PRINTED: 01/12/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345397	B. WING		12/08/2016
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	0	
F 314 SS=D	the complaint investi Event ID# Q50J11.		F 31	4	1/5/17
SS=D	(b) Skin Integrity - (1) Pressure ulcers.				
	facility must ensure t				
	professional standard pressure ulcers and ulcers unless the ind	s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and			
	necessary treatment professional standard healing, prevent infed from developing.	essure ulcers receives and services, consistent with ds of practice, to promote ction and prevent new ulcers T is not met as evidenced			
	Based on nurse practinterview, and record put nutrition recomm registered dietitian (Finurse practitioner (N	ctitioner (NP) interview, staff I review the facility failed to endations, made by the RD) and signed off on by the P), into place for 1 of 4 Resident #33) with pressure		The statements made on this plan correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all fe	and do he
	ulcers who was admi pressure ulcer and d ulcer prior to being d also failed to put nutr	itted to the facility with a eveloped a new pressure ischarged home. The facility rition interventions, made by ff on by the physician, into		and state regulations the facility had or will take the actions set forth in a plan of correction. The plan of corrections the facility's allegation of compliance such that all alleged deficiencies cited have been or will	as taken this rection of
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u>(</u>	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

12/21/2016 **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.

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	TE SURVEY MPLETED		
		345397	B. WING _			2/08/2016
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO	•	
				200 FLOWER-PRIDGEN DRIVE		
SHORELA	ND HLTH CARE & R	ETIREME		WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From p	age 1	F 3	14		
	· ·	NP and the Director of Nursing		corrected by the dates indicate	ated	
		ampled residents (Resident		corrected by the dates make	atcu.	
	#49) with pressure	e ulcers who experienced a vound while waiting on the		F 314		
		e implemented. Findings		A corrective action for Affect	ed Resident	
	included:	, produce of		has been accomplished by:		
	1 Resident #33 v	vas admitted to the facility on		Resident #33 discharged from	om the facility	
		sident's documented diagnoses		on 10/05/2016. For resident		
		ressure ulcer, left buttock		recommendations made by		
		abetes, Parkinson's disease,		Registered Dietician for Med		
	and vitamin D defi	•		was put in place on 12/05/20		
		•		Prostat AWC was put in place		
	The 09/08/16 Pres	ssure Ulcer Review		12/04/2016.		
	documented Resid	dent #33 had an unstageable				
	pressure ulcer me	asuring 5 x 5.5 centimeters		A corrective action has beer	1	
	(cm) on the coccy	x. The wound bed was 75% of		accomplished on all residen	ts with the	
	slough and 25% g	ranulation tissue with no		potential to be affected by the	ie alleged	
		and no pain. The wound was		deficient practice by:		
		mal saline and Santyl was				
	applied every thre	e days and as needed.		All current residents that have		
				nutritional recommendations	•	
		admitted on 09/08/16 with		Registered Dietician (RD) ar		
	· ·	or a mechanically soft/chopped		affected. The nurse manage		
		sweet (LCS) diet and for a		will audit all nutritional recon		
	diabetic bedtime s	snack.		made by the RD since 09/15	o/2016 to	
	A 00/40/40 l	:		ensure that the nutritional		
		ian order changed the		recommendation has been a	•	
	resident's diet to L	.CS regular texture.		the MD and if agreed to, that put in place for the resident.		
	The 00/14/16 Wee	ekly Pressure Ulcer Review		and corrections if needed wi		
		dent #33's stage II pressure		completed by 1/5/2017.	II DC	
		x measured 4 x 5 cm. The		30111picted by 1/3/2017.		
	,	00% epitheleal tissue, there was		Systemic changes made we	ere.	
		eous drainage, no odor, and		Systemic changes made we	10.	
		e wound was controlled by		On 12/21/2016 an in-service	will be	
	medication.	o mountained by		conducted by the Clinical Nu		
				Consultant to the Director of		
	The resident's 09/	14/16 lab results documented		(DON), Dietary Manager, Ur	•	

