DEPART	MENT OF HEALTH	AND HUMAN SERVICES				RM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		-	NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			DATE SURVEY COMPLETED
		345397	B. WING			C 05/29/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SHORE	AND HLTH CARE & F	PETIREME			00 FLOWER-PRIDGEN DR	
ONORLE				V	VHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 157 SS=D	consult with the resknown, notify the resord or an interested fam accident involving the injury and has the printervention; a significantly and has the printervention; a significantly of the clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complication in heat status in either life to clinical complications of the resident from the §483.12(a). The facility must also and, if known, the more interested family change in room or more specified in §483.1 resident rights under regulations as specified in §483.1 resident rights under the address and philegal representative. This REQUIREMENT by:		F 1	57	The statements made on this plan of	6/16/14
	record review the fa primary physician o	acility failed to notify the f changes in resident DER/SUPPLIER REPRESENTATIVE'S SIGN			correction are not an admission to and not constitute an agreement with the	do (X6) DATE
LABURATURY	LURFULUR S OR PROVID	ICR/SUPPLIER REPRESENTATIVE'S SIGT			1111 -	

## Electronically Signed

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

06/16/2014

PRINTED: 06/17/2014

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COM	PLETED	
			D. MINIO			С	
		345397	B. WING			29/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
SHOREL	AND HLTH CARE & I	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 157	Continued From pa	ane 1	F 1	57			
	behavior/altered m	ental		alleged deficiencies.			
	status/disorientation/restlessness and agitation and failed to notify family with accurate lab result information for 1 of 1 sampled residents (Resident #1) who experienced UTIs. Findings included: Resident #1 was admitted to the facility on 11/02/06 and was readmitted on 05/13/14. The			To remain in compliance and state regulations the or will take the actions a plan of correction. The constitutes the facilityN compliance such that a	he facility has taken set forth in this plan of correction s allegation of Il alleged		
	resident's documer recurrent UTIs, chr chronic congestive	eadmitted on 05/13/14. The nted diagnoses included onic kidney disease-stage III, heart failure, and pulmonary chronic obstructive pulmonary		deficiencies cited have corrected by the dates F157 Corrective Action for Re	indicated.		
	Resident #1's 03/2 set (MDS) docume severely impaired, problems/behavior A 04/15/14 physicia	8/14 quarterly minimum data nted her cognition was and she did not exhibit mood s/psychosis/resistance to care.		Resident # 858 Physicia Responsible Party were change in condition on hall nurse upon dischar where resident received urinary tract infection (U	an and e notified of the 05/09/14 by the rge to the hospital d treatment for a		
	Resident #1 due to A 04/16/14 care pla documented, "I hav times. I have hx (h confusion, hallucin Monitor/record/repo onset s/sx (signs/s in behavior, altered in cognitive function communication dea restlessness and a dehydration, infection	ve confusional episodes at history) of episodes of ations" ort to MD (physician) new ymptoms) of delirium, changes I mental status, wide variation n through the day, cline, disorientation, lethargy, gitation, altered sleep cycle, on, delusions, hallucinations." aboratory results, available to		Corrective Action for Re Affected All residents have a pol affected by the alleged Beginning _6_/_9_/201 Management Team aud resident lab results from present for any abnorm and responsible party nor results. In addition to the residents were assesses symptoms of a potentia nurses under the direct management team. Sig of UTI assessed were:	tential to be deficient practice. 4_ the Nurse dited all current n 04/01/14 to hal labs without MD hotification of the his, all current ed for signs and al UTI by the hall ion of the nurse gns and symptoms		

