		& MEDICAID SERVICES	0.00 L		NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED C
		345383	B. WING		12/17/2014
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
SCOTTIS	H PINES REHABILIT	ATION AND NURSING CENTER		620 JOHNS ROAD LAURINBURG, NC 28352	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
F 000	INITIAL COMMEN	TS	F 000		
E 309	amended on 12/29	ment for tag F 514 was /14. CARE/SERVICES FOR	F 309		1/14/15
SS=D	HIGHEST WELL B	EING	1 308		1/14/13
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment			
	by: Based on record re facility failed to prov medication to 1 of 3	NT is not met as evidenced eview and staff interviews the vide PRN (as needed) pain 3 residents (Resident #1) who dication. The findings		Scottish Pines Rehabilitation and Nurs acknowledges receipt of the Statemen Deficiency and proposes the plan of correction to the extent that the summ of findings is factually correct and in or	t of ary der
	and readmitted on included hip replace	idmitted to the facility 6/4/14 10/23/14 with diagnosis that ement, postoperative infection, ago and degenerative disc		to maintain compliance with applicable rules and the provision of quality care residents. The below response to the Statement Deficiency and plan of correction does denote agreement with the citation by	of
	Assessment dated	imum Data Set (MDS) 11/4/14 coded the resident as naving no behaviors, with evel of 6 out of 10.		Scottish Pines Rehabilitation and Nurs The facility reserves the right to submi documentation to refute the stated deficiency through informal appeals procedures and/or other administrative	t
	Administration Rec 11/7/14 at 6:55 AM	t # 1 ' s November Medication ord (MAR) documented on , 2 PRN (as needed) pain ministered to the resident. A		legal proceedings. F309	
BORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Electronically Signed

12/29/2014

PRINTED: 01/16/2015

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.

DEDADTMENT OF LIEALTH AND LUMANN CEDVICES

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
	<b>345383</b> B. WING			C 12/17/2014		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SCOTTIS	6H PINES REHABILIT	ATION AND NURSING CENTER		620 JOHNS ROAD LAURINBURG, NC 28352		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 309	follow up notation a medication was eff indicated that 2 PR administered to the up notation. A follo PM the resident ha medications and th effective. In an interview with 12/17/14 at 9:17 A s nurse had signed then discovered the She stated that the the resident his pai and that he did not PM. The DON ind signed the MAR was facility. In an interview on aide who worked we that the resident to	age 1 at 7:28 AM documented the ective. A notation at 11:56 AM IN pain medicines were e resident. There was no follow ow up note documented at 6:19 id received 2 PRN pain the Director of Nursing on M she stated that the resident ' I out for the medication and e medication was not available. In medication as documented receive anything until 4:25 icated that the nurse who as no longer employed with the 12/17/14 at 9:45 AM the nurse with Resident # 1, she stated ok his pain medications every not want to miss any of his	F 30	<ol> <li>Resident #1 was discharged f facility on 11/12/2014 to resident following completion of therapy se</li> <li>Resident #1 was discharged f facility on 11/12/2014 with prescrip for a thirty-day supply of pain med and a follow-up appointment with care physician within two weeks of discharge from facility.</li> <li>Nurse that had signed out for medication (and then discovered in not available) was terminated from employment effective 11/7/2014.</li> <li>All facility licensed nursing stat in-serviced by facility Director of N Services or designee of facility po ensure that each resident receiver necessary care and services (to in medications) in accordance with th comprehensive assessment and p care. This in-service will be comp or before January 14th, 2015. This information will be included in new orientation and through annual rev 5) All facility licensed nursing stat in-serviced by facility Director of N Services or designee to ensure th clinical records on each resident a accurate and in accordance with a professional standards. This in-set will be completed on or before Jan 14th, 2015. This information will b included in new hire orientation ar through annual reviews.</li> <li>Results of plan will be discuss minutes recorded x 4 months duri facilityl s monthly QA meeting, wit adjustments to plan made as need followed by:</li> </ol>	s home rvices. rom obions ications primary f the t was n ff will be lursing licy to s hclude he olan of leted on s / hire //iews. ff will be lursing at are accepted ervice huary be d sed and ng the th	

Facility ID: 953087

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES			FO	RM A	01/16/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		345383	B. WING				<i>,</i> 7/2014
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	/.	
SCOTTIS	H PINES REHABILIT	ATION AND NURSING CENTER			20 JOHNS ROAD AURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 514 SS=D	Continued From page 2		F 309	<ul> <li>7) Results of compliance with plan will be discussed and minutes recorded quarterly x 3 quarters during the facilityl s quarterly QA committee meeting, with adjustments to plan made as needed followed by:</li> <li>8) Should revisions be necessary, appropriate staff will be re-in-serviced by facility Director of Nursing Services or appropriate designee.</li> <li>9) Any revisions to plan will require monitoring steps to begin again at step 6.</li> </ul>		1/14/15	
	information to ident resident's assessm services provided; t preadmission scree and progress notes	ening conducted by the State;					
	by: Based on record re facility failed to prov				Scottish Pines Rehabilitation and Nurs acknowledges receipt of the Statement Deficiency and proposes the plan of correction to the extent that the summa of findings is factually correct and in ord to maintain compliance with applicable	of	

