-1-18 to 5-20-18 to assure all injuries of unknown origin (IUO) were investigated was completed on 5/25/18 by the Assistant Director of Nursing. No other IUOs were found in the investigation. The licensed administrator (LNHA) audited results and presented findings to IDT meeting the following week on 5/26/18. -Beginning with 5/21/18, incident reports are reviewed daily by the ADON and/or weekend Clinical Manager and reported to the clinical team to determine if there had been any reportable IUOs that had not already been reported by within the last 24 hours. This review by the ADON will continue for three months and will be audited weekly by the LNHA for that time period. 3. Measures put into place to ensure that the deficient practice will not occur again include: - Currently, a skin assessment is performed on two residents per shift, but	

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 _____	05/10/2018

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 607	Continued From page 5 during care rounds and as needed. Staff will monitor skin during care rounds and as needed and notify physician and family of any areas of concern. An incident/ accident report dated 5/2/18 at 9:45 AM revealed Resident #24 was observed to have a bruise on left wrist, a bruise on the right wrist, a bruise on the right breast yellow in color, a bruise on the left lower arm and a bruise on the upper left arm. The investigation and follow up all dated 5/8/18 at 12:05 PM stated Resident #24 was assessed due to bruising. Physician was aware and to continue ASA (aspirin) 81 milligrams daily. Resident was noted to be combative during care. Staff to redirect and allow resident time to calm down. There was no documentation to show that an investigation had been conducted to determine the root-cause- analysis of the incident. A nursing note dated 5/2/18 stated Elder Assistant (EA) #1 notified writer of yellow bruise on right breast. Area was 7 centimeters x 4 centimeters. Power of Attorney and physician were notified. No noted pain or distress. There was no documentation of the bruises on the left wrist, right wrist, left upper and/or lower arm. A review of the nursing notes revealed there had been no behaviors documented regarding behaviors or combativeness since 3/25/18. On 5/8/18 at 2:33 PM, an interview was conducted with Elder Assistant (EA) #1. She stated she was familiar with Resident #24. EA #1 stated she provided care for Resident #24 on 5/2/18 and reported the bruises to Nurse #2 on 5/2/18. She stated Resident #24 had some	F 607	will be increased to three residents per shift in partnership with nurses and Elder Assistants (CNAs). This will be ongoing in an effort to further improve quality of care; - A review and update of the Incident and Accident Reporting and Response Philosophy and Process (P&P) took place by Healthcare Administrator and Director of Nursing on 5/18/18. Updates to the P&P included the Implementation of a Root Cause Analysis tool to create a greater understanding of why the incident occurred and to increase success of incident and accident prevention. In the event an IUO occurs, a 24-hour report will be filed with the state, and the DON will conduct an investigation to be followed by the submission of the 5-day report to the state. - Nurses and nursing aides were in-serviced at shift changes by memo and policy review on Incident and Accident P&P on 5/19/19 and as they reported to duty on all shifts including nights and weekends. All remaining staff members will be in-serviced at the Healthcare Services monthly meeting on 5/31/18 by the Director of Nursing. The Licensed Administrator & Director of Nurses will provide in-servicing to remaining Elder Assistants (Nursing Assistants) thus completing the corrective action by 6/7/18, putting the facility back in compliance. Any staff not in-serviced by that date will not be permitted to work. 4. For the next three months, Penick Village will monitor its performance to assure that solutions are sustained	

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 _____	05/10/2018

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 607	Continued From page 6 bruises that were yellow in color and other ones were purplish blue with yellow on the outer edges that were yellow. She said the bruise on the left arm was blue in color and looked like a new bruise to her. She stated Resident #24 was totally dependent on staff for all care and transferred from bed to chair with the use of a total lift and two-person transfer. EA #1 said Resident #24 was known to scratch and bite during care and had been a little agitated that morning. EA #1 said Nurse #2 assisted her with the completion of morning care and helped her put Resident #24 in the chair. On 5/8/18 at 4:18 PM, an interview was conducted with the Director of Nursing (DON). She said the Assistant Director of Nursing (ADON) did the investigations for all incidents/ accidents which included doing the root-cause-analysis. She said all incidents were discussed in the daily morning meeting. On 5/9/18 at 10:57 AM, an interview was conducted with the ADON. She stated she had been completing the incident reports for root-cause-analysis since last year. She said she had focused on falls to make sure all interventions were in place and completed the root-cause- analysis for falls. The ADON stated she did not do an investigation on bruises of unknown origin. The nurses were to monitor the resident and hold aspirin or an anticoagulant per physician ' s order. The ADON stated she read the nursing note dated 5/2/18 on 5/8/18 and the follow-up was completed 5/8/18. The ADON stated she needed to start investigating and doing the root-cause-analysis for more than falls. On 5/9/18 at 10:44 AM, a second interview was	F 607	through the following steps: - All incidents and accidents will continue to be reviewed at the Monday through Friday IDT meetings. - Charge nurses have the authority at all times to contact Licensed Administrator, Director of Nursing or nurse on call for further interventions and support for any incident or accident. - Any licensed nurse, Healthcare Administrator or nursing administrative staff is responsible for completing the 24 Hour Report and 5 Day Report to state. Investigations will be conducted by the DON. - Sample reports and website address will be added to Incident Tracking Binder to facilitate proper reporting if IUO. This will be included by 6/1/18. - Patterns, symptoms and behaviors that are identified through the incident and accident reports will be evaluated by the Licensed Administrator (LNHA), 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 weekly Interdisciplinary Care Team meeting and monthly QA meetings by ADON. Data will be further analyzed by the LNHA and addressed in the QAPI plan, in the event interventions are not successful.	