Facility ID: 923452

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	-	I AND HUMAN SERVICES			0		APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345397	B. WING			05/2	C 29/2014
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHOREL	AND HLTH CARE & F	RETIREME			00 FLOWER-PRIDGEN DR VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 157	Continued From pa	age 2	F 1	57			
	proteus mirabilis w urine sample.	ere found in the resident's			pain in the flank area; urine that is red or foul smelling urine; fever (10 degrees F or greater) or chills; and	00	
	Review of physician orders revealed no orders to treat the resident with an antibiotic. A 05/03/14 10:54 PM resident progress note documented, "Rsdt (resident) propelling self up and down hallway hollering out loudly demanding to be taken home; Stating she was not supposed to be left here; Rsdt apporaching other rsdts in hallway stating he has to go home, waving hand at resdts and becoming angry when they spoke to her: The note documented the staff was unable to console or redirect Resident #1, and her family had to be called to come calm the resident down.				worsening confusion. This was cor on 6/16/14 Number of residents with current signs and symptoms of	npleted noted	
					were 5The number of residents were unreported abnormal lab values we Affected residents had their physic responsible party notified of the UT and symptoms or abnormal labs of	with ere 0. ian and T signs	
					_6/16/14 by Rebecca Lamm.		
	"Pt. (patient) sitting	A 05/06/14 10:12 PM hospice note documented, "Pt. (patient) sitting in wheelchair. Alert and disoriented. She wanted to go home and was distressed." A 05/09/15 1:48 AM resident progress note documented, "Rsdt very confused with increased agitation and combativenessRsdt kept saying she wanted to go to bed because she did not feel good. On several attempts rsdt guided back to			Systemic Changes In-services were completed on 6/1 by the Staff Development Coordina Those who attended were all RNs,	ator.	
	documented, "Rsdi agitation and comb she wanted to go to good. On several a				LPNs FT, PT, and PRN. Any in-hc staff member who did not receive in-service training will not be allowe work 6/16/2014_ until training has completed. The in-service topic fo	ed to been r the	
	rsdt would yell and This is not my roon string off and wrap	npted to put back into bed but scream 'this in not my house. n.' Rsdt was taking alarm and ping it around her hands elling and trying to fight staff			The facility specific in-service was Hospice Providers whose employe residents care in the facility to prov training for staff prior to returning to facility to provide care. Any in-hou	es give ride o the	
	when they approch services to transpo evaluation. Out of	ed to help911 called for rt to ER (emergency room) for facility at 2:15 AM"			member who did not receive in-ser training will not be allowed to work training has been completed. The in-service topic for the RNNs and I	vice until _PNNs	
	documented, "Rece	/l resident progress note eived report from (name Rsdt as 'Bad' UTI. IV			included education on the following policies and procedures: ICP 137, 215 and NUP 611. In addition to th	NUP	

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CENTERS	FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
TATEMENT OF	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMI	E SURVEY PLETED
		345397	B. WING		C 05/29/2014	
NAME OF PRO	VIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SHORELAN	D HLTH CARE & F	RETIREME				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
(irr (n Al Ci x Af in he re of fa ar th pa co re re A( to co we re sy ex at aç se Af in th ar Th	nilligrams) administration (antibiotic)/UT pro antibiotic by r 3 days. 9:47 AM on 05/2 terview, Resident e almost always tr sults documented bacteria. The ph mily was very invo- drequested to be e resident's condi- articipate in makin ommented, after r cords, he had no sults, or C & S for cording to the ph treat a UTI with a but as high as gr buld expect the fa- sident began exh mptoms indicativ- colubeing notified gitated behaviors and the middle of exhibit anxiousne allucinations. Acc ast such behaviors	ge 3 quin (antibiotic) 750 mg stered at ERnew order for I." This new order was for nouth 500 mg BID (twice daily) 9/14, during a telephone #1's primary physician stated eated UTIs when the lab d greater than 100,000 CFUs hysician reported Resident #1's olved in the resident's care, e kept informed of changes in ition/health so they could to care decisions. He eviewing his own medical documentation of a UA, lab r Resident #1 in April 2014. hysician, even if he decided not an antibiotic, with a bacterial eater than 100,000 CFUs, he icility to notify him if the ibiting physical or behavioral e of a possible infection. He s nothing in his own notes d of Resident #1 experiencing until 05/09/14 when she was bital for altered mental status. 29/14, during a telephone member of Resident #1 stated vior had been stabilized until of April 2014 when she began ess, aggression, and ording to the family, in the s were an indicator of a UTI. reported the physician was	F 157	215, the nurses were in-serviced recognizing signs and symptoms and how to notify the Physician. Physician should be called wher change in condition occurs or we abnormal lab values are receive hours a day 7 days a week. This does not change due to time of week. The nurses were also in-s on the revised lab protocol. See attachments. The in-service topic for the CNA included education on the follow Reporting changes noted in a re condition to the nurse when they is very important. Changes to re includes but is not limited to the the resident: Seems different tha Talks or communicates less; Ov needs more help; Pain-new or w participates less in activities; Ate BM in 3 days or diarrhea; Drank Weight change; Agitated or nerv than usual, Tired, weak, confuse drowsy; Change in skin color or (new wound); Help with walking, transferring, toileting more than These changes can be reported nurse by using the INTERACT T and WATCH tool. Once complet reported to the Nurse, place the completed form in the file folder 100 hall documentation room do will be available at each nurseN in a file folder labeled STOP AN Tool. Signs and symptoms of a U	s of a UTI The a anen d 24 process day or serviced Ns ing: sidentNs are seen port following; an usual; erall following; an usual; erall rorsening, e less; No less; ous more ed or condition usual. to the fool STOP ed and on the for. Tools s station D WATCH	

