PRINTED: 05/01/2017 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		345415	B. WING _		0:	C 3/01/2017		
	NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP COD 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		70172011		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS	3	F 0	00				
	from 02/27/17 throug Jeopardy was identif CFR 483.10 and 483 and severity of J CFR 483.20 at tag Fi of J CFR 483.25 at tag Fi of J	3.12 at tag F221 at a scope 278 at a scope and severity 323 at a scope and severity						
F 221 SS=J	Quality of Care.  Immediate Jeopardy is ongoing. A partial conducted.	began on 02/16/2017 and it extended survey was  (a)(2) RIGHT TO BE FREE ESTRAINTS	F 2	21				
	and dignity, including §483.10(e)(1) The rig physical or chemical purposes of discipling required to treat the consistent with §483.12(a)(2).  42 CFR §483.12, 483 The resident has the neglect, misappropria and exploitation as discontinuous control of the resident has the neglect, misappropria and exploitation as discontinuous control of the resident has the neglect, misappropria and exploitation as discontinuous control of the resident has the neglect, misappropria and exploitation as discontinuous control of the resident has the neglect, misappropria and exploitation as discontinuous control of the resident has the neglect of the	ght to be treated with respect g: ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms,  3.12(a)(2) right to be free from abuse, ation of resident property, efined in this subpart. This						
ADODATORY	corporal punishment	nited to freedom from , involuntary seclusion and		TITLE		(X6) DATE		

Electronically Signed 03/06/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345415	B. WING _			C 03/01/2017		
	ROVIDER OR SUPPLIER  E REHABILITATION ANI	D LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	<u>'</u>	55/61/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 221	Continued From pag	e 1	F 2	221				
	any physical or chen treat the resident's s	nical restraint not required to ymptoms.						
	(a) The facility must-							
	or chemical restraint discipline or conveni required to treat the symptoms. When the indicated, the facility alternative for the lead ocument ongoing restraints.  This REQUIREMENT by:  Based on observations staff interviews and restraint and without Transfer Handle entrested the resident was four	e use of restraints is must use the least restrictive ast amount of time and e-evaluation of the need for  T is not met as evidenced ons, medical doctor interview, ecord reviews the facility out considering it to be a a medical symptom. The capped the resident and when and, he was dead. This was esident with a Transfer						
	Resident #1 was fou the fall mat beside the	began on 02/16/17 when nd lying on his left side on le low bed with his head hisfer Handle. When found by was dead.						
	The immediate jeopa	ardy is present and on-going.						
	The Findings include	d:						
	12/03/04 and expired	ally admitted to the facility on d in the facility on 02/16/17. uses included blindness, dent, right sided						

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	ROVIDER OR SUPPLIER  E REHABILITATION AND	LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP COI 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	DE			
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F 221	history of convulsions depressive disorder.  Review of Resident # comprehensive minir 10/30/16 revealed the short term memory p impaired for daily decivere identified on the revealed that Reside assistance of 1 staff required extensive as for transfers. The MD was 72 inches tall an falls were identified s MDS also revealed thospice services and restraint was used with bed.  A fall care plan updata resident was to have positioning and fall m while in bed to avoid Review of the cumula 02/01/17 through 02/11/22/16 a physician' positioning bars on the facility was unaborder. Further review revealed no diagnosi	sis, vascular dementia, s, heart failure, and major  #1's most recent mum data set (MDS) dated at Resident #1 had long and roblems and was moderately cision making. No behaviors at MDS. The MDS further mt #1 required extensive member for bed mobility and assistance of 2 staff members as stated that Resident #1 d weighed 198 pounds. No ince the prior MDS. The mat Resident #1 received at indicated no physical hile Resident #1 was in the led on 11/16/16 specified the positioning bars for lasts on both sides of the bed injury from a fall.	F 2					
	side rail assessment decision tree.  Review of a nurse's r	or a restraint enabler  note dated 02/16/17 at 11:32						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page		F	221			
	breathing at 5:15 PM #1 was lying on his le place, bed was in low was elevated betwee Hospice nurse was n and physician was no by Nurse #1.	Skin color pale, Resident of side. Floor mats were in position and head of bed in 45 and 90 degrees. Otified. Family was notified otified." The note was signed					
	on 02/28/17 at 10:00 bed revealed a bed the inches long and control each side of the bed. approximately 18 inches making the bottom of transfer handles. The inches by 4 inches we rail and was perpendicated at a flat mattress. The	AM made of Resident #1's nat was approximately 80 ained a Transfer Handle on The transfer handle was nes from the top of the bed a pillow in line with the transfer handle was a 24 ide by 24 inches tall metal icular to the bed. When bar created 90 degree angle e transfer handle was a and pillow in the bed was a 24 inches tall metal icular to the bed. When bar created 90 degree angle e transfer handle was ame per the manufacture					