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 _____	05/10/2018

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 607	Continued From page 7 conducted with the DON. She stated an investigation should have been done to find the root-cause-analysis for the bruises on Resident #24. The DON said she talked to the nursing assistants and to the nurse who wrote the incident report and nursing staff stated some of the bruises were different colors and not new bruises and Resident #24 was combative during care. The DON said she did not document any of the interviews with staff. She was not aware injuries of UKO should be reported to the state agency as noted in their abuse policy. She said the facility did not do a 24 hour and/or a 5 day report to the State agency. On 5/9/18 at 1:19 PM, a telephone interview was conducted with Nurse #2. She stated the bruise on the right breast was yellow in color. The bruises on Resident #24's arms were purple in color and the bruises were noticeable. Nurse #2 stated the Elder Assistant (nursing assistant) had just started doing personal care for Resident #24 when she called Nurse #2 to the room to observe the bruises. She said she called the responsible party and the physician and completed the incident report. On 5/10/18 at 10:50 AM, an interview was conducted with the Administrator who stated all incidents should be investigated and the abuse policy should be followed.	F 607		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		6/6/18

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 _____	05/10/2018

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 625	Continued From page 8 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide information on the bed-hold policy upon transfer to the hospital for 2 of 2 sampled residents reviewed (Residents #26 and #35). The findings included: 1. Resident #26 was admitted to the facility on 2/6/18 and most recently readmitted on 3/1/18 with diagnoses that included dementia. The admission Minimum Data Set (MDS)	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer 1. Resident #26 and #35 were admitted back to the facility per the bed hold policy. Bed hold policies were given to both residents by the Admissions Director on 5/14/18. Compliance for the deficient practice was complete on 5/14/18. 2. A copy of the bed hold policy was sent to all current residents and/or responsible party by the Admissions Director on	

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 _____	05/10/2018

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 625	Continued From page 9 assessment dated 2/13/18 indicated Resident #26 ' s cognition was moderately impaired. A review of the Resident #26's medical records revealed she had been transferred to the hospital and discharged from the facility on 2/24/18. She was readmitted to the facility on 3/1/18. A review of the social service progress notes revealed no documentation that the bed-hold policy was provided to Resident #26 upon transfer to the hospital. An interview was conducted with the Social Worker (SW) on 5/8/18 at 1:50 PM. She stated she began her role at the facility as a SW in November of 2017. She reported she had not provided the bed-hold policy to the resident and/or Responsible Party (RP) upon transfer to the hospital. She indicated she was not aware of who was responsible for this task. An interview was conducted with the Director of Nursing (DON) on 5/8/18 at 1:55 PM. She stated she was not aware of who was responsible for notifying the resident and/or RP of the facility bed-hold policy when a resident was transferred to the hospital. An interview was conducted with the Administrator on 5/8/18 at 2:25 PM. She stated the facility did not provide the resident and/or RP information on the facility ' s bed-hold policy when transferred to the hospital unless their census was full or close to being full. She explained that this was a customer service related matter for the facility as they had not wanted to trouble the resident and/or RP with worrying about a bed-hold when being transferred to the hospital	F 625	6/6/18. The bed hold policy is presented and reviewed with resident and/or responsible party with the Admissions Director upon admission. Signature receipt of this review is obtained at that time. The signed form will then be added to the Electronic Medical Record/Healthcare Administrator with admission paperwork. 3. The Admissions Director reviewed the current bed-hold policy to ensure compliance with the regulation on 5/14/18. -It was then added to the Transfer Out paperwork that the Charge Nurse completes upon transfer out on 5/25/18. -All nurses were in-serviced by the Healthcare Administrator and Director of Nursing on 5/31/18 on bed-hold policy and transfer out paperwork. Licensed nurses will be required to be in-serviced no later than 6/7/18 or they will be removed from the schedule. The in-servicing and distribution of bed-hold information will be complete by 6/7/18, thereby bringing Penick Village back in compliance. 4. To monitor Penick Village's performance to assure that solutions are sustained, the following will occur: - Weekly Interdisciplinary Care Team meeting will review all transfers to hospital and assure verification of bed hold policy with resident/responsible party for the next two months. - Weekly audits will be performed by Medical Records Specialist to verify that signed receipt of bed-hold policy review and Bed-Hold Policy have been scanned	