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		PLETED
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		345397	B. WING _		05/2	29/2014
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
SHOREL	AND HLTH CARE &	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 157	Continued From pa	age 4	F 15	57		
	behavior. At 12:42 PM on 05 (DON) stated Resi documented in the severe enough to v primary physician, the chart documen 100,000 CFUs of b At 4:08 PM on 05/2 conversation, a far stated on 04/19/14 called to tell the far resident was "clear thought this meant contamination of th family member, be family was asked t three or four times redirect or console reported they were	he change in the resident's /29/14 the director of nursing dent #1's behaviors 05/03/14 progress note were warrant notifying the resident's especially with lab results in ting the resident recently had bacteria in her urine. 29/14, during a telephone nily member of Resident #1 someone from the facility mily that the UA showed the ". The family explained they there was no bacterial he urine. According to the tween 04/15/19 and 05/09/14 o come sit with the resident because the facility could not Resident #1. The family puzzled about what was the behaviors if a UTI was not		to go to the bathroom of lower abdominal pain or back area; urine that is smelling urine; fever (10 greater) or resident com and new or worsening of attachment. In addition to this, this in been integrated into the orientation training and in-service refresher cou employees and will be re Quality Assurance Proce the change has been su Quality Assurance The Director of Nursing issue using the "Survey Monitoring Change in C Notification". The monit sampling 5 residents to residents noted with an change in condition had and Responsible Party in	<ul> <li>pain in the lower</li> <li>cloudy, red or foul</li> <li>00 degrees F or</li> <li>oplaints of chills;</li> <li>onfusion. See</li> <li>aformation has</li> <li>standard</li> <li>in the required</li> <li>rses for all</li> <li>eviewed by the</li> <li>ess to verify that</li> <li>ustained.</li> </ul> will monitor this QA Tool for ondition coring will include verify that abnormal lab or there Physician notified timely.	
F 312 SS=D	483.25(a)(3) ADL ( DEPENDENT RES		F 31	This tool will be complet weeks then monthly tim or until resolved by QOL See attachment . Repo the weekly Quality of Lif and corrective action ini appropriate. The QOL/0 attended by Administrat Nursing, Unit Manager, managers, Social Servio Manager.	es three months //QA committee. orts will be given to e- QA committee tiated as QA Meeting is or, Director of other nurse	6/16/14