	(ADON) on 02/27/17 on 02/16/17 the Direct been on vacation and evening finishing up office. The ADON statement and was walking she noted Nursing Asher to Resident #1's uput the chart down arroom. The ADON statement was a hour Resident #1 was a hour Resuscitate order	sistant Director of Nursing at 11:50 AM revealed that ctor of Nursing (DON) had a she was working late that some paper work in the ted she had gone to get a g down the hallway when esistant (NA) #2 summoning from. The ADON stated she had ran to Resident #1's ted that when she entered lurse #1 informed her ospice patient and had a Do in place and he had stated when she entered					

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NAME OF P	ROVIDER OR SUPPLIER	040410	1	STREET ADDRESS, CITY, STA	•	03/01/2017	
				1010 LAKEVIEW DRIVE	,		
PINEVILLI	E REHABILITATION AI	ND LIVING CTR		PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 221	the floor with his he and his chin "touch ADON described the "little yellow." The Astaff to lower Resid then assist the bod stated she was una had been going on knew she was then an office with the do obtain a chart ar summoned her so swhat happened but the way Resident #  Interview with the Astagonal Proximately 5:30 the ADON and was had expired. The irrithat the staff stated caught in the side of the ADON that she the facility. The Adrot of the facility aroun started interviewing stated that she were observed that Resine had assist bars were a restraint. The Adrobserved Resident bruising or discolor red bumps on his manual process.	ashe saw Resident #1 lying on ead resting on the mattress ing" the transfer handle. The ne color of Resident #1 as a ADON stated she directed the lent #1's head to the floor and y back into bed. The ADON aware of how long the incident and she did not think staff to because she was working in cor closed and had come out and the staff saw her and she just was really not clear on the she had some "concerns with the that on 02/16/17 at 1 and that on 02/16/17 at 1 and that on 02/16/17 at 1 and that Resident #1 and call from the ADON was 1 Resident #1's head was a rail, so the Administrator told would be on her way back to ministrator stated she returned don't staff. The Administrator and dent #1 did not have side rails that were 4 inches wide and the not considered a side rail or ministrator stated that she #1's body and did not see any ation, she stated he did have neek but that he had been to do the staff that were ed ay but nothing that had	F	221			
	observed Resident bruising or discolor red bumps on his n shaved earlier in th indicated he had go administrator stated	#1's body and did not see any ation, she stated he did have eck but that he had been					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	1 00/01/2017	
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F 221	the desk and used of happened. The staff was sitting on the faleaning on the mattress and his touching the assist she asked the staff stated he was white bluish color to him. that time she had no bars had anything to line with the mattress and anything to line with the mattress and anything to line with the mattress and anything to line with the line with line wit	further and brought the staff to charts to simulate what if told her that Resident #1 all mat with his shoulders ress, his head was lying on so forehead and chin were bar. The administrator stated what he looked like and they is as a ghost but did not see The administrator stated at o reason to believe the assist	F 22:			

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F 221	that when she enter could tell "he was de he was limp, and his NA #2 stated that Reposition and the head between 45 and 90 chin was "hooked" of his neck between the NA #2 stated that Reparallel to the bed e "hooked" on the transfer has chin (pointed to that they had to low remove Resident #1 #2 stated that after from the transfer has neck under his owhere has neck un	ent #1's room. NA #2 stated ed Resident #2's rooms she ead, there was no movement, is face was completely white." esident #1's bed was in low and of the bed was elevated degrees and Resident #1's ion the transfers handle with the mattress and the handle. esident #1's body was lying except his head which was ensfer handle. NA #2 stated the the transfer handle with the larynx area) and stated the larynx area) and stated the transfer handle. NA they removed Resident #1 endle there was a red area on hin (pointed to larynx area)	F 2	21			