Facility ID: 923452

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345397	B. WING _		12/08/2016
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP	•
				200 FLOWER-PRIDGEN DRIVE	
SHORELA	AND HLTH CARE & RE	ETIREME		WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 314	Continued From page	age 2	F3	314	
	her albumin level v (g/dL) with the normal range being. The resident's 09/7 set (MDS) documes she exhibited no be extensive assistant her activities of daileating, she was at had an unhealed pulcer), and she had interventions in plant A 09/15/16 Dietitia #33 weighed 217.2 might be beneficial was mostly over 50 ulcer to the coccyx documented the reat 2.3 g/dL with the	vas 3.1 grams per deciliter mal range being 3.6 - 5.1 g/dL, in level was 6.1 g/dL with the		and Staff Development Corfollowing topics: When nutritional recordare made by the RD, and to the DON and the Dietal the day the recommendations and will the Unit Manager to either or give the recommendations and will practitioner for review. Once a response is remodered to the within 72 hours of receipt. This information has been the standard orientation to the	ommendations email will be sent ry Manager on ion is made. If the I give them to r fax to the MD on to the Nurse eccived from the tary put in place In integrated into raining and in the mer courses for es and will be essurance
	"Recommend Pros supplement) 30 ml wound closed, Vit days, Zinc 220 mg (multi-vitamin) for will aid with low alt add Cardiac to cur history/dx (diagnos On 09/16/16 on the sheet the NP place RD's recommenda	stat SF (Sugar Free protein BID (milliliters twice daily) until C 500 mg (milligrams) BID x 30 once daily x 14 days, and MVI wound healing aid. Prostat SF oumin as well. Recommend rent diet orders due to medical sis)." e Nutritional Recommendation ed a check mark beside the tion to begin protein vitamin C, zinc, and a blaced a X by the		The facility plans to monit performance by: The Dietary Manager will issue using the QA for RE recommendations Tool for ensure dietary recommen have been implemented to hours of receipt from the Ecompleted on 5 residents weeks then monthly x 2 m resolved by QOL/QA com will be presented to the wommittee by the Adminis ensure corrective action in	monitor this monitoring to dations made imely within 72 MD. This will be weekly x 4 nonths or until mittee. Reports eekly QA trator or DON to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	TIREME		STREET ADDRESS, CITY, STATE, ZIP 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION OF THE APPROPRIATE COMPLETION DATE
F 314	October 2016 med (MARs) documented protein zinc, and a multi-vitario, and pain caused by medication. On 09/23/16 Residual Trequire acids, minerals, as healing." The 09/28/16 Wee documented Residual Resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #33 deveto the left buttock round bed was 10 resident #34 deveto the left buttock round bed was 10 resident #35 deveto the left buttock round protein #35 deveto the left buttock round protein #36 deveto the left buttock round protein #	t #33's September 2016 and ication administration records In supplementation, vitamin C, tamin were never initiated. It with the content of	F3	appropriate. Compliance and ongoing auditing prog the weekly QA Meeting. The Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator, Therapy, HII Manager and the Administration of the Meeting is attended by the Coordinator of the	gram reviewed at The weekly QA e DON, MDS M, Dietary

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	IREME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	Continued From pag	e 4	F 3	14		
	Record review docui	mented resident #33 was 10/05/16.				
	supplements played wound healing. She the RD to start Prost quickly after wounds commented she four Recommendation shecause there were suggestions, but only or disagree at the bollast year and a half sproblem by putting or individual suggestion initiate the recommendation. Sonursing (DON) revier recommendations, a initiated for the recommendations, a initiated for the recommendation place 1 - 2 days after She stated she was days Monday - Frida Nutrition Recommendation, vitimulti-vitamin, but shediet order to be charter of the state of the residence of the commendation of the commendations.	y two boxes to checkagree of the she stated she solved the hecks or Xs by each not checks documenting to not addition and the Xs implement the she reported the Director of swed all nutrition and made sure orders were shown and she would expect to she approved to be put in a she signed off on them. In the facility daily for half she signed on the she signed on the she signed on the she stated she meant dent to receive protein amin C, zinc, and a she did not want the resident's she signed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345397	B. WING	 		2/08/2016	
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP COD 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 314	there was only one lisheets for the physical agreed or disagreed line for comments. So noticed any checks a recommendation she the NP was writing a individual recommendobserved during recording Resident is she stated she would (checks and x's) to make supplements implements implemented would resolved. She commould expect RD recommended Prost the NP, to be implemented would resolved it was very interventions as soon ulcer was identified. The recommended Prost and zinc for stage II stage III to unstage a AWC (advance wour already had vitamins wound healing. According the physician or NP, and sure they were initiated.	ause many ere listed on one form, and ne on the bottom of the ian to check whether he/she with recommendations and a She commented she had not and x's on the RD eets. Instead, she reported gree or disagree beside each dation (this was not ord review). However, after 133's recommendation sheet, d interpret the NP's notations nean she wanted the nutrition ented, but did not want the 100N explained the only ents would not be be if the resident's ulcer was nented at the maximum, she commendations approved by nented within a week. 18/16, during a telephone s RD stated she tried to be in le of hours weekly. She important to start nutrition as possible after a pressure She commented she at, a multi-vitamin, vitamin C, pressure ulcers, and for ble ulcers she recommended and care) Prostat which and minerals in it to promote ording tot he RD, she lake sure her	F 31	4			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		E SURVEY PLETED
		345397	B. WING _			12	/08/2016
	ROVIDER OR SUPPLIER	REME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		OWER-PRIDGEN DRIVE		
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F 314	11/09/16. The reside included left heel pressure uld and atrial fibrillation. The resident's 11/09 documented she had the resident's 11/14. Review documented unstageable pressur measured 1.7 x 1.3 does not exudate and not of the resident's 11/16 physician administration of vitativice daily (BID) x 30 Resident #49's left had 11/16/16 physician administration of a magnetic pressure under the resident's 11/16 set (MDS) document cognitive impairment required extensive a her activities of daily was at risk for pressur unhealed pressure unspecified, but the work having eschar).	admitted to the facility on ent's documented diagnoses eer, anemia, hypertension, 16 admission nursing review of no pressure ulcers. 16 Weekly Pressure Ulcer the presence of an e ulcer to the left heel which centimeters (cm). There was dor. order initiated the min C 500 milligrams (mg) of days and sureprep to eel. order started the multi-vitamin and zinc sulfate and red Resident #49. 16 admission minimum data and Resident #49 had severe to exhibited no behaviors, essistance from the staff with living (ADLs) except eating, are ulcers, and had an licer (the stage was not und bed was documented as	F3	314			
	Review documented	/16 Weekly Pressure Ulcer Resident #49's ulcer to the red as a suspected deep					

ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345397	B. WING	 	1	2/08/2016
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F 314	tissue injury (SDTI), no exudate and no complete the surplement of	measuring 1.3 x 1 cm with odor. Intly have a pressure ulcer to entified as a problem in the Interventions to this problem supplemental protein, amino ordered to promote wound Note documented the standard supplemental protein, amino ordered to promote wound Note documented the standard supplemental protein, amino ordered to promote wound Note documented the standard supplemental protein in the standard supplement was at 3.6 grams per deciliter and the resident had an refulcer to her left heel. The RD) recommended Prostate advance wound care protein in continueters three times are wound closed and Med as supplement) 120 cc BID x all intake. It is sician placed check marks attions for Prostat and Med (16 Nutritional neet.) If Weekly Pressure Ulcer I Resident #49's left heel in size, now measuring 3.4 x attering order initiated use of a heel ent #49's left foot, worn at all	F 31	4		

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345397	B. WING		12/08/2016	
	ROVIDER OR SUPPLIER	 TIREME	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FLOWER-PRIDGEN DRIVE VHITEVILLE, NC 28472	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 314	Resident #49's treat (TAR) documented 12/15/16 she was to on her bilateral lowe unless showering. A 12/04/16 physicia of Prostat AWC 30 or recommended by the off on by physician administration of medays (this intervent RD on 11/17/16 and 11/22/16). During a 12/07/16 2 interview the facility Treatment Aide staulcer on Resident # reported it was foun after the resident was They remarked sure ulcer since its discoutreatment, the resid boot and TED hose was about 1 x 1 cm.	d Resident #49's left heel m with no exudate or odor. Itment administration record from 12/01/16 through of wear knee high support hose or extremities at all times In order started administration occ TID (this intervention was be RD on 11/17/16 and signed on 11/22/16). In ordered initiated the ed pass 2.0 120 cc BID x 60 ion was recommended by the disigned off on by physician on the disigned off on by physician on the disigned developed, but they are developed, but they are admitted to the facility. The left heel SDTI and light purple in coloration.	F 314			
	(NP) stated nutritior important role in wo she worked with the C, and zinc quickly discovered. The NF	n supplements played a very und healing. She reported e RD to start Prostat, vitamin				

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	ROVIDER OR SUPPLIER	TIREME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	12/00/2010	
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F 314	multiple suggestion checkagree or dis sheet. For the last she solved the prol by each individual documenting to init the Xs documentin recommendation. Nursing (DON) rev recommendations, initiated for the recapproved. The NP nutrition interventic place 1 - 2 days aff She stated she was days Monday - Fric Nutrition Recommendation Reco	ecause there were bullets with its, but only two boxes to sagree at the bottom of the year and a half she stated olem by putting checks or Xs suggestion, checks itate the recommendation and g not to implement the She reported the Director of itewed all nutrition and made sure orders were commendations she (the NP) commented she would expect in she approved to be put in iter she signed off on them. It is in the facility daily for half iter she stated the resident end Prostat and Med Pass in the dup being initiated by the	F 31			
	recommendations. RD Nutritional Reconfusing at first be recommendations there was only one sheets for the physicagreed or disagreed line for comments. noticed any checks recommendation sithe NP was writing individual recommendations.	She reported she thought the ommendation sheets were ecause many were listed on one form, and line on the bottom of the cician to check whether he/she d with recommendations and a She commented she had not				