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 _____	05/10/2018

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 625	Continued From page 10 unless it was necessary due to a limited number of available beds. The Administrator stated the SW would have been responsible for providing the bed-hold policy information to the resident and/or RP if the facility ' s census was full or close to being full. She reported that since the SW began at the facility (November 2017) their census had not been close to maximum capacity so the bed-hold policy had not been provided to any resident and/or RP when a resident was transferred to the hospital. A follow up interview was conducted with the Administrator on 5/10/18 at 10:40 AM. She revealed she was not aware of the regulation that required information on the facility's bed-hold policy to be provided to the resident and/or RP upon each transfer to the hospital. 2. Resident #35 was admitted to the facility on 3/6/18 with multiple diagnoses including Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). The significant change in status Minimum Data Set (MDS) assessment dated 4/20/18 indicated that Resident #35's cognition was intact. Review of Resident #35's medical records revealed that he was discharged to the hospital on 3/26/18. Review of the social service progress notes revealed no documentation that the bed hold policy was provided to the resident upon transfer to the hospital. On 5/8/18 at 1:50 PM, the Social Worker (SW) was interviewed. She stated that she started her role as SW in November 2017 and she didn't know who was responsible for the bed hold	F 625	to the resident EMR for each transfer out for the next three months. Complete compliance was achieved on 6/6/18.	

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 _____	05/10/2018

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 625	Continued From page 11 policy. On 5/8/18 at 2:25 PM, the Administrator was interviewed. She stated that the bed hold policy had not been provided to any resident since at least November 2017 when the new SW had started. The Administrator added that the facility's census had not been full and if the beds were not filled, the facility did not provide the bed hold policy to residents or Responsible Party (RP). She indicated that the SW was responsible for providing the bed hold policy but she would only do this if the facility was low on beds. On 5/10/18 at 10:20 AM, Resident #35 was interviewed. He stated that he didn't remember that he was provided a copy of the bed hold policy when he went to the hospital in March 2018.	F 625		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 1 of 13 sampled residents (Resident #24). The findings included: Resident #24 was most recently admitted to the facility on 9/27/16 with diagnoses that included dementia.	F 638	F638 Quarterly Review Assessment 1. A required quarterly assessment (occurring not less than once every three months) was missed for Resident #24. The missed quarterly assessment (12/29/17) could not be done since backdating of an assessment is not an option. The Matrixcare Electronic Medical Records automated list was incorrect,	6/7/18

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 _____	05/10/2018

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 638	Continued From page 12 A review of Resident #24's medical record revealed an annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/27/17. Resident #24's next MDS assessment was a quarterly MDS with an ARD of 3/28/18. This quarterly assessment was completed 182 days after the most recent MDS assessment's ARD (9/27/17). An interview was conducted on 5/8/18 at 2:40 PM with the MDS Coordinator. The annual MDS assessment dated 9/27/17 and the quarterly MDS assessment dated 3/28/18 for Resident #24 were reviewed with the MDS Coordinator. She revealed there should have been a quarterly assessment completed between those two assessments. She indicated one MDS assessment had been missed for Resident #24. She stated the electronic Medical Records system provided an automated list of MDS assessments that were due to be completed. She reported this list was not always accurate. An interview was conducted on 5/11/18 at 10:40 AM with the Director of Nursing (DON). She stated she expected the MDS assessments to be completed within the required timeframes.	F 638	resulting in a missed assessment. Upon review of the resident care plan, documentation, and the subsequent quarterly assessment; no drastic changes occurred with the resident that would have required any plan of care change. The comprehensive assessment for Resident #24 was completed on 9/29/17. The quarterly assessment following the missed assessment was completed on 3/28/18 and the next schedule quarterly assessment is scheduled for 6/27/18. 2. Any residents could potentially be impacted by this method of assessment scheduling. - The MDS Coordinator contacted the Matrixcare representative on 5/8/18 to report the system error. - An MDS Consultant was brought in to further scrutinize MDS operations. She provided a new tool to use for scheduling all resident assessments. The tool provided by the consultant has a recommended audit schedule of once per month. This tool will be used as a primary guide, and the Matrixcare automated list will serve as the secondary method for monitoring for the next six months to ensure complete corrective action has been sustained over two quarters. - On 5/30/18, the MDS Coordinator and MDS Consultant audited the previous six months for all residents who had been in the facility to ensure compliance. The audit revealed no other missed assessments. -An MDS Consultant will audit at three months and six months to ensure these	

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 _____	05/10/2018

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 638	Continued From page 13	F 638	monitoring tools have prevented any further missed assessment. These methods will be employed to protect current and future residents from being affected. 3. To monitor Penick Villages MDS performance to assure regulatory compliance, the following steps will occur: at weekly IDT care meeting there will be a review of the MDS Assessment Calendar. Using the tool created by the MDS Consultant, there will be a weekly audit completed by the DON to assure compliance with Minimum Data Set assessments for three months, and periodically thereafter. 4. Audit results to be reviewed monthly by the DON at the QA meeting to include any issues that needed to be addressed; number of Annual Assessments; number of Quarterly Assessments; number of Admission Assessments; and number of Significant Change Assessments will be included. Using the aforementioned plan designed by the MDS Coordinator in addition to the weekly meeting/audits, Penick Village will be in compliance as of 6/7/18.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/7/18