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		AND HUMAN SERVICES				FORM	06/17/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (	COM	E SURVEY PLETED
		345397	B. WING	;			_ 29/2014
NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•••	
SHOREL	AND HLTH CARE & F	RETIREME			00 FLOWER-PRIDGEN DR VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 5	F	312			
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observation interviews, the facil care based upon the infection control guisampled residents, Findings included: Resident #1 was and hospital on 05/02/2 included, but were hypertension, and the A review of the Min Assessment (MDS) Resident #1 was sea and required extension personal hygiene, a continent of bowel as Significant Change progress which was A review of the tele chart revealed that made by the physic local hospital emerging	dmitted to the facility from the 014 with diagnoses which not limited to, dementia,			The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all fede and state regulations the facility has or will take the actions set forth in thi plan of correction. The plan of correct constitutes the facilityNs allegation of compliance such that all alleged deficiencies cited have been or will b corrected by the dates indicated. F 312 Corrective Action for Resident Affect Resident # 858 NA #1 and #2 receive education on perineal care from the Development Coordinator on 05/28/ Corrective Action for Resident Potent Affected All residents have a potential to be affected by the alleged deficient prace On 6/17-6/18/2014 the Nurse Management Team held a skills fair FT and PT CNANs. During the skills CNANs were checked off on providin	eral taken is ction of be ted ved Staff 14. ntially ctice. for all s fair,	

Facility ID: 923452

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		345397	B. WING _		C 05/29/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	-
SHOREL	AND HLTH CARE & F	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 312	Continued From pa	age 6	F 31	2	
	A review of the Hos revealed that Resid diagnosis of a urina concussion. The s she was treated wit discharged to the fa 500 milligrams by r days. In an observation of Resident #1 on 05/ nursing assistants washed their hands disposable gloves. resident that she w to her. Then NA# <sup>2</sup> the resident to her of the disposable b amount of soft stor buttocks and in the three disposable m hand to wipe the st the perineum) to ba gluteal fold.) NA# <sup>2</sup> wipes in her hand a to again wipe the s	spital Discharge Summary lent #1 had an admitting ary tract infection and a fall with ame summary indicated that th Ancef (antibiotic) and was acility on Keflex (antibitotic), nouth 4 times per day for 7 of incontinent care provided for 28/2014 at 4:22 PM, two (NA), NA #1 and NA #2, s and then donned clean NA #1 explained to the as providing incontinent care 1, assisted by NA #2, turned right side to inspect the back rief. A small to moderate of was noted on the resident's gluteal fold. NA #1 then used oistened wipes in her gloved ool from front (area closest to ack (area at the top of the 1 rearranged the same three and re-used the group of wipes tool away from front to back. in the wipes as NA #1		perineal care according to po 611. See attached skills chec attachment . Systemic Changes An in-service was conducted 6/16/2014 by the Staff Devel Coordinator. Those who atte all CNANs FT, PT, and PRN specific inservice was sent to Providers whose CNANs giv care in the facility to provide staff prior to returning to the provide care. Any in-house s who did not receive in-servic not be allowed to work until t been completed. The in-servin included education on policies procedures: NUP 611. See a In addition to this, this inform been integrated into the stan orientation training and in the in-service refresher courses employees and will be review Quality Assurance Process to the change has been sustain	I on opment ended were . The facility o Hospice e residents training for facility to staff member e training will raining has vice topic es and ttachment . lation has dard e required for all ved by the o verify that
	wipe the area from discarded the soile trash bin and used wiping away the sto folded over to be re NA #2 assisted Res Wearing the same washcloth moisten the frontal pelvic re	bosable wipes a third time to front to back. NA #1 then d wipes in the plastic lined two more wipes to finish bol. The disposable brief was emoved, and both NA #1 and sident #1 to lie on her back. pair of gloves, NA #1 used a ed with warm water to clean gion and labia majora from her NA #1 nor NA #2 separated		Quality Assurance The Staff Development Coor monitor this issue using the ' Monitor". The monitoring wil sampling 4 residents to verify care is provided according to Procedure NUP 611. This to completed daily times two we monthly times three months resolved by QOL/QA commit	'ADL Care I include y that perineal o Policy and ool will be eeks then or until