Facility ID: 953087

If continuation sheet Page 3 of 5

				FORM	01/16/2015 APPROVED 0938-0391
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
	345383	B. WING			」 17/2014
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
SH PINES REHABILIT	ATION AND NURSING CENTER		620 JOHNS ROAD LAURINBURG, NC 28352		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
Continued From pa	age 3	F 51			
	Resident # 1 was admitted to the facility 6/4/14		rules and the provision of a residents.	quality care to	
included hip replace	ement, postoperative infection,		Deficiency and plan of corr denote agreement with the	rection does not e citation by	
Assessment dated cogitatively intact, h frequent pain at a lo	11/4/14 coded the resident as naving no behaviors, with evel of 6 out of 10.		The facility reserves the rig documentation to refute th deficiency through informa	ght to submit e stated Il appeals	
Administration Rec 11/7/14 at 6:55 AM medicines were ad follow up notation a medication was effe indicated that 2 PR administered to the up notation. A follo PM the resident ha	ord (MAR) documented on , 2 PRN (as needed) pain ministered to the resident. A at 7:28 AM documented the ective. A notation at 11:56 AM N pain medicines were e resident. There was no follow w up note documented at 6:19 d received 2 PRN pain		facility on 11/12/2014 to re following completion of the 2) Resident #1 was disch facility on 11/12/2014 with for a thirty-day supply of pa and a follow-up appointme care physician within two v discharge from facility.	sident1 s home erapy services. harged from prescriptions ain medications ent with primary veeks of	
12/17/14 at 9:17 All s nurse had signed then discovered the She stated that the the resident his pai and that he did not PM. The DON indi signed the MAR wa facility. In an interview on 1 aide who worked w	M she stated that the resident ' out for the medication and e medication was not available. nurse probably never gave n medication as documented receive anything until 4:25 cated that the nurse who as no longer employed with the 12/17/14 at 9:45 AM the nurse rith Resident # 1, she stated		medication (and then disco not available) was termina employment effective 11/7 4) All facility licensed nur in-serviced by facility Direc Services or designee of fa ensure that each resident necessary care and servic medications) in accordanc comprehensive assessme care. This in-service will b or before January 14th, 20 information will be included	overed it was ted from /2014. sing staff will be ctor of Nursing cility policy to receives es (to include e with the nt and plan of be completed on 15. This d in new hire	
	RS FOR MEDICARE OF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER SH PINES REHABILIT SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa Resident # 1 was a and readmitted on included hip replac chronic pain, lumba disease. The Admission Min Assessment dated cogitatively intact, h frequent pain at a la Review of Residen Administration Rec 11/7/14 at 6:55 AM medicines were ad follow up notation a medication was effi- indicated that 2 PR administered to the up notation. A follo PM the resident ha medications and the effective. In an interview with 12/17/14 at 9:17 AI s nurse had signed then discovered the She stated that the the resident his pai and that he did not PM. The DON indi signed the MAR wa facility. In an interview on fa- aide who worked war	DF CORRECTION       IDENTIFICATION NUMBER:         345383         PROVIDER OR SUPPLIER         SH PINES REHABILITATION AND NURSING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3         Resident # 1 was admitted to the facility 6/4/14 and readmitted on 10/23/14 with diagnosis that included hip replacement, postoperative infection, chronic pain, lumbago and degenerative disc disease.         The Admission Minimum Data Set (MDS) Assessment dated 11/4/14 coded the resident as cogitatively intact, having no behaviors, with frequent pain at a level of 6 out of 10.         Review of Resident # 1 's November Medication Administration Record (MAR) documented on 11/7/14 at 6:55 AM, 2 PRN (as needed) pain medicines were administered to the resident. A follow up notation at 7:28 AM documented the medication was effective. A notation at 11:56 AM indicated that 2 PRN pain medicines were administered to the resident. There was no follow up notation. A follow up note documented at 6:19 PM the resident had received 2 PRN pain medications and that the medication was effective.         In an interview with the Director of Nursing on 12/17/14 at 9:17 AM she stated that the resident 's nurse had signed out for the medication and then discovered the medication was not available. She stated that the nurse probably never gave the resident his pain medication as documented and that he did not receive anything until 4:25 PM. The DON indicated that the nurse who signed the MAR was no longer employed with the	RS FOR MEDICARE & MEDICAID SERVICES         COF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         ABUILDIN         345383         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3         Continued From page 3         Resident # 1 was admitted to the facility 6/4/14 and readmitted on 10/23/14 with diagnosis that included hip replacement, postoperative infection, chronic pain, lumbago and degenerative disc disease.         The Admission Minimum Data Set (MDS) Assessment dated 11/4/14 coded the resident as cogitatively intact, having no behaviors, with frequent pain at a level of 6 out of 10.         Review of Resident # 1 's November Medication Administration Record (MAR) documented on 11/7/14 at 6:55 AM, 2 PRN (as needed) pain medicines were administered to the resident. A follow up notation at 7:28 AM documented the medication was effective. A notation at 11:56 AM indicated that 2 PRN pain medicines were administered to the resident. There was no follow up notation. A follow up note documented at 6:19 PM the resident had received 2 PRN pain medications and that the medication was effective.         In an interview with the Director of Nursing on 12/17/14 at 9:17 AM she stated that the resident 's surse had signed out for the medication and then discovered the medication as documented and that he did not receive anything until 4:25 PM. The DON indicated that the nurse who signed the MAR was no longer employed with the facility.         In an intervie	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         OF DEFICIENCIES         PEORDECTION         ABUILDING         ABUILDING         B WING         STREET ADDRESS, CITY, STATE, ZIP         SCHOMER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES         IMPROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         Resident # 1 was admitted to the facility 6/4/14 and readmitted on 10/23/14 with diagnosis that included hip replacement, postoperative infection, chronic pain, lumbago and degenerative disc disease.         The Admission Minimum Data Set (MDS) Assessment dated 11/4/14 coded the resident as cogitatively intact, having no behaviors, with frequent pain at a level of 6 out of 10.         Review of Resident # 1 's November Medication Administration Record (MAR) documented to n11/7/14 at 6:55 AM, ZPRN (as needed) pain medicates and that the medication was effective.         In an interview with the Director of Nursing on 12/17/14 at 9:17 AM she stated the resident has than the probably never gave the resident has than the proceive anything until 4:25 PM. The DON indicated that the nurse who signed the MAR was no longer employed with the facility.         In an interview on 12/17/14 at 9:45 AM the nurse aide who worked with Resident # 1, she stated	IMENT OF HEALTH AND HUMAN SERVICES         FORM.           SE FOR MEDICARE & MEDICAID SERVICES         OMB NO.           OF CORRECTION         (X1) PROVIDERSUPPLEVICUES         OMB NO.           STREET ADDRESS, CITY, STATE, 2/P CODE         8. WING         12/           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2/P CODE         520 JOHNS ROAD           SH PINES REHABILITATION AND NURSING CENTER         INTEGET ADDRESS, CITY, STATE, 2/P CODE         520 JOHNS ROAD           SUMMARY STATEMENT OF DEFICIENCIES (RECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION)         INTEGET ADDRESS, CITY, STATE, 2/P CODE         520 JOHNS ROAD           Continued From page 3         INTEGET ADDRESS, CITY, STATE, 2/P CODE         10         12/           Continued From page 3         F 514         Intel and integration of quality care to residents.         Intel and the provision of quality care to residents.           The Admission Minimum Data Set (MDS) Assessment dated 11/4/14 coded the resident as cogitatively intact, having no behaviors, with frequent pain at level of 6 out of 10.         F514           The Admission Minimum Data Set (MDS) Assessment dated 11/4//14 coded the resident A follow up notation at 7.28 AM documented of 11//7/14 at 5:57 AM Se stated that the ensident A follow up notation at 7.28 AM documented the medications and that the durate or vasing on 12//7/14 at 5:77 AM she stated that the resident A sinee the asigned out for the medication and then discovered the medication as a columented and that he did not the ena