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 _____	05/10/2018

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 689	Continued From page 14 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain safe bed equipment as evidenced by Resident #26 sustaining a skin tear caused by a protruding sharp steel edge of her bedframe for one of one sampled resident reviewed for accidents with skin tears. The findings included: Resident #26 was admitted to the facility on 2/6/18 and most recently readmitted on 3/1/18 with diagnoses that included dementia, hip fracture, and hemiparesis (weakness of one side of the body). The significant change Minimum Data Set (MDS) assessment dated 3/8/18 indicated Resident #26 ' s cognition was severely impaired. She had no behaviors and no rejection of care. She required the extensive assistance of 2 or more staff with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #26 was not steady on her feet and was only able to stabilize with staff assistance. An incident report dated 4/26/18 completed by Nurse #1 indicated Resident #26 bumped her left outer calf on her bed rail causing a skin tear measuring 1.5 centimeters (cm) by 0.7 cm. Nurse #1 noted that her follow up actions included, "Wound dressed and temporary padding/cover placed on protruding pipe at lower part of bed where side rails would be. Work order placed to fix pipe or place some type of	F 689	F689 Free of Accidents Hazards/Supervision/Devices 1. The bed protrusion for Resident #26 was repaired by Maintenance staff on 4/30/2018. 2. On 5/10/18, all beds were inspected by Nursing Administration and Maintenance staff for safe equipment to further prevent injury. All beds were determined to be safe, indicating no risk for facility residents. 3. Measures put in place that will ensure that the deficient practice will not occur again: -Review of work order system and education to healthcare staff occurred on 5/31/18 and was led by the Healthcare Administrator and Director of Nursing. -Licensed Nurses and Elder Assistants (CNAs) will be educated on placing a work order in the event a piece of equipment becomes unsafe during use. -Maintenance staff will be educated by 6/7/18 that in the event the equipment poses a potential risk to a resident or staff member, it will be immediately removed and replaced until the repair can be made. -Nurses, Elder Assistant and Maintenance staff is expected to complete this in-service training by 6/7/18 or will be removed from the schedule.	

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 _____	05/10/2018

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 689	Continued From page 15 permanent protection [to] prevent mishaps." A nursing note dated 4/27/18 completed by Nurse #1 indicated Resident #26 bumped her leg on the bed railing resulting in a skin tear. Resident #26 ' s wound was dressed and her bed rail was examined. Nurse #1 placed padding over the protruding pipes for a temporary fix until maintenance fixed the bed permanently. A Maintenance Request form date 4/27/18 completed by Nurse #1 indicated Resident #26 had a pipe protruding at the lower end of her bed. The description of the problem read, "Pipe for side rail protruding at lower end of bed causing skin tears to legs; please cut off or place some type of protection." Hand-written on this form indicated a note dated 4/27/18 that the end of the bed rail was taped to provide protection and a saw was going to be brought in on 4/30/18 to fix the pipe. An additional hand-written note dated 4/30/18 indicated the protruding pipe was cut off and taped. A phone interview was conducted with Nurse #1 on 5/9/18 at 9:15 AM. She confirmed she was the nurse assigned to Resident #26 on 4/26/18 when she sustained a skin tear caused by her bedframe. She stated there was a little pipe at the edge of Resident #26 ' s bedframe that had a rough edge on it. Nurse #1 explained that Resident #26 had rubbed against this rough edge and sustained a skin tear. She indicated she covered the rough edge with gauze and tape as a temporary fix and she completed a maintenance request form for a permanent repair. Nurse #1 stated she had not known how long Resident #26 ' s bed had been in that condition or how it got that way. She also indicated she was unsure if	F 689	-Safety checklist will be created by Licensed Administrator and Admissions Director, which will be completed by 6/1/18. The checklist will include the room number, date of inspection, inspector(s) signatures and any action required. In the event equipment is found to be unsafe, the inspector(s) will: *Put in a work order for immediate repair to be completed before use, or *If repair is not possible as deemed by the Maintenance Department, the equipment will be replaced with a safe alternative. No admission to that room will be permitted until one of these options is completed. *The inspection will occur prior to any new admission to each room. *The checklist will be submitted to the Licensed Administrator upon completion. Upon completion and implementation of the safety checklist on 6/7/18, all vacated rooms will be inspected according to the Plan of Correction from that date forward by the Healthcare Services housekeeping staff. By implementing the use of the Safety Checklist and work order system, safe equipment will be verified before use by residents to ensure the deficient practice does not occur again. 4. At monthly QA meeting, Healthcare Administrator will provide report of equipment status and any updates to safety checklist for next three months. As of 6/7/18, Penick Village was in complete compliance.	