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F 314	At 11:46 AM on 12/08 interview, the facility's the facility for a couplireported it was very in interventions as soon ulcer was identified. recommended Prosta and zinc for stage III p stage III to unstageab AWC (advance wound already had vitamins wound healing. Acco checked weekly to ma recommendations we physician or NP, and sure they were initiated were not initiated with resubmitted her record 483.25(g)(1)(3) MAIN UNLESS UNAVOIDA (g) Assisted nutrition (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident (1) Maintains accepta status, such as usual body weight range and	proved by the physician or ad within a week. 2/16, during a telephone of RD stated she tried to be in the of hours weekly. She important to start nutrition as possible after a pressure of She commented she of the ulcers she recommended of care) Prostat which and minerals in it to promote of the ulcers she recommended of care) Prostat which and minerals in it to promote of the RD, she has sure her of the ulcers she also made of the RD, she has sure her of the ulcers she also made of the RD, she has sure her of the ulcers she also made of the RD, she has sure her of the ulcers of the ulcers she also made of the RD, she has sure her of the ulcers of the ulcers of the ulcers of the ulcers of nutritional body weight or desirable of electrolyte balance, unless condition demonstrates that		325		1/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 325	Continued From pag	e 11	F 325			
	nutritional problem a orders a therapeutic This REQUIREMEN' by: Based on nurse prainterview, and record put nutrition interven signed off on by the parameters consider the Director of Nursir residents (Resident is loss. Findings include Resident #94 was ac 09/23/16. The reside included anemia, hy	ctitioner (NP) interview, staff dreview the facility failed to tions, made by the RD and NP, into place within time red acceptable by the NP and ng (DON) for 1 of 2 sampled #94) reviewed for weight ded: dmitted to the facility on ent's documented diagnoses pertension, hyperlipidemia,		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 fed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correctionstitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will to an admission of correction.	eral taken is ction	
	weighed 158.6 poun pounds on 10/03/16. On 09/28/16 "I have problem r/t (in regard diet" was identified a #94's care plan. Interincluded, "RD to evarecommendations Plant Resident #94's 09/30 data set (MDS) documoderately impaired she required extensi of daily living (ADLs)	a potential nutritional d to) receiving therapeutic is a problem in Resident erventions to this problem luate and make diet change		F 325 A corrective action for Affected Resinas been accomplished by: Resident #94 the nutritional recommendation for Med Pass was initiated on 11/17/2016 by the Direct Nursing (DON). A corrective action has been accomplished on all residents with the potential to be affected by the allege deficient practice by: All current residents that have had nutritional recommendations made to Registered Dietician (RD) are poten	tor of the ed by the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 325	Continued From pag	e 12	F 3	25			
	A 10/06/16 Dietician resident experienced 09/26/16 (when the repounds), weight main was working to revier resident was on a regresident was eating a The registered dietitic weight loss noted to Pass (liquid nutrition centimeters twice dapass x 60 days." Record review revea Nutritional Recommendation for resident prevent furth The resident's Weight weighed 147.2 pounds on 10/18/16, 11/15/16. A 11/17/16 physician	Note documented the lover a 5% weight loss since esident weighed 161.7 Intenance was desired, staff waccuracy of all weights, the gular cardiac diet, and the at least 50% of most meals. In (RD) documented, "If continue, recommend Med supplement) 120 cubic lily (cc BID) given with med led there was not a RD endation sheet in Resident cumented the RD's Med Pass to help the her weight loss. In Summary documented sheets on 10/10/16, 148.4 and 149.2 pounds on order initiated Med Pass 2.0 is for Resident #94. (The on for this nutrition		will audit all nutritional recommade by the RD since 09/15 ensure that the nutritional recommendation has been at the MD and if agreed to, that put in place for the resident. and corrections if needed with completed by 1/5/2017. A needelivering nutritional recommendations made to the DON was implemented of 11/17/2016. The RD emails recommendations made to the Dietary Manager. Systemic changes made were conducted by the Clinical Nutronsultant to the Director of (DON), Dietary Manager, Urrand Staff Development Cooffollowing topics: When nutritional recommare made by the RD, an emate to the DON and the Dietary the day the recommendation. The DON will print off the recommendations and will gothe Unit Manager to either face.	addressed by addressed by at it has been. This audit all be ew process for mendations to on all nutritional the DON and the DON and the mendations ail will be urse for Nursing all manager, redinator on the mendations ail will be sent Manager on a is made. The mendations are unive them to		
	weighed 147.4 pound At 10:05 AM on 12/0	at Summary documented she ds on 12/05/16. 8/16 the NP stated nutrition a very important role in		or give the recommendation Practitioner for review. Once a response is rec MD/NP, the approved dietar recommendations will be pu	eived from the		
	preventing weight los with the RD to addre a significant problem commented she dep	ss. She reported she worked ss weight loss quickly when was first identified. The NP		within 72 hours of receipt. This information has been in the standard orientation train required in-service refresher	ntegrated into ning and in the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345397	B. WING_	B. WING		12/	08/2016
	NAME OF PROVIDER OR SUPPLIER SHORELAND HLTH CARE & RETIREME			20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FLOWER-PRIDGEN DRIVE /HITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	she reviewed a RD N sheet for Resident #9 of Nursing (DON) kep sheets in a notebook on them, either approrecommendations. Tapproved almost all corecommendations for interventions, but occrecommendations to The NP commented sinterventions she app 2 days after she signs she was in the facility Friday. The NP reponutrition supplement loss, waiting for over supplement recommendations. SRD Nutritional Reconconfusing at first becarecommendations we there was only one ling sheets for the physiciagreed or disagreed within a frecommendations was the DON, at the maxing recommendations ap implemented within a	she could not remember if sutritional Recommendation 14, but thought the Director of all the recommendation after she (the NP) signed off oving or rejecting the the NP remarked she of the RD's a supplements and food casionally rejected change resident diet orders. She would expect nutrition proved to be put in place 1 - the difference of the All th	F	3325	al management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Dietary Manager will monitor this issue using the QA for RD recommendations Tool for monitoring to ensure dietary recommendations made have been implemented timely within 7 hours of receipt from the MD. This will completed weekly x 4weeks then mont x 2 months or until resolved by QOL/Q committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure correct action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	e 22 be hly A to tive	