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					OMB NO.			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED		
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		345397	B. WING _			29/2014		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI				
SHOREL	AND HLTH CARE &	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE		
F 312	any stool residue. applied a clean dis #1. Still wearing the readjusted the resi- bed using the elect NA #1 removed he trash bin, and tied carried the trash ba- it in the hallway tra- resident's room to In an interview with PM immediately for stated that Resider assistance with inco- returned to the faci 05/23/2014. She at trained to start with resident (rectal are clean the front peri- she should separar perineal area and at the stool had been A review of the faci #NUP-611, issued resident was soiled should be turned of perineum and recta- policy stated that the turned on her back separated to be clean An interview was co- Infection Control N PM. During the int	The nursing assistants then posable adult brief on Resident he same pair of gloves, NA #1 dent's bed level and head of tric control on the bed. Then r gloves, placed them in the the trash bag. She then ag out into the hall, disposed of sh bin, and came back into the wash her hands. NA #1 on 05/28/2014 at 4:50 llowing the observation, NA #1 ht #1 had needed more continent care ever since she lity after her hospitalization on also stated that she had been n cleaning the back of the ea) and then turn the resident to neal area. She explained that te the labia to clean the also to inspect whether all of removed. ility's Perineal Care Policy, 10/01/2014, indicated that if a d with feces, the resident n her side and that the al area should be cleaned. The ne resident should then be a and that the labia should be		2 weekly Quality of Life- QA corrective action initiated The QOL/QA Meeting is a Administrator, Director of Manager, other nurse ma Service, and Dietary Man	as appropriate. attended by Nursing, Unit magers, Social			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY PLETED
		345397	B. WING			C 29/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SHOREL	AND HLTH CARE & F	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 315 SS=D	further stated that if the stool from the b perineum, she shou and don clean glow care. In addition, si for providing perine female residents, w urinary tract infection In an interview with on 05/29/2014 at 4: should be changed perineal cleaning, a should be used per or rearranging one she would expect th the labia to check for in the perinal area a acknowledged that Policy should be ch disposable wipes, th dispose of them, ar 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the far resident's clinical co catheterization was who is incontinent of treatment and servit infections and to re- function as possible	The nursing assistant cleaned uttocks prior to cleaning the uld definitely wash her hands as before providing perineal he stated that the procedure al care is the same for all thether they have a history of ons or not. The director of Nursing (DON) 25 PM, she stated gloves in between stool cleaning and and that one disposable wipe "swipe" rather than re-using to use again. She also stated he nursing assistants to open or any stool that might still be and to clean it. In addition, she the facility's Perineal Care anged to address the use of he use of gloves, when to hd when to wash hands. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder	F 31			6/16/14

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	דוסו נ			0938-039 SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
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		345397	B. WING			05/2	29/2014	
AME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
HOREL	AND HLTH CARE & I	RETIREME			00 FLOWER-PRIDGEN DR /HITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
F 315	Continued From pa	age 9	E 3	315				
	by:	.90 0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		n interview, staff interview, and			The statements made on this plan	of		
	record review the facility failed to provide				correction are not an admission to			
	treatment for a urinary tract infection (UTI) presenting with greater than 100,000				not constitute an agreement with the	ne		
		is (CFU) of bacteria and the			alleged deficiencies.			
		aviors for 1 of 3 sampled			To remain in compliance with all fe	deral		
	residents (Residen	t #1) who experienced UTIs.			and state regulations the facility ha	is taken		
		ed to allow family members to			or will take the actions set forth in t			
i		lating a plan of care to			plan of correction. The plan of corr			
		r providing the family with tion regarding lab results.			constitutes the facilityNs allegation compliance such that all alleged	01		
	Findings included:	tion regarding tab results.			deficiencies cited have been or will	be		
					corrected by the dates indicated.			
		dmitted to the facility on			-			
		readmitted on 05/13/14. The			F 315			
		nted diagnoses included onic kidney disease-stage III,			Corrective Action for Resident Affe	otod		
		heart failure, and pulmonary			Resident # 858 received treatment			
		chronic obstructive pulmonary			urinary tract infection (UTI) on 05/0			
	disease.	, , ,			The Physician and Family were no			
					the change in condition upon send	-		
	set (MDS) docume	8/14 quarterly minimum data nted her cognition was she was occasionally			resident to the emergency room or 05/09/14.	ו		
		el and bladder, she required			Corrective Action for Resident Pote	entially		
		n a staff member with toileting,			Affected	-		
	and she did not exi				All residents have a potential to be			
	problems/behavior	s/psychosis/resistance to care.			affected by the alleged deficient pr Beginning 6/9/2014 the Nurse	actice.		
		t progress note documented			Management Team audited all curr			
		ary physician office called on			resident lab results from 04/01/14			
	urinalysis (UA) be o	ent's family to request that a			present for any abnormal labs with and responsible party notification of			
		sompleted.			results. In addition to this, all curre			
	A 04/15/14 physicia	an order documented a UA, C			residents were assessed for signs			
	& S (culture and se	ensitivity) was to be drawn for			symptoms of a potential UTI by the	e hall		
	Resident #1 due to	increased confusion.			nurses under the direction of the n management team. Signs and sym			