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 _____	05/10/2018

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 689	Continued From page 16	F 689		

there were any other beds in the facility that were in a similar condition.

An interview was conducted with the Maintenance Supervisor and the Maintenance Technician on 5/9/18 at 2:25 PM. The Maintenance Supervisor reported the Maintenance Technician was the staff member who completed the repair for Resident #26 ' s bed. The Maintenance Technician reported there was an approximately three-quarter inch steel piece with an exposed rough edge that stuck out on Resident #26 ' s bed. He explained that sometime in January of 2018 the maintenance staff had made alterations to the facility beds that included cutting off a section of the steel bedframe. He further explained that they had cut the steel at an angle so there were no exposed sharp steel edges protruding from the bedframe. He revealed Resident #26 ' s bedframe had not been altered in this same fashion as the steel edge was not cut at an angle which left an exposed sharp steel edge on her bedframe. He stated he had repaired Resident #26 ' s bedframe on 4/30/18 by cutting the protruding steel piece at an angle so there were no longer any exposed sharp steel edges. He was unable to explain why this bedframe had not been altered as the other beds in January of 2018 or how this bedframe came to be in use in Resident #26 ' s room. The Maintenance Supervisor was also unable to explain why this bedframe had not been altered as the other beds in January of 2018 or how this bedframe came to be in use in Resident #26 ' s room.

An interview was conducted with the Director of Nursing (DON) on 5/9/18 at 2:20 PM. She was asked if the remaining resident beds in the facility

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 _____	05/10/2018

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 689	Continued From page 17 were inspected after this incident on 4/26/18 for Resident #26 to ensure no other beds had exposed steel edges. She stated she had to follow up on this to provide an answer. A follow up interview was conducted with the DON on 5/9/18 at 3:20 PM. She revealed all of the facility beds were not inspected after this incident to ensure no other beds had exposed steel edges. An interview was conducted with the Administrator and DON on 5/10/18 at 10:40 AM. They both indicated they expected the facility to maintain safe bed equipment to avoid a preventable injury.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		6/1/18

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 _____	05/10/2018

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 756	Continued From page 18 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, Pharmacy Consultant and staff interview, the facility failed to act upon the Pharmacy Consultant's recommendation for Resident #18 and failed to write the rationale when a gradual dose reduction (GDR) for a psychotropic medication was denied for Residents # 12 & # 4 for 3 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1 a. Resident #12 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and mental retardation. The quarterly Minimum Data Set (MDS) assessment dated 2/16/18 indicated that Resident #12 had severe cognitive impairment, had received an antidepressant medications and had no	F 756	F 756 Drug Regimen Review 1. For Residents #12, #18 and #4 pharmacy consultant reviewed medical record and addressed recommendations and rationale with Medical Director (MD) on 5/12/18. 2. All residents have the potential to be impacted by this so a full review was completed on 5/30/18 by the pharmacy consultant. Any additional residents identified to be missing rationale will be corrected by MD by 6/1/18, putting facility in complete compliance. 3. To properly monitor that performance is sustained, at least once per month:	

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 _____	05/10/2018

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 756	Continued From page 19 behaviors. Review of the current physician's orders revealed that Resident #12 was on Prozac (anti-depressant medication) 10 mgs 1 tablet by mouth at bedtime for depression. Resident #12's care plan dated 2/22/18 was reviewed. One of the care plan problems was Resident #12 was receiving psychotropic medication. The goal was for Resident #12 to have no complications secondary to the use of the medication. The approaches included to administer the medication as ordered, to monitor for changes in behavior/cognition related to the use of the medication and for the pharmacy to monitor medication for side effects and possible need for gradual dose reduction (GDR). The monthly drug regimen review notes for Resident #12 were reviewed. The notes dated 11/9/17 revealed that the Resident #12 had been on Prozac for about a year and there had been no behaviors documented. The Pharmacy Consultant had recommended a GDR for the Prozac to 10 mgs every other day for 2 weeks and then discontinue. On 11/10/17, the Physician had denied the recommendation made by the Pharmacy Consultant with no rationale for the denial documented in the resident's medical records. On 5/9/18 at 10:10 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON was responsible for ensuring the Pharmacy Consultant's recommendations were acted upon by the physician. She indicated that from now on,	F 756	- The ADON and Pharmacy Consultant will perform a drug regimen review of all pharmacological orders submitted since last audit to check for facility compliance. - The Pharmacy Consultant will immediately report any irregular findings to the MD and Director of Nursing so that they may be acted on accordingly. - The findings will also be submitted in writing to the MD and DON, to include: the residents name, the drug involved, and the identified irregularity. - The MD will then document in the residents' medical record what action, if any, is to be taken and the related rationale. - The ADON will bring audit results to monthly QA meetings for the next three months. 4. Pharmacy consultant will present monthly report of pharmacy recommendations and rationale compliance at monthly QA meeting for the next three months.	

