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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						R-C
		345415	B. WING _			03/14/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DINEVILLE	E REHABILITATION AND	LIVING CTP		1010 LAKEVIEW DRIVE		
PINEVILLE	E REHABILITATION AND	LIVING CTR		PINEVILLE, NC 28134		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION DATE
TAG	REGULATORTORT	100 IDENTIFICATION ON O	IAG	DEFICIENCY)	THOTRIATE	
{F 000}	INITIAL COMMENTS		{F 00	00}		
	A complaint investiga	tion ourses was conducted				
		ation survey was conducted				
	Jeopardy was identifi	n 03/01/17. Immediate				
	Jeopardy was identified	cu at.				
	CFR 483.10 and 483.12 at tag F221 at a scope and severity of J					
	_	78 at a scope and severity				
	of J	To at a scope and seventy				
		323 at a scope and severity				
	of J	,				
	The tags F221 and F323 constituted Substandard Quality of Care.					
	Quality of Care.					
	Immediate Jeopardy	began on 02/16/2017 and it				
	is ongoing. A partial e					
	conducted					
	The facility provided t	he State Agency and the				
		and Medicaid with an				
	acceptable allegation	of compliance on 03/10/17.				
	A					
		conducted on 03/14/17 for				
	verification of the faci	, ,				
	ongoing Immediate J	termine the status of the				
	• •	ed on 03/14/17 at 12:50 PM.				
		on 03/14/17, the facility				
		pliance at F 221, F 278, F				
	-	ver scope and severity of				
		I harm with potential for				
		arm that is not immediate				
		cility continues the process				
	of monitoring the imp	·				
	correction actions.					
{F 221}	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE	{F 22	21}		3/21/17
SS=D	EDOM BUNGLOM BE					
ADODATODY	DIRECTOR'S OR BROVINER'S	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u> </u> =	TITLE		(X6) DATE

03/16/2017 **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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED		
		345415	B. WING			R-C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	E	03/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
{F 221}	Continued From page	e 1	{F 22	21}			
	§483.10(e) Respect a	and Dignity.					
	and dignity, including §483.10(e)(1) The rig physical or chemical purposes of discipling	ght to be treated with respect that to be free from any restraints imposed for e or convenience, and not resident's medical symptoms,					
	neglect, misappropria and exploitation as d includes but is not lin corporal punishment,	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to					
	(a) The facility must-						
	or chemical restraints discipline or convenie required to treat the r symptoms. When the indicated, the facility alternative for the lead ocument ongoing restraints. This REQUIREMENT by:	e use of restraints is must use the least restrictive st amount of time and e-evaluation of the need for is not met as evidenced					
	staff interviews and reutilized a device with	ons, medical doctor interview, ecord reviews the facility out considering it to be a a medical symptom. The		F Tag 221 Right To Be Free F Physical Restraints Corrective action that will be	From		
	Transfer Handle entra	apped the resident and when		accomplished:			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY PLETED
					F	R-C
		345415	B. WING _		03	/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
DIMENUL I	- DELLA DIL ITATIONI A	AND LIVING OTD		1010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION A	AND LIVING CIR		PINEVILLE, NC 28134		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 221}	Continued From p	iana 2	{F 22	241		
(1 22 1)		-	{Γ Z	•		
		ound, he was dead. This was		Resident #1 received physicia		
	Handle (Resident	resident with a Transfer		11/22/16 for Supportive device positioning bars on both sides		
	Tianule (Nesident	#1).		assistance with positioning ar		
	Immediate Jeonar	dy began on 02/16/17 when		control. Resident #1 received		
		ound lying on his left side on		clarification order on 12/6/16		
		the low bed with his head		states for Supportive devices,		
		ransfer Handle. When found by		bars on both sides for assista	•	
	the staff the reside	ent was dead.		positioning and trunk control.	The	
				positioning bars are the transf	fer handles	
	The immediate jed	opardy is present and on-going.		on Resident #1□s bed.		
	The facility provide	ed the State Agency and the		The facility did not assess Re	sident #1□s	
		are and Medicaid with an		need for the transfer handles		
	acceptable allegate	tion of compliance (AOC) on		adding them to the resident□s	s bed on	
	03/10/17.			12/6/16 or while they were in		
				bed from 12/06/16 to 2/16/17.		
		as conducted on 03/14/17 to		Resident #1 was found lying of		
		tus of the ongoing Immediate		side on the fall mat beside the		
		cility provided documentation		with his head on the transfer h		
	for review of the for	bilowing:		02/16/2017. Resident assess (Licensed Practical Nurse) to		
	- Systematic of	nanges implemented on the use		vital signs; resident was DNR		
		s, the use of restraints, and the		Resuscitate) and hospice and	,	
	accurate coding o			(Primary Care Physician) imm		
	(MDS).			notified. Death Certificate sign		
		staff in-servicing on the use of		Medical Director on 03/06/201		
	bed accessories,	the use of restraints, and the		cause of death: cardiac arrest	t, heart	
	accurate coding o			failure, and hypertension.		