Facility ID: 923452

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1				APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:	COMF	SURVEY
		345397	B. WING			C 05/29/2014	
NAME OF I	PROVIDER OR SUPPLIER		I		TREET ADDRESS, CITY, STATE, ZIP CODE	00/2	
SHOREL	AND HLTH CARE & F	RETIREME			00 FLOWER-PRIDGEN DR VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 315	documented, "UA c confusion per's designation's) requinant A 04/16/14 care plat documented, "I have times. I have hx (h confusion, hallucina antipsychotic medic History 'seeing ants See nurse's notes. little 4 year old son. included, "Check un needed for volume. Monitor/record/repo onset s/sx (signs/sy in behavior, altered in cognitive function communication dec restlessness and a dehydration, infecti Clean catch urine la the facility on 04/19 than 100,000 CFU proteus mirabilis we urine sample. Documentation on they were faxed to on 04/21/14. Howe	e clinical update/progress note obtained for increased s (family member est." an for Resident #1 ve confusional episodes at istory) of episodes of ations. No routine cation per request of family. s on food', none were present. Wants to go home to see my " Interventions to this problem rine per order/protocol and as , color, and odor. ort to MD (physician) new ymptoms) of delirium, changes mental status, wide variation in through the day, cline, disorientation, lethargy, gitation, altered sleep cycle, on, delusions, hallucinations." aboratory results, available to 0/14, documented that greater of klebsiella pneumoniae and ere found in the resident's the lab results indicated that the primary physician's office ever, there was no returned fax	F 3	15	of UTI assessed were: painful urination new or worsening urgency, frequency incontinence; lower abdominal pain or pain in the flank area; urine that is clored or foul smelling urine; fever (100) degrees F or greater) or chills; and new orsening confusion. This was complion 6/16/2014. Number of residents in with current signs and symptoms of U were 5 The number of current residents with unreported abnormal lavalues were 0 Affected residents hat their physician and responsible party notified of the UTI signs and symptom abnormal labs on6/16/2014_ by Rebecca Lamm Systemic Changes in-services were completed on 6/16/2 by the Staff Development Coordinator Those who attended were all RNs, an LPNs FT, PT, and PRN. Any in-hous staff member who did not receive in-service training will not be allowed for work 6/16/2014 until training has been completed. The facility specific in-service residents care in the facility to provide training for staff prior returning to the facility to provide care Any in-house staff member who did not be allowed in receive in-service training will not be allowed to the facility to provide training for staff prior returning to the facility to provide care Any in-house staff member who did not be allowed to the facility to provide training will not be allowed to the facility to provide training for staff prior returning to the facility to provide care Any in-house staff member who did not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training for staff prior returning to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide training will not be allowed to the facility to provide trai	y or pudy, ew or leted noted JTI ab ad ns or 2014 r. nd se to en rvice e or to e. not	
	in the resident's me acknowledged rece and there was no n abnormal lab result interview with unit s	edical record indicating eipt from the physician office, notation that a response to ts had been obtained (see supervisor). A physician date, was observed on these			allowed to work until training has been completed. The in-service topic for th RNNs and LPNNs included education the following policies and procedures: 137, NUP 215 and NUP 611. In additi the policy 215, the nurses were in-serviced on recognizing signs and	he n on :: ICP	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	OMB NO.	0936-038 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
					(	C
		345397			05/2	29/2014
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOREL	AND HLTH CARE & F	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 315	Continued From pa	ige 11	F 31	5		
	Review of physician treat the resident w A 04/26/14 physicia Resident #1 was as information was ind the lab result/C & S resident did have c kidney disease. Th labs are pending." (However, no order repeat labs). A 04/30/14 hospice documented, "UA r A 05/03/14 10:54 P documented, "Rsdt and down hallway h to be taken home; to be left here; Rsd hallway stating he h at resdts and becon her: The note do to console or redire had to be called to A 05/06/14 10:12 P "Pt. (patient) sitting disoriented. She w distressed." A 05/09/15 1:48 AM documented, "Rsdt agitation and comb she wanted to go to	n orders revealed no orders to ith an antibiotic. an progress note documented ssessed in the facility, but no cluded about a recent UA or 5. The note documented the hronic UTIs and chronic he physician did note, "Repeat rs were found to draw any		symptoms of a UTI and how to r Physician. The Physician should when a change in condition occi when abnormal lab values are re hours a day 7 days a week. This does not change due to time of week. The nurses were also in-so on the revised lab protocol. See attachments. Quality Assurance The Director of Nursing will more issue using the "Survey QA Tool Monitoring Change in Condition. Notification". The monitoring wi sampling 5 residents to verify the residents noted with an abnormatic change in condition had there P and Responsible Party notified to This tool will be completed daily weeks then monthly times three or until resolved by QOL/QA cor See attachment . Reports will be the weekly Quality of Life- QA co and corrective action initiated as appropriate. The QOL/QA Meet attended by Administrator, Direct Nursing, Unit Manager, other nu managers, Social Service, and I Manager.	I be called urs or eceived 24 s process day or serviced itor this for 'Lab II include at al lab or hysician imely. times two months nmittee. be given to ommittee ing is tor of rse	