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F 221	NA #1 came running hollering for help. No jumped up and ran #1 stated she walked and Resident #1 was the bed with his chin handles and his necession and the mattress. No summoned for the Noshe had no idea who she did confirm that no respiration and horder in place. The Resident #1 back in mortem care. Nurse to lower the head of #1 from the transfer had notified the host the physician that Revealed that she read on 02/16/17 at had provided incont #3 stated that when lying on his side on she had to reposition bed and after provided and after provided and ensured the bethe room. NA #3 stated the left side of his bot times during her shireposition Resident but he would always NA #2 stated that latte transfer handle.	ge 7 e #1 stated that immediately g back to the dining room urse #1 stated that all the staff to Resident #1's room. Nurse ed around the side of the bed as lying on the floor parallel to in firmly between the transfer eck between the transfer handle lurse #1 stated that she had NA to get some help because at to do. Nurse #1 stated that excessident #1 had expired with had a Do Not Resuscitate ADON advised them to place the bed and perform post e #1 also stated that they had f the bed to remove Resident handle. Nurse #1 stated she epice provider, the family, and desident #1 had expired.  3 on 02/27/17 at 4:39 PM entinely cared for Resident #1 approximately 3:45 PM she inent care to Resident #1. NA a she entered his room he was the left side of the bed and an him near the middle of the ding care and repositioning d raised the head of his bed d was in low position and left ated that Resident #1 favored ed and generally about 3 ff she would have to go in and #1 near the middle of the bed as scoot back to the left side. tely he would rest his head on that was attached to his bed e throw his legs off the side of	F 22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345415	B. WING				C /01/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2017	
				1	010 LAKEVIEW DRIVE			
PINEVILLI	E REHABILITATION A	ND LIVING CTR		P	INEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 221	Continued From pa	~	F	221				
		ted that on 02/16/17 at						
		5 PM the staff was in the dining						
		ad taken Resident #1's tray to						
		nim with the meal. NA #3						
		ately NA #1 came running back						
		and stated "Resident #1 is jumped up and ran to his						
	•	d that when she entered his						
		Resident #1 was dead, she						
		pale and white in color. NA #3						
		's body was lying on the floor						
		his chin was between the						
		ith his neck between the						
		ttress. NA #3 stated that there						
		re the bar had been on						
		under his chin (pointed to						
		ey had to lower the head of the						
		sident #1 from the transfer						
	handle. NA #3 state	ed that his bed was in the low						
		ead of the bed was just as she						
	had left it earlier af	ter rendering care. NA #3						
	stated that after the	ey removed Resident #1 from						
	the transfers handl	e they assisted the body back						
	into bed and post r	nortem care was provided.						
		Director of Maintenance on						
		AM revealed that on 01/04/17						
		new bed for the facility. On						
		ed arrived to the facility and on						
		' he assembled the new bed						
		Transfer handles. The Director						
		ated that the new bed had						
		handles and he attached						
		r the manufacturer instructions						
		was assembled the bed was						
	' '	room until someone needed						
		tor of Maintenance stated that						
	· ·	dent #1 needed a new bed and						
	someone had grab	bed the bed with the Transfer						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
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F 221	Continued From pag	e 9	F 2	221		
	Director of Maintena involvement in assig with the Transfer Ha Maintenance stated were just switched a was anything wrong Interview with the ho	spice nurse on 02/28/17 at				
	Resident #1 but had a bed to Resident #* that the facility would	hat she routinely visited no involvement in assigning I. The hospice nurse stated If handle any type of bed or ded for the resident. The				
	Resident #1 was usu left side with his hea of the transfer handl that she would move the bed but Residen left side of the bed.	I that when she would visit, ually found him lying on his d resting on the top upper rail e. The hospice nurse stated him closer to the middle of t #1 would wiggle back to the The hospice nurse stated she he Resident #1's preferred				
	position of resting hi and if she would hav would have immedia The hospice nurse s seemed to be comfo preferred the left sid	s head on the transfer handle re had any concerns she tely notified the facility staff. tated that Resident #1 also rtable and obviously e of bed. The hospice nurse d with Resident #1 on				
	02/28/17 at 11:22 Al out of work for medic returned to work at t central Supply clerk 12/08/16 Resident # on his bed and wher	entral Supply Clerk on M revealed that he had been cal reason from 12/08/16 and he facility on 01/19/2017. The stated that when he left on 1 had a different type of rail he returned to work at the hed the Transfer handles				

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F 221	Continued From page	ge 10	F 22	1		
	Resident #1 was a '	ntral Supply clerk stated that fidgety person in bed and round to the left side of the				
	02/28/17 at 12:04 P vacation when Resi participate in any ty with his death or the found. The DON sta "busy body" in the bother devices that the DON stated that at able to pull a device device that secured stated that they had of beds to find what #1 "but we felt like the attached to the bed for him." The DON sesident #1 got the	tor of Nursing (DON) on M revealed that she was on dent #1 expired and did not be of investigation associated a manner in which he was atted that Resident #1 was a ed and would pull on the hey had in place for him. The one point Resident #1 was called a "Halo" out of the them to the bed. The DON tried several different types would work best for Resident he Transfers Handle that frame was sturdier and better stated that she believed that Transfer Handle a couple of ld not recall for sure.				