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRU A. BUILDING			1 ' '	E SURVEY PLETED	
		345397	B. WING		12	/08/2016
	NAME OF PROVIDER OR SUPPLIER SHORELAND HLTH CARE & RETIREME			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 325	interview, the facility's the facility for a coupl reported it was very in interventions as soon loss issue was identificated she checked weekly for recommendations were physician or NP, and sure they were initiated they were not initiated she resubmitted her or the coupling of the control of the coupling of the coup	RD stated she tried to be in e of hours weekly. She important to start nutrition as possible when a weight ied. According to the RD, to make sure her approved by the if they were, she also made ed. The RD commented if divithin 1 1/2 weeks then recommendation. B/16 the DON stated she I Recommendation sheets ere was no 10/06/16 sheet dent #94. 16, during a follow-up on with the RD, she stated her she completed a indation sheet for Resident is when her are acted upon. GIMEN IS FREE FROM UGS gs-General. Each resident's ere free from unnecessary ary drug is any drug when (including duplicate drug		329		1/5/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345397	B. WING		12/08/2016
NAME OF PROVIDER OR SUPPLIE SHORELAND HLTH CARE 8			STREET ADDRESS, CITY, STATE, ZIP CO 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE COMPLETION HE APPROPRIATE
F 329 Continued Fron (4) Without ade	n page 15 quate indications for its use; or	F 3:	29	
which indicate t discontinued; o (6) Any combin	ations of the reasons stated in			
This REQUIRE by: Based on reco Pharmacist inte a gradual dose antipsychotic m sampled reside unnecessary m Review of the O (MDS) dated 10 was admitted to Diagnoses inclu Schizophrenia. Review of the F dated 10/12/15 an attempted G medication) to S hour of sleep. Review of the N (MAR) from 11/ Resident #62 w anti-psychotic m (milligrams) by by mouth at ber mouth twice ear Resident #62 h	1) through (5) of this section. MENT is not met as evidenced rd review and staff and Consultant rviews the facility failed to attempt reduction (GDR) of three edications as required for 1 of 5 ints (Resident #62) reviewed for edications. Findings included: Quarterly Minimum Data Set 10/19/16 revealed Resident #62 the facility on 01/17/09. Ided psychotic disorder and resychotherapy Services notes revealed a recommendation for DR of Zyprexa (an anti-psychotic redication Administration Records 10/15 through 12/07/16 revealed as being given the following medications: Abilify 15 mg mouth every day, Zyprexa 5 mg of time, and Geodon 60 mg by ch day. The MAR's also revealed and minimal behaviors noted by 10/1/15 through 12/07/16.		The statements made on the correction are not an admiss not constitute an agreemen alleged deficiencies. To remond compliance with all federal regulations the facility has the take the actions set forth in correction. The plan of conconstitutes the facility's alle compliance such that all alled deficiencies cited have been corrected by the date or date. F 329 Corrective Action for Reside For resident # 62, Kelli King contacted on 12/08/2016 are Risk/Benefit statement was anti-psychotic medications. Abilify. In addition to this, a Reduction of Zyprexa was in 12/08/2016 by Kelli King, Not was reduced to 2.5 mg.	esion to and do to the with the main in and state taken or will this plan of rection regation of reged n or will be tes indicated. The written for Geodon and Gradual Dose initiated on P. Zyprexa

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345397	B. WING		12/08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,
CHODEL A	ND III TH CADE & DET	DEME		200 FLOWER-PRIDGEN DRIVE	
SHUKELA	ND HLTH CARE & RETI	REME	,	WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 329	Continued From page	e 16	F 329	9	
	pharmacy review per	protocol to consider dosage		Affected	
	reduction when clinic				
	Review of the Psycho	otherapy Progress Notes		All current residents receiving	
		gh 11/22/16 revealed no		anti-psychotic medications have the	
		tions or orders for attempting		potential to be affected by the alleged	
		otic medications for Resident		deficient practice. The pharmacy	
	#62.	ly Consulting Pharmacist		consultant will complete a medication	ina
		5 through 11/28/16 revealed		regimen review for all residents receiv an anti-psychotic medication for the ne	-
		cting a GDR for Resident		of a Gradual Dose Reduction. This	seu
	#62.	oung a CDT (or recolacine		review will be completed by 12/30/201	6. If
		/08/16 the Nurse Practitioner		any Gradual Dose Reductions are	·
	(NP) stated she had	not received a		identified as needed, it will be forward	ed
	` '	n the Consultant Pharmacist		to the Director of Nursing to contact th	
	that a GDR attempt v	was needed for Resident		attending physician or nurse practition	er
		she relied on the Consultant		for a response.	
		know when GDR attempts			
		dications were required.		Systemic Changes	
	-	ust been informed by the		The Administrator and Director of Nur	ning
	or reduction was nee	DON) that a GDR statement		The Administrator, and Director of Nur were in-serviced by the Clinical Nurse	sing
		/08/16 at 10:15 AM the DON		Consultant on the regulations for	
	stated she had been			anti-psychotic monitoring. Topics inclu	ded:
		showed GDR's had been		and population morning. Topics maid	.
		ent #62's anti-psychotic		The regulation addressing the use of	
		st year. She indicated the		antipsychotic medications identifies th	е
		versus benefit statement		process of tapering as a "gradual dose	
	that morning for Abilit			reduction (GDR)" and requires a GDR	
	-	iew on 12/08/16 at 10:18 AM		unless clinically contraindicated.Within	
		nacist stated she performed		first year in which a resident is admitte	
		reviews for each resident.		on an antipsychotic medication or after	
		OR was needed she sent a		the facility has initiated an antipsychot	IC
		he physician. She indicated		medication, the facility must attempt a	
		a long term resident in the nly needed one time. The		GDR in two separate quarters (with at least one month between the attempts	
	-	ist stated once a risk versus		unless clinically contraindicated. After	
		s written there was no need		first year, a GDR must be attempted	
		ne indicated she had not		annually, unless clinically contraindica	ted.
		ons for a GDR for Resident		For any individual who is receiving an	