		on of audits for the use of bed				
	1	ise of restraints and the		The Director of Clinical Opera		
	accurate coding o	t the MDS.		reviewed the Bed Safety police		
	Obconvetions of m	poidonts had and anvironment		with the ADON (Assistant Dire		
		esidents bed and enviroment h staff present in the facility on		Nursing) via telephone on 02/ ADON (Assistant Director of N		
		of all documentation to support		educated the Unit Manager of		
		views with the facility's		Safety policy on 2/16/17. The		
		Director of Nursing provided		(Assistant Director of Nursing		
		e to support corrective action by		Manager then immediately re		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245445	B. WING			R-C
NAME OF B	DOLUBER OR OLIBBLIER	345415	B. WING		(03/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEVILL	E REHABILITATION AND	LIVING CTR		1010 LAKEVIEW DRIVE		
				PINEVILLE, NC 28134		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 221}	Continued From pag	e 3	{F 22	1}		
	F- 221 at a lower socisolated, no actual hat than minimal harm the jeopardy, while the factor of monitoring the impaction. The Findings include Resident #1 was initionally 12/03/04 and expired Resident #1's diagnot cerebrovascular accihemiplegia/hemipare	decility continues the process olementation of the corrective d: ally admitted to the facility on din the facility on 02/16/17. Uses included blindness,		resident beds in the facility for us physical restraints, including all be and assistive devices/bed access including but not limited to side rathalo bed rails to validate devices and any immediate concerns for No immediate concerns were not including no unacceptable spacin between rail and mattress during on the evening of 02/16/17; this rather was conducted by staff making dobservations of each resident the assistive device/restraint which place on the bed. This was repersident to the side of the occupant of the sidescribed below.	ed rails sories ails and in use safety. ed ng the audit eview irect bed and ch was in eated on	
	Review of Resident #1's most recent comprehensive minimum data set (MDS) dated 10/30/16 revealed that Resident #1 had long and short term memory problems and was moderately impaired for daily decision making. No behaviors were identified on the MDS. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member for bed mobility and required extensive assistance of 2 staff members for transfers. The MDS stated that Resident #1 was 72 inches tall and weighed 198 pounds. No falls were identified since the prior MDS. The MDS also revealed that Resident #1 received hospice services and indicated no physical restraint was used while Resident #1 was in the bed.			On 2/28/17, Director of Operation conducted education/in-servicing nursing management team (i.e. Dof Nursing, Assistant Director of Nurse Supervisor) on use of the Decision Tree. The Device Decision Tree. The Device Decision that they are otherwise caperforming, does device assist in improvement of the resident status, and instruction to proceed plan. After the education/in-service conducted by Director of Operation 2/28/17, the nursing management completed the Device Decision Tevaluations.	to Director Nursing, Device ion Tree vice g an pable of the unctional d to care cing was ons on ut team	
	resident was to have	nats on both sides of the bed		Another review was conducted a 3/7/17 by nursing management to using the Pre restraint Assessme	eam	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345415	B. WING			R-C 8/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	714/2017
PINEVILL	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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 221}	02/01/17 through 02. 11/22/16 a physician "positioning bars on assistance with positioner the facility was unat order. Further review revealed no diagnos use of the transfer haside rail assessment decision tree. Review of a nurse's PM read, "Resident: breathing at 5:15 PM #1 was lying on his leplace, bed was in low was elevated betwee Hospice nurse was nand physician was nby Nurse #1. Observations on 02/2 on 02/28/17 at 10:00 bed revealed a bed to inches long and conteach side of the bed approximately 18 incomaking the bottom of transfer handles. The inches by 4 inches we rail and was perpendiculated the vertical to a flat mattress. To attached to the bed to instructions.	ative physician orders for /28/17 revealed that on 's order was written for both sides of bed for cioning and trunk control." ole to locate the original of the medical record is or medical symptom for andle and did not reveal a or a restraint enabler note dated 02/16/17 at 11:32 #1 was observed not 1. Skin color pale, Resident eft side. Floor mats were in w position and head of bed en 45 and 90 degrees. notified. Family was notified otified." The note was signed 27/17 at 10:00 AM and again of AM made of Resident #1's that was approximately 80 tained a Transfer Handle on 1. The transfer handle was these from the top of the bed of a pillow in line with the extransfer handle was a 24 wide by 24 inches tall metal dicular to the bed. When bar created 90 degree angle the transfer handle was frame per the manufacture	{F 221	Training/in-servicing was complete the Director of Operations on corr of the tool on 2/28/17. The Pre re evaluation tool directs the staff to whether a bed accessory (includir rails and halos) is a restraint, this on the resident is individualized assessment. The Pre restraint Assessment Tool is conducted to all areas of resident