	revealed that she ro and on 02/16/17 at was in the dining ro she had taken Resic his room to assist h stated that when sh Resident #1's legs v stated when she go Resident #1 with his handles and his neo mattress and it was chin/neck (pointed t ran for help but I kn	I on 02/28/17 at 3:39 PM putinely cared for Resident #1 approximately 5:10 PM she can and when the trays arrived dent #1's tray down the hall to m with the meal. NA #1 are entered the room she saw evere outside of the bed. NA #1 at to the bedside she saw as chin between the transfer esk between the handle and the purple in the area of his to larynx area). NA #1 stated "I sew that he was already dead, noises, he was limp and very				

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F 221	that "the rail is chok asked to describe the rail was in his neck rail, and he could not stated that the head we had to lay the him from the transfer when we removed handle there was because the transfer of that they were instructed that they were instructed the floor and then because the floor and then because the transfer of the t	she ran and told Nurse #1 king him come now." When he choking NA #1 replied "the his neck was trapped in the ot get out of the rail." NA #1 d of the bed was elevated and lead of his bed flat to remove ler handle. NA #1 stated that Resident #1 from the transfer lueish/purplish bruise still le area (points to larynx area) handle had been. NA #1 stated lucted to lower Resident #1 to lack to bed and perform post  O PM in a follow up interview for she stated that the assist ide and physically impossible luck and the facility did not ler handle a restraint or a side luctor stated she had not he as Resident #1's body was lacility at the time, however she late the scene. The lo provide the written lading the circumstances of the  the Medical Director (MD) on M revealed that he did not der for Resident #1 to have to landles but could not deny it. he did not assess the need the facility would handle that ley needed anything from him to his knowledge and le stated he did not assess of transfer handle or other	F 22			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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		345415	B. WING			03/	01/2017
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F 221		s notified of the immediate	F	221			
F 278 SS=J	jeopardy on 02/28/17 483.20(g)-(j) ASSESS ACCURACY/COORD	SMENT	F	278			
		esments. The assessment ct the resident's status.					
	(h) Coordination A registered nurse muleach assessment with participation of health						
	(i) Certification (1) A registered nurse the assessment is co	e must sign and certify that mpleted.					
		no completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsific (1) Under Medicare a who willfully and know	nd Medicaid, an individual					
	. ,	and false statement in a is subject to a civil money nan \$1,000 for each					
	and false statement in	dividual to certify a material n a resident assessment is ey penalty or not more than ssment.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345415	B. WING	_		03/	01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AND	LIVING CTR		1	TREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	material and false state This REQUIREMENT by: Based on observation interviews, the facility the quarterly minimum reflect the use of a phaservice for 1 of 3 resident #1's chin was two bars of a Transfet to his bedframe and had the Transfer Handle at resident was found, humediate Jeopardy nursing home failed to use of a device that material and had the resident. On 2/16/17 lying on the left side of beside the low bed worth Transfer Handle. When the staff, the resident 1.a.  The immediate jeopa The findings included 1a. Resident #1 was facility on 12/03/04. For included vascular der A fall care plan updat resident was to have	nent does not constitute a stement.  Tis not met as evidenced  In, record review and staff of ailed to accurately code in data set assessment to assessment to assessment and hospice dent reviewed (Resident #1). The assessment to assess restrained between the resident was attached his neck was stuck between and the mattress. When the rewas deceased.  The definition of a seffect of restraining the passess Resident #1 for the first his body on a fall mat was found of his body on a fall mat was dead. See findings in the resident was found by was dead. See findings in the death of the sesident #1's diagnoses mentia and heart failure.  The death of the bed in the bed in the death of the sesident #1's diagnoses mentia and heart failure.	F	278			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345415	B. WING				01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AN	D LIVING CTR	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 010 LAKEVIEW DRIVE PINEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	02/01/17 through 02 11/22/16 a physician "positioning bars on assistance with posi Further review of the diagnosis or medica Transfer Handle and assessment or a res In an interview with 10 03/01/17 at 4:08 PM not recall writing the have to have the Tra deny it. The MD state need for devices like handle that assessm needed anything fro his knowledge and r did not assess Resid Handle or other devi Observations on 02/ on 02/28/17 at 10:00 bed revealed a bed inches long and con each side of the bed approximately 18 ind making the bottom of Transfer Handles. T metal rail that measu inches tall and was p When the Transfer F bedframe, the vertic angle to a flat mattre was attached to the manufacturer's instru removed.	ative physician orders for /28/17 revealed that on 1's order was written for both sides of bed for tioning and trunk control." medical record revealed no 1 symptom for use of the 1 did not reveal a side rail traint enabler decision tree. The Medical Director (MD) on the MD revealed that he did order for Resident #1 to ansfer Handles but could not led that he did not assess the ethat. The facility would ment and notify him if they ment and notify	F	278			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		X3) DATE SURVEY COMPLETED
		345415	B. WING _			C <b>03/01/2017</b>