Facility ID: 923452

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345397	B. WING			12/	08/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS	S, CITY, STATE, ZIP CODE			
SHORELA	AND HLTH CARE & RETII	REME		200 FLOWER-PR				
				WHITEVILLE, N	IC 28472			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 329	29 Continued From page 17		F3	29				
F 329	#62 because she did every year. In an interview on 12/ stated she expected the regulations and expected the regulations and expected the regulations.	not realize one was needed /08/16 at 3:48 PM the DON GDR's to be completed per xpected the Consultant he facility and the physician		antipsycho behavioral the GDR m contraindic. The reserver returned or recent attempt at a tempted would be lift function or For any incantipsycho psychiatric symptoms example, since depression GDR may lift. The contrainding the physicial rationale for reduction we resident's finstability be psychiatric. The reserver returned or recent attempt at a tempted would be lift.	symptoms related to dementally be considered clinically cated if: esident's target symptoms in worsened after the most a GDR within the facility; and hysician has documented the onale for why any additional dose reduction at that time kely to impair the resident's increase distressed behavioral distriction to treat a disorder other than behavior related to dementia (for schizophrenia, bipolar manian with psychotic features), the be considered contraindicated on the current standards of praction why any attempted dose would be likely to impair the function or cause psychiatric or esident's target symptoms in worsened after the most and GDR within the facility and an has documented the onale for why any additional dose reduction at that time kely to impair the resident's cause psychiatric instability to impair the resident's cause psychiatric instability	dee or. oral , or eed, ee ticee ical		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345397	B. WING _			12/	08/2016
	ROVIDER OR SUPPLIER	REME		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 FLOWER-PRIDGEN DRIVE HITEVILLE, NC 28472		
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 18	F3	329	by exacerbating an underlying medical psychiatric disorder. Monthly, the DON will complete the Anti-psychotic Review QA form to mon for GDR and Risk/Benefit statements for all residents receiving Anti-psychotic medications. This information has been integrated in the standard orientation training and in required in-service refresher courses for all pharmacy consultants and management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Clinical Nurse Consultant will mon this issue using the "Survey Quality Assurance Tool for Monitoring Antipsychotics. The monitoring will include auditing Antipsychotics for the need of a Gradual Dose Reduction monthly for 3 months or until resolved I Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee corrective action initiated as appropriat The Quality of Life Committee consists the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary	itor or ato the or itor oy e and e. of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345397	B. WING		12/08/2016
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 329	Continued From page 19		F 32	Manager and Social Worker.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, F 3' STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or	1	1/6/17		
		rom sources approved or ry by federal, state or local			
	, . ,	ood items obtained directly subject to applicable State lations.			
	facilities from using p	s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices.			
		es not preclude residents s not procured by the facility.			
		, distribute and serve food in essional standards for food			
	foods brought to residual visitors to ensure safe handling, and consun	egarding use and storage of dents by family and other e and sanitary storage, aption. is not met as evidenced			
	Based on observatio facility failed to air dry them in storage overr	n and staff interview the tray pans prior to stacking hight and failed to discard aded interior surfaces.		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 federal and state regulations the facility has taken or well as the constitution of the constitution	nd do
	At 9:25 AM on 12/07/16 3 of 7 tray pans stacked on top of one another on a storage shelf			take the actions set forth in this plan correction. The plan of correction	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345397	B. WING _			2/08/2016
NAME OF P	ROVIDER OR SUPPLIER	l	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		2/00/2010
				200 FLOWER-PRIDGEN DRIVE		
SHORELA	ND HLTH CARE & RE	TIREME		WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From page	age 20	F 3	71		
	had moisture trapp dietary employee of sink stated she had the sink system all	ped inside. At this time a operating the 3-compartment d not run any tray pans through morning so the tray pans with ide were stacked wet the night		constitutes the facility's alle compliance such that all all deficiencies cited have bee corrected by the date or da	leged en or will be	
	(DM) stated since stacility in mid-June	08/16 the dietary manager she became the DM in this 2016 she had held in-servicing		Corrective Action for Resid	manager	
	which included information about the storage of kitchenware. According to the DM, dietary staff was instructed not to stack kitchenware wet because bacteria could grow in trapped moisture.			audited all kitchen pans for trapped inside and kitchen abraded interior surfaces a or corrected any items note	ware for nd discarded ed to be	
	was taught that kite dry before stacking if kitchenware was	08/16 the PM cook stated she chenware should be clean and it in storage. She commented stacked wet overnight bacteria night make residents sick.		affected. On 12/8/16 replace kitchenware was Implement storage. Back up Kitchenwordered 12/22/16. Staff will monitor for moisture trapped abraded kitchenware and described witchenware and described witchen	nted from ware will be Il continue to ed pans and discard or	
	10:12 AM on 12/07 dessert cups were plastic soup/cereal	vare inspection, beginning at 1/16, 3 of 20 small plastic abraded inside, 10 of 29 bowls were abraded inside,		Corrective Action for Resident Affected	ent Potentially	
	of 67 pieces of kitc	mugs were abraded inside. 19 henware or 28% of bund to be compromised by rfaces.		On 12/08/2016, the dietary audited all kitchen pans for trapped inside and kitchen abraded interior surfaces a or corrected any items note.	moisture ware for nd discarded	
	(DM) stated dietary of kitchenware that chips, and abrasion supposed to inform kitchenware so she However, she com	08/16 the dietary manager / staff were taught to dispose t was compromised by cracks, ns. She reported her staff was n her when they disposed of e could reorder replacements. mented she tried to keep extra facility as back-up so she did		affected. On 12/22/16 replative kitchenware will be ordered continue to monitor for moi pans and abraded kitchenwidiscard or correct as needed basis. Systemic Changes	acement d. Staff will sture trapped vare and	
		replacement stock to be		An in-service will be comple	eted on	