physical, nemotional, environmental, and sowell-being are addressed to identife lease restrictive intervention. Each was assessed to determine wheth was a restraint based on individual assessment, meaning whether the restricted resident is movement in of the bed. If the accessory was determined to be a restraint, the M (Minimum Data Set) was coded to same and care plans updated accessory the MDS Coordinator by 3/8/17. Residents with assistive devices of beds such as ¿ side rails and ¿ si and halos were safety-checked by management team (Director of Nu Assistant Director of Nursing, Nur Supervisor) on 2/17/17 and again 3/8/17 with any need for adjusting repair completed immediately. The check included ensuring that no gexisted that could cause entrapmed being caught between the mattres bed accessory or in the bed accessitself with no immediate concerns. The resident bed accessory & cincluding the halos, were assessed determine if they meet the definition of the definition of the province of the	ect use straint evaluate straint evaluate ag side is based ensure nental, cial fy the ch halo per it all e halo in or out MDS preflect cordingly on their de rails or nursing per its property of the second or estate or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391 </u>
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				SURVEY PLETED
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	345415	B. WING _			03	/14/2017
ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
E DELIABII ITATION AND	LIVING CTP		10	10 LAKEVIEW DRIVE		
2 REHABILITATION AND	LIVING CTK		PI	NEVILLE, NC 28134		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
(ADON) on 02/27/17 on 02/16/17 the Direct been on vacation and evening finishing up soffice. The ADON start and was walking she noted Nursing Asher to Resident #1's rout the chart down arroom. The ADON start Resident #1's room Nat Resident #1's room Nat Resident #1's room Sat Resident #1's room Sa	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 durse #1 informed her espice patient and had a Do r in place and he had stated when she entered he saw Resident #1 lying on the rasting on the mattress great the transfer handle. The color of Resident #1 as a shoN stated she directed the ent #1's head to the floor and back into bed. The ADON hare of how long the incident and she did not think staff because she was working in a r closed and had come out the staff saw her and the just was really not clear on the had some "concerns with was positioned." The provided Hamber of the ADON was positioned that Resident #1 at all call from the ADON was desident #1's head was the south Administrator told.	{F 2:	21}	restraint by the nursing managementeam (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor This task was completed after Administrator and nursing leadership team (leadership team consists of Director of Nursing, Assistant Director Nursing, Nursing supervisor, and Minimum Data Set Coordinators) we serviced by outside RN consultant of 3/8/17. The training included: 1) the definition of a restraint as any device attached to or adjacent to the reside which limits the residents movement out of a bed based that on that resid individualized assessment; 2) coding resident smods MDS for restraints where applicable; 3) conducting a safety assessment of the device for risk / brand least restrictive 4) ensuring an appropriate physician or therapy ord in place for the device; and 5) ensuring the clinical record reflects an underly medical condition supporting the use the restraint. If they did, the MDS (Minimum Data Set) for that resident coded appropriately, and the care plaupdated to reflect same by the MDS (Minimum Data Set) Coordinators. The was completed by 3/9/17. On 2/17/17, an assessment was performed by the Interdisciplinary Teon each resident with any assistive device, including side rails and halos Based on that assessment, fourteen residents based upon their current	r). or of re in - on on on on on on on on on o	
	CONTINUED FROM SUPPLIER E REHABILITATION AND SUMMARY ST. (EACH DEFICIENC REGULATORY OR IN 1997) Continued From page (ADON) on 02/27/17 on 02/16/17 the Direct been on vacation and evening finishing up soffice. The ADON start and was walking she noted Nursing Asher to Resident #1's room Not Resident #1's room Not Resident #1's room Not Resident #1 was a hour to Resident #1's room Start and was walking she noted Nursing Asher to Resident #1's room Not Resident #1's room Not Resident #1's room Not Resident #1's room start and his chin "touching ADON described the "little yellow." The ADON staff to lower Resider then assist the body stated she was unaw had been going on arknew she was there than office with the door to obtain a chart and summoned her so she what happened but sthe way Resident #1 Interview with the Adon 12:13 PM revealed that approximately 5:30 PM the ADON and was in had expired. The initit that the staff stated Reaught in the side rail the ADON that she was the way Resident #1	CORRECTION IDENTIFICATION NUMBER:	TOT DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345415 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 (ADON) on 02/27/17 at 11:50 AM revealed that on 02/16/17 the Director of Nursing (DON) had been on vacation and she was working late that evening finishing up some paper work in the office. The ADON stated she had gone to get a chart and was walking down the hallway when she noted Nursing Assistant (NA) #2 summoning her to Resident #1's room. The ADON stated she put the chart