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 _____	05/10/2018

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 756	Continued From page 20 she would make sure that the Physician had written a statement concerning the rationale when a GDR for psychotropic medication was denied. On 5/9/18 at 3:55 PM, the Pharmacy Consultant was interviewed. She stated that she expected the Physician to write a brief statement concerning the rationale when a GDR for a psychotropic medication was not approved. On 5/10/18 at 10:45 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to write the rationale when a recommendation for GDR was denied. 1 b. Resident #12 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and mental retardation. The quarterly Minimum Data Set (MDS) assessment dated 2/16/18 indicated that Resident #12 had severe cognitive impairment, had received anti-anxiety medication and had no behaviors. Review of the current physician's orders revealed that Resident #12 was on Ativan (anti- anxiety medication) 0.5 mgs 1 tablet by mouth every morning for agitation. Resident #12's care plan dated 2/22/18 was reviewed. One of the care plan problems was Resident #12 was receiving psychotropic medication. The goal was for Resident #12 to have no complications secondary to the use of the medication. The approaches included to administer the medication as ordered, to monitor for changes in behavior/cognition related to the	F 756		

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 _____	05/10/2018

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 756	Continued From page 21	F 756		

use of the medication and for the pharmacy to monitor medication for side effects and possible need for gradual dose reduction (GDR).

The monthly drug regimen review notes for Resident #12 were reviewed. The notes dated 1/5/18 revealed that the Resident #12 had no behaviors noted and Ativan was restarted in May 2017. The Pharmacy Consultant had recommended to reduce the Ativan to 0.25 mgs every morning.

On 1/8/18, the Physician had denied the recommendation made by the Pharmacy Consultant with no rationale for the denial documented in the resident's medical records.

On 5/9/18 at 10:10 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON was responsible for ensuring the Pharmacy Consultant's recommendations were acted upon by the physician. She indicated that from now on, she would make sure that the Physician had written a statement concerning the rationale when a GDR for psychotropic medication was denied.

On 5/9/18 at 3:55 PM, the Pharmacy Consultant was interviewed. She stated that she expected the Physician to write a brief statement concerning the rationale when a GDR for a psychotropic medication was not approved.

On 5/10/18 at 10:45 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the Physician to write the rationale when a recommendation for GDR was denied.

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 _____	05/10/2018

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 756	Continued From page 22	F 756		

2. Resident #18 was admitted to the facility on 11/30/17 with multiple diagnoses including chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated 3/2/18 indicated that Resident #18's cognition was intact and she had received an opioid medication. The assessment further indicated that Resident #18 had received scheduled and as needed (PRN) pain medications. The frequency of pain was "frequent" and the pain intensity was "8".

Resident #18 had a doctor's order on admission (11/30/17) for Norco (narcotic pain medication) 5/325 milligrams (mgs) 1 tablet by mouth every 4 hours PRN for pain.

Rif there was Resident #18's drug regimen review notes were reviewed. The notes dated 4/1/18 revealed that Resident #18 had received Norco between 2-4 times daily and it was noted multiple times that there was little effectiveness. The Pharmacy Consultant had recommended changing the Norco to Oxy IR to see if there was an improvement in pain.

The Medication Administration Record (MAR) for May 2018 revealed that Resident #18 was still on Norco.

On 5/9/18 at 10:10 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON was responsible for ensuring the Pharmacy Consultant's recommendations were acted upon by the physician.
She indicated that she could not find the Pharmacy Consultant's recommendation dated

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 _____	05/10/2018

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 756	Continued From page 23	F 756		

4/1/18 for Resident #18 and therefore it was not acted upon.

On 5/9/18 at 3:55 PM, the Pharmacy Consultant was interviewed. She stated that she had sent all her recommendations in one folder for April 2018 and she expected the facility to ensure that her recommendations were acted upon.

On 5/10/18 at 10:45 AM, the Director of Nursing (DON) was interviewed. She stated that she expected that all the recommendations from the Pharmacy Consultant were acted upon.

3. Resident #4 was admitted to the facility on 12/6/16 and most recently readmitted on 1/16/18 with diagnoses that included dementia with behavioral disturbance.

A physician's order dated 1/16/18 indicated Seroquel (antipsychotic medication) 25 milligrams (mg) once daily at night for Resident #4.

A Consultant Pharmacist Communication to Physician form dated 4/6/18 indicated a recommendation for a Gradual Dose Reduction (GDR) of Resident #4's Seroquel. The Pharmacy Consultant requested a reduction of Resident #4's Seroquel 25 mg dosage to 12.5 mg. The physician indicated he was not in agreement with this recommendation on 4/9/18. The bottom portion of the form required the physician to write a brief statement concerning the rationale if he was not in agreement with the recommendation. There was no rationale documented on the form.