Facility ID: 923452

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345397	B. WING _	B. WING		12/08/2016	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SHORELA	ND HLTH CARE & RETII	REME		200 FLOWER-PRIDGEN DRIVE 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 371 Continued From page 21 shipped. The DM stated utilizing kitchenware with abraded interior surfaces posed the risk that bacteria and contamination could be harbored		F 3	71 12/21/2016 by the clinical nutritic specialist (registered dietitian). who attended were dietary staff				
	and affect the health of residents eating eat out of or off of it. At 1:30 PM on 12/08/16 the PM cook stated staff gathered compromised kitchenware, informed the DM, threw the damaged kitchenware away, and the DM reordered replacements. She commented she had not noticed any abraded			employees -FT and PT. Any in-h dietary staff member who did no in-service training will not be allo work until training has been com	t receive wed to		
				Staff was in-serviced on the follotopics: Food Service Sanitation: & Sanitizing.	owing Cleaning		
	kitchenware recently.			This information has been integrethe standard orientation training required in-service refresher could all kitchen employees and will be reviewed by the Quality Assurant process to verify that the change been sustained.	and in the irses for e ce		
				Quality Assurance The dietary manager will monito issue using the Quality Assurance Monitor Tool for monitoring Clea Sanitation. This will be complete a week for 2 weeks and then months or until resolved by Qual Life/Quality Assurance Committe Reports will be given to the week of Life- Quality Assurance commonrective action initiated as app The Quality of Life/Quality Assurance Committee consists of the Admir Director of Nursing, Staff Develor Coordinator, Unit Managers, Sul Nurses, Social Workers, Dietary and Business Office Manager.	ce Dietary ning and d 5 times onthly x 3 lity of ee. kly Quality nittee and ropriate. cance nistrator, opment		
F 428 SS=D	483.45(c)(1)(3)-(5) DI REPORT IRREGULA	RUG REGIMEN REVIEW, R, ACT ON	F 4	28		1/5/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345397	B. WING			12/08/2016	
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 428	Continued From page	e 22	F 42	28			
	c) Drug Regimen Re	view					
		of each resident must be ee a month by a licensed					
	brain activities assoc and behavior. These	ug is any drug that affects iated with mental processes drugs include, but are not e following categories:					
	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.						
	to the attending phys	ctor and director of nursing,					
	drug that meets the o	de, but are not limited to, any criteria set forth in paragraph an unnecessary drug.					
	during this review museparate, written reported attending physician a director and director minimum, the resider	noted by the pharmacist ast be documented on a port that is sent to the and the facility's medical of nursing and lists, at a not's name, the relevant drug, we pharmacist identified.					
	resident's medical re- irregularity has been	ysician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345397	B. WING		12/08/2016	
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	, .2.09.20.10	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 428	Continued From page be no change in the rephysician should door the resident's medical (5) The facility must of and procedures for the review that include, but frames for the different steps the pharmacist identifies an irregular to protect the resident This REQUIREMENT by: Based on record revent Pharmacist interview recognize an attempt (GDR) of three antiperequired for 1 of 5 sand #62) reviewed for uniform from the Country of the Quarter (MDS) dated 10/19/1 was admitted to the form the required to the form and the recognize of the Quarter (MDS) dated 10/19/1 was admitted to the form the resident page 10 to 1	medication, the attending ument his or her rationale in all record. develop and maintain policies me monthly drug regimen out are not limited to, time int steps in the process and must take when he or she ity that requires urgent action it. T is not met as evidenced iew and staff and Consultant is the facility failed to at gradual dose reductions sychotic medications was impled residents (Resident inecessary medications.	F 42	DEFICIENCY)	of nd do e vill of	
	dated 10/12/15 reveal an attempted GDR of to 5 mg (milligrams) by sleep. Review of the Medica (MAR) from 11/01/15 Resident #62 was be anti-psychotic medica (milligrams) by mouth by mouth at bedtime, mouth twice each day	n every day, Zyprexa 5 mg and Geodon 60 mg by y. The MAR's also revealed nimal behaviors noted during		F 428 Corrective Action for Resident Affect For resident # 62, Kelli King, NP was contacted on 12/08/2016 and a Risk/Benefit statement was written for anti-psychotic medications Geodon a Abilify. In addition to this, a Gradual Reduction of Zyprexa was initiated of 12/08/2016 by Kelli King, NP. Zyprex dose was reduced to 2.5mg at HS.	or and Dose in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345397	B. WING _			12/08/2016	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATI	•		
				200 FLOWER-PRIDGEN DRIV	'E		
SHORELA	ND HLTH CARE & RE	TIREME		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE			
F 428	Continued From page 24		F4	28			
	Review of Resident #62's Care Plan revised on 11/23/16 revealed interventions of observation and reporting of behavioral symptoms and a pharmacy review per protocol to consider dosage reduction when clinically appropriate. Review of the monthly Consulting Pharmacist Notes dated 11/27/15 through 11/28/16 revealed no mention of conducting a GDR for Resident #62.			Corrective Action for Affected All current residents r anti-psychotic medica potential to be affected deficient practice. The consultant will complete the consultant will be consultant will b	receiving ations have the ed by the alleged e pharmacy ete a medication		
	(NP) stated she had recommendation from that a GDR attempt #62. She indicated Pharmacist to let he attempts for anti-ps In an interview on 1 stated she had bee documentation whice	2/08/16 the Nurse Practitioner d not received a com the Consultant Pharmacist was needed for Resident she relied on the Consultant er know when the GDR ychotics were required. 2/08/16 at 10:15 AM the DON in unable to find any ch showed GDR's had been lent #62's anti-psychotic		regimen review for all an anti-psychotic med of a Gradual Dose Refereview will be comple any Gradual Dose Refidentified as needed, to the Director of Nurattending physician of for a response. Systemic Changes	dication for the need eduction. This eted by 12/30/16. If eductions are it will be forwarded sing to contact the		
	medications in the I In a telephone inter the Consultant Pharmonthly medication She indicated if a G recommendation to				sychotic monitoring uded:		
	facility a GDR was a Consultant Pharma benefit statement w for another GDR. S made recommenda #62 because she di every year. In an interview on 1 stated she expected the regulations and	conly needed one time. The cist stated once a risk versus has written there was no need the indicated she had not tions for a GDR for Resident d not realize one was needed 2/08/16 at 3:48 PM the DON d GDR's to be completed per expected the Consultant of the facility and the physician		antipsychotic medica process of tapering a reduction (GDR)" and	tions identifies the as a "gradual dose d requires a GDR, raindicated.Within the esident is admitted medication or after ed an antipsychotic by must attempt a equarters (with at ween the attempts), raindicated. After the		