Facility ID: 953087

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PRINTED: 01/16/2015

	EMENT OF DEFICIENCIES PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		345383	B. WING			) 17/2014	
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	/		
SCOTTIS	SH PINES REHABILI	TATION AND NURSING CENTER		320 JOHNS ROAD LAURINBURG, NC 28352			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 514	4 hours and would pain medications. In an interview on stated that nurses	not want to miss any of his 12/17/14 at 2:00 PM the DON are expected to administrator a ition first, then document on the	F 514	<ul> <li>5) All facility licensed nursing stin-serviced by facility Director of I Services or designee to ensure the clinical records on each resident accurate and in accordance with professional standards. This in-swill be completed on or before Jat 14th, 2015. This information will included in new hire orientation at through annual reviews.</li> <li>6) Results of plan will be discuss minutes recorded x 4 months dur facility I s monthly QA meeting, wadjustments to plan made as neeffollowed by:</li> <li>7) Results of compliance with p be discussed and minutes record quarterly x 3 quarters during the figuraterly QA committee meeting, adjustments to plan made as neeffollowed by:</li> <li>8) Should revisions be necessa appropriate staff will be re-in-servicality Director of Nursing Servical appropriate designee.</li> <li>9) Any revisions to plan will require monitoring steps to begin again a service of the serv</li></ul>	Nursing nat are accepted service inuary be nd sed and ring the ith eded, lan will led facility1 s with eded ry, viced by es or		

Facility ID: 953087

If continuation sheet Page 5 of 5