	ROVIDER OR SUPPLIER  E REHABILITATION AND	D LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP OF 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	CODE	000000000000000000000000000000000000000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 278	02/28/17 at 11:22 AN out of work from 12/0 on 01/19/2017. The of that when he left on different type of rail or returned to work at the the Transfer Handles. Review of Resident minimum data set (Morevealed that Reside term memory problet impaired for daily derevealed that Reside assistance of one per required extensive as members for Transfet that Resident #1 had assessment, indicate (defined as any man mechanical device, rattached or adjacent the individual cannot restricts freedom of r	A revealed that he had been 08/16 and returned to work Central Supply Clerk stated 12/08/16 Resident #1 had a on his bed and when he he facility on 01/19/17 he had son his bed.  #1's most recent quarterly IDS) dated 01/30/17 nt #1 had long and short ms and was moderately cision making. The MDS also nt #1 required extensive rson for bed mobility and esistance of two staff or. The MDS further revealed in no falls since the prior ed no physical restraint ual method or physical or material or equipment to the resident's body that remove easily which movement or normal access	F2	278		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		345415	B. WING _			C 03/01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AN	D LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	<u> </u>	00/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	the side of the bed at the floor parallel to the the floor parallel to the tween the Transfer neck was between the mattress. Nurse #1 Resident #1 had exphad a Do Not Resus #1 also stated that the bed to remove Flandle.  Interview with the Di 02/28/17 at 12:04 Pl was a "busy body" in the other devices that The DON stated that was able to pull a de Ring" out of the post The DON stated that different types of bebest for Resident #1 Handle that attached sturdier and better for she believed that Reflandle a couple of ristated that residents assessed using the in the electronic med were assessed using decision tree also lo The DON stated that Transfer Handle a reflandle a reflandle a reflandle and the sturdier and better for stated that residents assessed using the in the electronic med were assessed using the in the Alpha that attached assessed using the interest and better for stated that residents assessed using the interest also lo The DON stated that Transfer Handle a reflandle a reflandle and the pool of the po	1 stated she walked around and Resident #1 was laying on the bed with his chin firmly ar Handle vertical rails and his the Transfer Handle and the stated that she confirmed bired with no respiration and acitate order in place. Nurse they had to lower the head of desident #1 from the Transfer director of Nursing (DON) on M stated that Resident #1 on the bed and would pull on the bed and would pull on the tat one point Resident #1 evice called a "Halo Safety that secured it to the bed. It they had tried several do to find what would work "but we felt like the Transfer do to the bed frame was or him." The DON stated that tesident #1 got the Transfer months ago. The DON also	F 2	78		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345415	B. WING			C 03/01/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		310112017	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 278	with side rails were a side rail assessment electronic medical rewere assessed using decision tree. The Adalways try to use the possible and they be was appropriate for Administrator stated Resident #1 was use. The Administrator stated Resident #1 was use. The Administrator wajeopardy on 03/06/17.  1.b. Review of a doc Palliative care Certific Statement" that was read in part, "I have beneficiary's clinical that the beneficiary is expectancy of six more illness runs its normal was signed by the hound of 1/04/17. The certific 04/17/17.  Review of Resident aminimum data set (Norevealed that Reside term memory probletimpaired for daily derevealed that Reside services, but did not had a life expectancy (section J1400 of the Interview with the MI	or stated that all residents assessed for safety using the document located in the cord and that other devices in the restraint enabler diministrator stated that they least restrictive device dieved the Transfer Handle Resident #1. The that the Transfer Handle for ed for positioning.  The seast notified of immediate at 11:39 AM.  The seast notified of immediate at 12:39 AM.  The seast no	F 2	78			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25.	_			
		345415	B. WING _			03/	01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AND	LIVING CTR		10	TREET ADDRESS, CITY, STATE, ZIP CODE 010 LAKEVIEW DRIVE INEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=J	was receiving hospice assessment period. They never checked the months to live (section the physician wrote a 6 months or less to live that it was very rare for MDS in section J, become frame how long some line a follow up interview the MDS nurse confine have reflected that Reservectancy of less that the MDS to be completed that MDS to be completed that Section 3/01/17 at 4:31 PM in the MDS to be completed that Section 1. The MDS to be completed that Section 1. The facility must ensure confine that the modern section 1. The facility must ensure correct in the modern section 1. The facility	dated 01/30/17 and that he care during the che MDS nurse stated that he prognosis of less than 6 in J1400) on the MDS unless note stating that they have be. The MDS nurse stated for them to check that on the cause "doctors do not time one has to live."  We on 03/01/17 at 11:28 AM, med the assessment should esident #1 had a life an 6 months to live.  The of Nursing (DON) on revealed that she expected eted accurately to reflect the estated accurately to reflect the estate as is possible; and estate and estate accurate supervision estate to prevent accidents.  The comment remains as free estate acquate supervision estate to prevent accidents.  The comment remains as free estate acquate supervision estate to prevent accidents.  The comment remains as free estate acquate supervision estate province to installing a side or ide rail is used, the facility installation, use, and alls, including but not limited		323			

PRINTED: 05/01/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.5445	D WING				
		345415	B. WING			03/	01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AND	LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 19	F	323	3		
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with not representative and obtain or to installation.					