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		345397	B. WING _	B. WING		12/08/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD)E		
SHORELA	ND HLTH CARE & RETII	REME		200 FLOWER-PRIDGEN DRIVE			
				WHITEVILLE, NC 28472			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
F 428	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F4	annually, unless clinically confor any individual who is receantipsychotic medication to the behavioral symptoms related the GDR may be considered contraindicated if: The resident's target symptoms attempt at a GDR within the founction or increase distresses for any individual who is receantipsychotic medication to the psychiatric disorder other than symptoms related to dementive ample, schizophrenia, bipodepression with psychotic fear GDR may be considered confif: The continued use is in a with relevant current standard and the physician has documented rationale for why any attempted dosered after the resident's function or cause prinstability by exacerbating and psychiatric disorder; or The resident's target symptoms and the physician has documented attempt at a GDR within the founce or worsened after the recenting and and socumented or worsened after the recenting and and the physician has documented attempt at a GDR within the founce or worsened after the recenting and	clinically contraindicated. I who is receiving an dication to treat oms related to dementia, considered clinically is target symptoms end after the most. I within the facility; and in has documented the or why any additional eduction at that time impair the resident's se distressed behavior. If who is receiving an dication to treat a er other than behavioral if to dementia (for hrenia, bipolar mania, or sychotic features), the sidered contraindicated, and use is in accordance ent standards of practice. I documented the clinical any attempted dose to likely to impair the receiving an underlying er; or is target symptoms and after the most. I within the facility and documented the or why any additional		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345397	B. WING _			12/	08/2016
NAME OF PROVIDER OR SUPPLIER SHORELAND HLTH CARE & RETIREME				STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	,		F	428	would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical psychiatric disorder. This information has been integrated in the standard orientation training and in required in-service refresher courses for all pharmacy consultants and management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Clinical Nurse Consultant will monthis issue using the "Survey Quality Assurance Tool for Monitoring Antipsychotics. The monitoring will include auditing Antipsychotics for the need of a Gradual Dose Reduction monthly for 3 months or until resolved Ruality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee corrective action initiated as appropriat The Quality of Life Committee consists the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	or to the or itor by e and ee. of	