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CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			0MB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		B. WING _		05	C 5/29/2014		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SHOREL	AND HLTH CARE & F	RETIREME		200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 315	This is not my room string off and wrapp tightly. Rsdt was ye when they approac services to transpo evaluation. Out of the A 05/09/14 6:29 AM documented, "Rece of hospital nurse)/ F (intravenous) Levac (milligrams) admini ABT (antibiotic)/UT Cipro antibiotic by r x 3 days. At 9:47 AM on 05/2 interview, Resident he almost always tr results documented of bacteria. The ph family was very inve and requested to be the resident's condi participate in makin commented, after r records, he had no results, or C & S fo According to the ph to treat a UTI with a count as high as gr would expect the fa resident began exh symptoms indicativ At 10:22 AM on 05/	age 12 scream 'this in not my house. h.' Rsdt was taking alarm and bing it around her hands elling and trying to fight staff hed to help911 called for rt to ER (emergency room) for facility at 2:15 AM" A resident progress note eived report from (name Rsdt as 'Bad' UTI. IV quin (antibiotic) 750 mg stered at ERnew order for I." This new order was for nouth 500 mg BID (twice daily) 9/14, during a telephone #1's primary physician stated reated UTIs when the lab d greater than 100,000 CFUs hysician reported Resident #1's olved in the resident's care, e kept informed of changes in ition/health so they could ng care decisions. He eviewing his own medical documentation of a UA, lab r Resident #1 in April 2014. hysician, even if he decided not an antibiotic, with a bacterial eater than 100,000 CFUs, he icility to notify him if the ibiting physical or behavioral e of a possible infection. '29/14, during a telephone member of Resident #1 stated	F 31	5			