	This REQUIREMENT by: Based on observatio record reviews the fact Transfer Handle as an residents (Resident #	sident's size and weight.  is not met as evidenced  ns, staff interviews, and cility failed to identify a n accident hazard for 1 of 1 1) that resulted in a resident in a Transfer Handle and					
	Resident #1 become Handle that was attac Resident #1 was four side on the fall mat be head entrapped in the	began on 02/16/17 when entrapped in the Transfer ched to his bed. When and he was lying on his left eside the low bed with his e transfer bar and was dead.					
	The Findings included	d:					
	December 2007 read deaths/injuries from the equipment (including headboard, footboard facility shall promote identify additional safewho have been identify	cy titled "Bed Safety" revised in part, To try to prevent he beds and related frame, mattress, side rails, l, and bed accessories), the the following approaches: ety measure for residents fied as having a higher than cluding entrapment (e.g.,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345415	B. WING		C 03/01/2017
	ROVIDER OR SUPPLIER  E REHABILITATION AN	ND LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	1 00/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 323	Resident #1 was in 12/03/04 and expire Resident #1's diagr cerebrovascular achemiplegia/hemipal history of convulsio depressive disorder Review of Resident comprehensive min 10/30/16 revealed the short term memory impaired for daily divere identified on the revealed that Residuassistance of 1 staff required extensive for transfers. The MResident #1 was 72 pounds. No falls we MDS. The MDS also received hospice see physical restraint where was in the bed.  A fall care plan upd resident was to have positioning and fall while in bed to avoid Review of the cumu 02/01/17 through 0.011/22/16 a physicia "positioning bars or assistance with positioning bars or assistance with positioning with positioning bars or assistance with positioning bars or a	itially admitted to the facility on ed in the facility on 02/16/17. hoses included blindness, cident, right sided resis, vascular dementia, ns, heart failure, and major r.  #1's most recent himum data set (MDS) dated that Resident #1 had long and problems and was moderately ecision making. No behaviors the MDS. The MDS further lent #1 required extensive ff member for bed mobility and assistance of 2 staff members IDS stated that the prior or revealed that Resident #1 ervices and indicated no as used while Resident #1 atted on 11/16/16 specified the re positioning bars for mats on both sides of the bed	F 32		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE S	ETED
		345415	B. WING		03/0	, )1/2017
	ROVIDER OR SUPPLIER	ND LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	1 03/0	7172017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 21	F 32	23		
	PM read, "Residen breathing at 5:15 P #1 was lying on his place, bed was in le was elevated betwee Hospice nurse was and physician was by Nurse #1.  Observations on 02 on 02/28/17 at 10:0 bed revealed a bed inches long and co each side of the bed approximately 18 ir making the bottom transfer handles. Tinches by 4 inches rail and was perper attached the verticat to a flat mattress.	s note dated 02/16/17 at 11:32 t #1 was observed not M. Skin color pale, Resident left side. Floor mats were in ow position and head of bed een 45 and 90 degrees. notified. Family was notified notified." The note was signed  2/27/17 at 10:00 AM and again 00 AM made of Resident #1's I that was approximately 80 ntained a Transfer Handle on d. The transfer handle was nches from the top of the bed of a pillow in line with the the transfer handle was a 24 wide by 24 inches tall metal ndicular to the bed. When al bar created 90 degree angle The transfer handle was I frame per the manufacture				
	02/27/17 at 3:05 PI took care of Reside often slid to the left have to straighten I Resident #1 was a from the middle of bed. NA #2 also sta had swallowing issue keep the head of hi that on 02/16/17 at PM they were in the	ing Assistant (NA) #2 on M revealed that she routinely ent #1 and Resident #1 quite side of the bed and she would nim back up. NA #2 stated that "busy body" and would scoot the bed to that left side of the ated that because Resident #1 ues they had been advised to as bed elevated. NA #2 stated approximately 5:15 PM-5:30 e dining room and NA #1 had as tray to his room to assist him				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		345415	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.01.0		STREET ADDRESS, CITY, STATE, ZIP COD		3/01/2017	
				1010 LAKEVIEW DRIVE	_		
PINEVILLI	E REHABILITATION AND	LIVING CTR		PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page with the meal. NA #2	e 22 stated that immediately NA	F 3	323			
	stated "he is choking.	k into the dining room and " NA #2 stated that all the ran to Resident #1's room.					