A quarterly Minimum Data Set (MDS) assessment dated 4/23/18 indicated Resident #4's cognition was intact. He had no behaviors and no rejection of care. Resident #4 received

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 _____	05/10/2018

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 756	Continued From page 24 antipsychotic medication on 7 of 7 days during the MDS review period. A review of Resident #4's Medication Administration Records (MARs) from 4/1/18 through 5/9/18 indicated Resident #4 continued on Seroquel 25 mg once daily at night. A phone interview was conducted with the Pharmacy Consultant on 5/9/18 at 3:50 PM. She indicated she expected the physician to document on the Consultant Pharmacist Communication to Physician form a brief statement concerning their rationale if a recommendation for a GDR was declined. An interview was conducted with the DON on 5/10/18 at 10:40 AM. She stated she expected the physician to write a rationale on the Consultant Pharmacist Communication to Physician form if a recommendation for a GDR was declined.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		6/7/18

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 _____	05/10/2018

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 758	Continued From page 25 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation, Pharmacy Consultant and staff interview, the facility failed to have adequate indication and a rationale for the use of an antipsychotic medication and failed to	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use 1. Resident #12 received 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 _____	05/10/2018

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 758	Continued From page 26 try non-pharmacological approaches before increasing the dose of an antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 12). Findings included: Resident #12 was admitted to the facility on 3/30/11 with multiple diagnoses including autistic disorder and mental retardation. The quarterly Minimum Data Set (MDS) assessment dated 2/16/18 indicated that Resident #12 had severe cognitive impairment, had received an antipsychotic medication and had no behaviors. Review of the current physician's orders revealed that Resident #12 was on Chlorpromazine (an antipsychotic medication) 100 milligrams (mgs) 1 tablet by mouth every morning for impulsivity, Ativan (anti- anxiety medication) 0.5 mgs 1 tablet by mouth every morning for agitation and Fluoxetine (anti-depressant medication) 10 mgs 1 tablet by mouth at bedtime for depression. Resident #12's care plan dated 2/22/18 was reviewed. One of the care plan problems was Resident #12 was on antipsychotic medication. The goal was for Resident #12 to have no complications secondary to the use of the medication. The approaches included to administer the medication as ordered, to monitor for changes in behavior/cognition related to the use of the medication and for the pharmacy to monitor medication for side effects and possible need for gradual dose reduction (GDR). The monthly drug regimen review notes for Resident #12 were reviewed. The notes dated 4/6/18 revealed that the Abnormal Involuntary Movement Scale (AIMS) test (used to detect	F 758	comprehensive pharmacy review on 5/30/18 to ensure gradual dose reduction (GDR) placing the deficient practice back in compliance. 2. Monitoring efforts put in place to prevent the deficient practice from impacting other residents are as follows: - A pharmacy review of all resident on psychotropic drugs was completed on 5/30/18 by the pharmacy consultant to ensure compliance with rational for any denial or reversal on gradual dose reduction (GDR). - The Medical Director was made aware of the regulation and proper protocol by the Assistant Director of Nursing on 5/11/2018. - All GDRs and GDR reversals must be accompanied by rationale. - Regulation requiring 14-day PRN prescription for psychotropic drugs will be observed. - Only with documented MD rationale upon evaluation will the prescription by extended. - Nurses and Elder Assistants (EAs) were in-serviced on 5/31/18 regarding use of non-pharmacological interventions and the documentation of their use. - Concurrently, licensed nurses were in-serviced on the importance of documentation of all interventions tried and success or failure of each one utilized. Nurses and EAs not in-serviced on 5/31/18 must complete in-service by 6/7/18 in order to remain on work schedule. Facility was in compliance on 6/7/18.	

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 _____	05/10/2018

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 758	Continued From page 27 tardive dyskinesia) for Resident #12 showed mild upper extremity movement and the resident had no behaviors noted. The Pharmacy Consultant had recommended a GDR for the Chlorpromazine from 100 mgs to 75 mgs. daily. On 4/26/18, Resident #12 had a doctor's order to decrease the dose of Chlorpromazine to 75 mgs daily. Resident #12's nurse's notes from 4/26/18 through May 3, 2018 were reviewed and revealed no documentation of behaviors. On 5/4/18 at 7:19 PM, Nurse #4 documented that Resident #12 was noted to be hyperactive and overly excited with repetitive conversation and informed the Physician of these behaviors. The Physician ordered to increase the Chlorpromazine back to 100 mgs daily. The notes did not indicate that a non-pharmacological intervention had been tried. On 5/9/18 at 9:45 AM, Resident #12 was observed up in the chair in her room. She was watching the television and no behavior was noted. On 5/9/18 at 9:50 AM, Nurse #4 was interviewed. She stated that on that day (5/4/18) Resident #12 was noted to be overexcited and hyperactive, she informed the doctor and the doctor had ordered to return the dose of Chlorpromazine back to 100 mgs. After reviewing the nurse ' s notes, Nurse #4 was unable to find any documentation of Resident #12's behavior or any non-pharmacological intervention that was tried prior to the increase of the dose of the Chlorpromazine.	F 758	3. Using the following steps, Penick Village will monitor its performance to ensure compliance is sustained: - At least once per month, the ADON and Pharmacy Consultant will perform a review of all psychotropic drugs since last audit to check for facility compliance. - The Pharmacy Consultant will immediately report any irregular findings to the MD and Director of Nursing so that they may be acted on accordingly. - The findings will also be submitted in writing to the MD and DON, to include: the residents' name, the drug involved, and the identified gradual dose reduction. - The MD will then document in the residents' medical record what action, if any, is to be taken and the related rationale. - The ADON will bring audit results to monthly QA meetings for the next three months. 4. Pharmacy consultant will present monthly report of psychotropic monitoring as well as GDR and non-pharmacological interventions at monthly QA meeting for the next three months.	