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		AND HUMAN SERVICES				FORM	06/17/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345397	B. WING				C 29/2014
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SHOREL	AND HLTH CARE & F	RETIREME			200 FLOWER-PRIDGEN DR NHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	around the middle of to exhibit anxiousne hallucinations. Acc past such behaviors The family member asked for help in o because the facility much attention to th behavior. At 12:22 PM on 05/ Resident #1 on first when the resident be aggressive about w refused medication sometimes such be recurrent UTIs. Sh drew UAs when the for the presence of unable to recall if R behaviors prior to th hospitalization beca help was needed th At 12:30 PM on 05/ #4, who regularly ca shift, stated sporad out, get anxious an She reported this fr had a UTI. She con experiencing these couple weeks befor 05/09/14. At 12:42 PM on 05/ (DON) stated labs r the physician office	of April 2014 when she began ess, aggression, and ording to the family, in the swere an indicator of a UTI. reported the physician was btaining a UA for the resident did not seem to be paying he change in the resident's 29/14 Nurse #1, who cared for t shift, stated there were times became agitated, combative, ranting to go home, and s and alarms. She reported ehaviors were symptoms of e explained the facility usually behaviors emerged to check bacteria in the urine. She was esident #1 exhibited such he resident's 05/09/14 ause her assignment varied as proughout the facility. 29/14 nursing assistant (NA) ared for Resident #1 on first ically the resident would yell d combative, and resist care. equently meant the resident mmented Resident #1 was symptoms at least for a re being hospitalized on 29/14 the director of nursing results were always faxed to s, and if there was no return e lab results were refaxed or	F3	315			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	a. Buildi	ING	i	COMPLETED		
		345397	B. WING					29/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SHOREL	AND HLTH CARE & R	<b>RETIREME</b>			200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECT	ION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	E APPROPRIATE DATE		
F 315	Continued From pa	Continued From page 14		815				
	At 12:50 PM on 05/	29/14 the unit supervisor						
	stated Resident #1	's primary physician always						
		I by facility staff, and did not or concerns to be faxed to his						
	office. She stated t	the 04/19/14 lab results for						
		not initialed and marked						
		ined that "noted" indicated ived from the physician or						
	action was taken by	y the physician in response to						
		pervisor also commented 9/14 lab results were signed in						
	pen by the physicia	n which meant he was in the						
		ned off on them. However, hysician forgot to supply a date						
	with his signature o	on the 04/19/14 lab results,						
	which was not like h	him. She pointed out all the						
		Resident #1's chart with dated resident's physician.						
	At 1:50 PM on 05/2	9/14, during a telephone						
	interview with Nurse #2, who regularly cared for							
		t shift, stated sporadically yell out, demand to be taken						
		ve with staff, and family would						
		calm her down. She						
		s such behaviors indicated the She explained the facility						
	usually drew a UA t	o see if bacteria was present						
		nese behaviors emerged. e knew for sure that these						
		were exhibited by Resident #1						
		s before going out to the 4, maybe even longer.						
		9/14, during a telephone hily member of Resident #1						
	stated on 04/19/14	someone from the facility						
	called to tell the fan	nily that the UA showed the						

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PRINTED: 06/17/2014

		AND HUMAN SERVICES			FORM	: 06/17/2014 APPROVED : 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED				
345397		345397	B. WING		C 05/29/2014					
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•					
SHOREL	AND HLTH CARE & F	RETIREME	200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE				
F 315	thought this meant contamination of th family member, bet family was asked to three or four times redirect or console reported they were	Inge 15 ". The family explained they there was no bacterial e urine. According to the tween 04/15/19 and 05/09/14 o come sit with the resident because the facility could not Resident #1. The family puzzled about what was me behaviors if a UTI was not	F 31							

Facility ID: 923452