	NA #2 stated that who	en she entered Resident I tell "he was dead, there					
	completely white." NA	e was limp, and his face was A #2 stated that Resident position and the head of the					
	bed was elevated bet	tween 45 and 90 degrees in was "hooked" on the					
	mattress and the han	his neck between the idle. NA #2 stated that					
	except his head whic	vas lying parallel to the bed h was "hooked" on the					
	against Resident #1's	2 stated the bar was tight s neck under his chin area) and stated that they					
	had to lower the head	d of the bed to remove transfer handle. NA #2					
	stated that after they	removed Resident #1 from					
	neck under his chin ( where the transfer ha	pointed to larynx area) ındle had been.					
		#1 on 02/27/17 at 3:24 PM s the nurse taking care of					
	Resident #1 on 02/16 arrived for her shift at	6/17. Nurse #1 stated she t 3:00 PM and got report and on cart and then walked					
	#1 stated that at that	check on her patients. Nurse time Resident #1 was in his nd the head of the bed was					
	elevated and was his	"normal self." Nurse #1 up the hall after ending her					
	medication pass at a looked in on Residen	round 4:30 PM and again t #1 and he was he was					
		#1 stated that after she ation pass she had gone					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		C 03/01/2017	
	ROVIDER OR SUPPLIER  E REHABILITATION AN	ID LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	03/01/2017	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 323	she could assist res #1 stated that at ap took Resident #1's to with the meal. Nurse NA #1 came running hollering for help. N jumped up and ran #1 stated she walke and Resident #1 wa the bed with his chin handles and his ned and the mattress. N summoned the ADO what to do. Nurse # that Resident #1 ha and had a Do Not R ADON advised ther the bed and perforn also stated that they bed to remove Resi handle. Nurse #1 st hospice provider, th that Resident #1 ha  Interview with NA # revealed that she re and on 02/16/17 at had provided incont #3 stated that when lying on his side on she had to reposition	to wait for the dinner trays so sidents with the meal. Nurse proximately 5:15 PM NA #1 tray to his room to assist him to his room to assist him to e #1 stated that immediately go back to the dining room the urse #1 stated that all the staff to Resident #1's room. Nurse and around the side of the bed as laying on the floor parallel to the firmly between the transfer the between the transfer handle have #1 stated that she had to be because she had no idea that stated that she did confirmed to the providence of the bed in to place Resident #1 back in the post mortem care. Nurse #1 of had to lower the head of the dent #1 from the transfer ated she had notified the to e family, and the physician did expired.  3 on 02/27/17 at 4:39 PM poutinely cared for Resident #1 approximately 3:45 PM she intent care to Resident #1. NA is she entered his room he was the left side of the bed and in him near the middle of the	F 323	,		
	bed and after provice Resident #1 she hat and ensured the betthe room. NA #3 statche left side of his bettimes during her shi	ding care and repositioning d raised the head of his bed d was in low position and left ated that Resident #1 favored ed and generally about 3 ft she would have to go in and #1 near the middle of the bed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245445	D WING			С	
		345415	B. WING _			03/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEVILLI	E REHABILITATION ANI	D LIVING CTR		1010 LAKEVIEW DRIVE			
				PINEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 323	Continued From page but he would always stated that lately he transfer handle that would often time through bed. NA #3 stated the approximately 5:15 Froom and NA #1 had his room to assist his stated that immediat to the dining room and choking", so we all juroom. NA #3 stated to room she could tell Froom she fall mat and hot transfer handles with handle and the matter was a red line where Resident #1's neck to larynx area) and the bed to remove Resident #3 stated position and the hea had left it earlier after Interview with the Di 02/28/17 at 10:00 All he had ordered a ne 01/11/17 the new be or around 01/16/17 from which included the Troom Maintenance stated come with Transfer Froom she would she with Transfer Froom she with Transfer Froom she with Transfer Froom she would she with Transfer Froom she with Transfer Froom she would she Transfer Froom she would she with Transfer Froom she would she would she with Transfer Froom she with Transfer Froom she with Transfer Froom she would she with Transfer Froom she with Transfer	scoot to the left side. NA #2 would rest his head on the was attached to his bed and ow his legs off the side of the at on 02/16/17 at  The Month the staff was in the dining I taken Resident #1's tray to m with the meal. NA #3 ely NA #1 came running back and stated "Resident #1 is umped up and ran to his that when she entered his Resident #1 was dead, she hale and white in color. NA #3 body was lying on the floor is chin was between the make his neck between the make his neck between the make the bar had been on under his chin (pointed to make his hed was in the low dof the bed was just as she month trendering care.  The color of Maintenance on Month the revealed that on 01/04/17 with bed for the facility. On do arrived to the facility and on the assembled the new bed fransfer handle. The Director and that the new bed had mandles and he attached					