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 _____	05/10/2018

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 758	Continued From page 28 On 5/9/18 at 10:10 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON was responsible for ensuring the Pharmacy Consultant's recommendations were acted upon by the physician. The ADON stated that a GDR for Chlorpromazine was just approved by the Psychiatric Nurse Practitioner. She added that overexcitement and hyperactivity were not new behaviors for Resident #12 and she didn't expect the Nurse to call the doctor to increase the dose for one episode of overexcitement and hyperactivity. The ADON also indicated that she expected the Nurses to try non-pharmacological interventions before increasing the dose of any psychotropic medications. On 5/9/18 at 3:55 PM, the Pharmacy Consultant was interviewed. She stated that a GDR for Chlorpromazine to 75 mgs was just approved by the Psychiatric Nurse Practitioner. She indicated that she was not aware that the dose was increased back to 100 mgs. She indicated that the Chlorpromazine was used for impulsivity and an episode of overexcitement and over hyperactivity were not considered adequate indications or rationale for the increase of the dose. On 5/10/18 at 10:45 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the Nurses to try non-pharmacological intervention before increasing the dose of any psychotropic medications for some residents but not all residents.	F 758		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865		5/25/18

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 _____	05/10/2018

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 865	Continued From page 29 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 interviews and record review, the facility' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 5/5/16 and 4/27/17 recertification surveys. This was for a recited deficiency in the area of Accident Hazards (483.25). This deficiency was cited again on the current recertification survey of 5/10/18. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 483.25 Accident Hazards: Based on record review and staff interviews, the facility failed to	F 865	F865 Quality Assurance and Performance Improvement (QAPI) Program. 1. All residents have the potential to have been affected by the QAPI Program not being implemented and followed. Resident #26 was found to be affected. Penick Village failed to maintain previously implemented procedures and did not monitor the use of interventions previously put in place on 5/5/16 and 4/27/17 indicating an ineffective Quality Assessment and Assurance Program. 2. Effective 5/29/18, the steps to reach complete compliance on findings of the requirements for F689 Accident Hazards are the following: The Chief Operating Officer (COO) will attend the monthly	

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 _____	05/10/2018

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 865	Continued From page 30 maintain safe bed equipment as evidenced by Resident #26 sustaining a skin tear caused by a protruding sharp steel edge of her bedframe for one of one residents reviewed for accidents with skin tears. During the recertification survey of 5/5/16 the facility was cited at 483.25 Accident Hazards for failing to implement effective interventions to prevent further falls. During the recertification survey of 4/27/17 the facility was cited at 483.25 Accident Hazards for failing to investigate and implement effective interventions to address multiple falls and failing to supervise and provide direction to nurse aides on appropriate techniques to transfer a resident. On the current recertification survey of 5/10/18 the facility was cited for failure to maintain safe bed equipment resulting in a resident sustaining a skin tear from a protruding sharp steel edge of her bedframe. An interview was conducted with the Administrator and Director of Nursing (DON) on 5/10/18 at 10:50 AM. The Administrator indicated she was the head of the facility's QAA Committee. She stated she began working at the facility as an Administrator in October of 2017 and therefore was not the Administrator at the time of the last recertification survey (4/27/17). The DON stated she was aware Accident Hazards was a repeat citation from the previous recertification survey. She indicated the facility's previous Plan of Correction (POC) focused primarily on falls rather than all types of accidents. She reported that during this current recertification survey they have identified the need to investigate and monitor all types of accidents and incidents.	F 865	Quality Assurance (QA) Meeting for the next six months; the Licensed Administrator and Director of Nursing (DON) will meet weekly for six months with COO to review quality assurance and necessary QAPI Program. The COO will work with the Licensed Administrator and DON on an ongoing basis to create an action plan that is necessary to attain sustained compliance to include: position-specific assigned tasks, due dates, and specific action steps to be taken. Follow-up will occur at the next subsequent weekly meeting. If COO is unavailable, the Chief Executive Officer will serve as substitute for the week. 3. A QA meeting summary of results and actions, will be reported to Penick Village□s Board of Directors Healthcare Committee by the Chief Operating Officer or Licensed Administrator. The committee will require the committee to present audit results to prove compliance is being maintained. 4. Beginning 6/1/18, the Plan of Correction, specific to F689, will be reviewed during the monthly QA meeting by the Licensed Administrator. Using the steps listed in this Plan of Correction, the Licensed Administrator will monitor its implementation through the next standard survey inspection to prevent further noncompliance.	