	and once the bed wa placed in an empty r the bed. The Directo	the manufacturer instructions as assembled the bed was oom until someone needed r of Maintenance stated that ent #1 needed a new bed and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 323	handles on it and a Director of Mainteninvolvement in assiwith the Transfer Hamaintenance stated were just switched was anything wrong.  Interview with the halicon American anything wrong.  Interview and the top us handle. The hospic move him closer to Resident #1 would the bed. The hospic concerns with Resident #1 would the bed. The hospic concerns with Resident and ob of bed. The hospic with Resident #1 or usual self.  Interview with NA #revealed that she roand on 02/16/17 at was in the dining roshe had taken Resident #1's legs with the sident #1's legs	ped the bed with the Transfer assigned it to Resident #1. The ance stated he had no gning Resident #1 to the bed andles. The Director of I to his knowledge the beds and was not sure that there	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		C 03/01/2017
NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	1 03/01/2017
(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 CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRINCE OF	JLD BE COMPLETION
F 323	handle and his neck to mattress and it was punder his chin (pointed stated "I ran for help la laready dead, he was limp and very pale." In told Nurse #1 that "th now." When asked to replied "the rail was in trapped in the rail, an rail." NA #1 stated that elevated and we had flat to remove him fro #1 stated that when we transfer handle there still present in the sar area) where the transfer handle there still present in the sar area) where the transfer handle there still present in the sar area) where the transfer handle there still present in the sar area still present in the fact used charts to simula Administrator failed to	chin between the transfer between the handle and the urple in the area of his neck and to larynx area). NA #1 but I knew that he was making no noises, he was NA #1 stated she ran and the rail is choking him come describe the choking NA #1 in his neck, his neck was and he could not get out of the latter the head of the bed was to lay the head of his bed in the transfer handle. Na we removed him from the was blueish/purplish bruise the area (points to larynx fer handle had been.  PM In an interview with the sted that the assist rail was 4 sically impossible to get your inistrator stated she had not as Resident #1's body was the tet the scene. The	F 32	23	
F 514 SS=D	Jeopardy on 02/28/17 483.70(i)(1)(5) RES	s notified of Immediate 7 at 4:20 PM. TE/ACCURATE/ACCESSIB	F 51	4	
	(i) Medical records. (1) In accordance with	n accepted professional			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345415	B. WING _		03	C 5/01/2017	
NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP C 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 514	maintain medical mare- (i) Complete; (ii) Accurately document of the complete of the comprehent of the	ctices, the facility must ecords on each resident that cumented; sible; and organized cord must containation to identify the resident; resident's assessments; resident's asse	F	514			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		C 03/01/2017	
NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	1 03/01/2017	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 514	PM read, "Resident at 5:15 PM. Skin colying on his left side bed in low position between 45 and 90 notified. Resident faphysician was notifical record about the revealed that she was revealed that she was revealed that at ap 02/16/17 she was soom because he was room	a note dated 02/16/17 at 11:12 I was observed not breathing flor was pale, resident was E. Floor mats were in place, and head of bed elevated degrees. Hospice nurse amily notified and the ed." Signed by Nurse #1. ional documentation in the jut this event.  E #1 on 02/27/17 at 3:24 PM has the nurse taking care of 16/17 and that she wrote the 102/16/17 at 11:12 PM. Nurse proximately 5:15 PM on jummoned to Resident #1's has reportedly choking. Nurse and around the side of the bed has lying on the floor parallel to in firmly between the transfer has between the transfer handle flurse #1 stated that she had hursing Assistant (NA) to get has had no idea what to do. It she did confirm that pired with no respirations and scitate order in place. Nurse was told by the Assistant (ADON) to only document that has become the transfer that has become the transfer of has been and to not has found or any details of the had, "I documented what she	F 51	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345415	B. WING			C
NAME OF PROVIDER OR SUPPLIER  PINEVILLE REHABILITATION AND LIVING CTR			B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  1010 LAKEVIEW DRIVE  PINEVILLE, NC 28134	<u> </u>	03/01/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	#1 that Resident #1 v Do Not Resuscitate of expired. The ADON s "concerns" with the w positioned and she re Administrator. The A recall instructing the s Interview with the Adi 12:13 PM revealed the the staff had notified that they were being and what not to chart that the individual wh employee what to do action and was instru	vas a hospice patient with a order in place and he had stated she had some vay Resident #1 was eached out to the ADON stated she did not staff what to document.  ministrator on 02/27/17 at mat during the investigation the Director of Operations instructed as to what to chart and the Director of Operations instructed as to what to chart and allegedly instructed the cument was given corrective cted that she could not do see was free to document	F 5	14		