down and ran to Resident #1's room. The ADON stated that when she entered Resident #1 was a hospice patient and had a Do Not Resuscitate order in place and he had expired. The ADON stated when she entered Resident #1's room she saw Resident #1 lying on the floor with his head resting on the mattress and his chin "touching" the transfer handle. The ADON described the color of Resident #1 as a "little yellow." The ADON stated she directed the staff to lower Resident #1's head to the floor and then assist the body back into bed. The ADON stated she was unaware of how long the incident had been going on and she did not think staff knew she was there because she was working in an office with the door closed and had come out to obtain a chart and the staff saw her and summoned her so she just was really not clear on what happened but she had some "concerns with the way Resident #1 was positioned." Interview with the Administrator on 02/27/17 at 12:13 PM revealed that on 02/16/17 at approximately 5:30PM she got a phone call from the ADON and was informed that Resident #1 had expired. The initial call from the ADON was that the staff stated Resident #1's head was caught in the side rail, so the Administrator told the ADON that she would be on her way back to	PEDEFICIENCIES CORRECTION (X1) PROVIDER SUPPLIER A BUILDING B. WING 345415 ROVIDER OR SUPPLIER E REHABILITATION AND LIVING CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 (ADON) on 02/27/17 at 11:50 AM revealed that on 02/16/17 the Director of Nursing (DON) had been on vacation and she was working late that evening finishing up some paper work in the office. The ADON stated she had gone to get a chart and was walking down the hallway when she noted Nursing Assistant (NA) #2 summoning her to Resident #1's room. The ADON stated she put the chart down and ran to Resident #1's room. 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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345415	B. WING _			03/	14/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINEVII I I	E REHABILITATION AND	LIVING CTP		10	010 LAKEVIEW DRIVE		
FINEVILLE	E REHABILITATION AND	LIVING CIK		Р	INEVILLE, NC 28134		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 004)	0 11 15						
{F 221}	Continued From page		{F 2	21}			
	-	8:00 PM and immediately			less restrictive bed accessory, such as		
		ne staff. The Administrator			assist bars or halos and those devices		
		nto Resident #1's room and			were ordered on 2/17/17 by the		
		nt #1 did not have side rails			maintenance department for installatio	n	
		at were 4 inches wide and			upon delivery. Delivery is expected by	_	
		not considered a side rail or nistrator stated that she			03/10/17. On 3/8/17 after training by a		
		1's body and did not see any			outside consultant (as described herein the IDT (Interdisciplinary Team) again	1),	
		on, she stated he did have			assessed and reviewed each resident	٦ و	
		ck but that he had been			use of any bed accessory including bu		
	•	day but nothing that had			not limited to side rails and halos. Bed	•	
		hung on the assist bar. The			accessory is defined as any item e.g.		
	_	hat through her interviews			fixtures such as handrails, grab bars, a	ind	
		ry of what happened and			devices/equipment such as transfer lift		
	even took it a step fui	ther and brought the staff to			canes, and wheelchairs, etc. that is us	ed	
	the desk and used ch	arts to simulate what			by, or in the care of a resident to prome	ote,	
	happened. The staff t	old her that Resident #1			supplement, or enhance the resident□	S	
	was sitting on the fall	mat with his shoulders			function or safety. The assessment of		
	_	ss, his head was lying on			use on 03/08/17 included a review of the		
		forehead and chin were			resident□s current clinical record, staft		
	_	ar. The administrator stated			interviews regarding how /if resident us		
		hat he looked like and they			the accessory, and resident observation		
		as a ghost but did not see			was performed by a licensed nurse. T		
		ne administrator stated at			has resulted in the removal of assistive	•	
		reason to believe the assist			devices for all but 12 residents. As of		
	bars had anything to	uo พเก การ death.			3/8/17, upon arrival, any assistive devi		
	Intorvious with NA # 4	on 02/27/17 at 2:58 PM			will be assessed by nursing management	eni	
		tinely cared for Resident #1.			team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor,	ااد	
		I fed him breakfast and			whom received training by outside	ali	
		d he was his usual self. NA			consultant on 3/8/17 using the		
		nt #1 was a "wiggler in bed			pre-restraint assessment tool to		
		the left side of the bed." NA			determine if device is a restraint based		
	-	ntly throughout her shift			upon the resident⊡s individualized		
		ion Resident #1 back to the			assessment. If they are restraints, the		
	middle of the bed.				MDS (Minimum Data Set) will be code	d	
					accordingly and the care plan updated		
	Interview with NA #2	on 02/27/17 at 3:05 PM			MDS (Minimum Data Set) Coordinators		

revealed that she routinely took care of Resident

This will include the alternative devices for

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CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						R	-C
		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
DIMEN /// L		ALIMANO OTO		10	010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CTR		Р	INEVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 221}	Continued From page	2.7	(F. 2)	241			
11 22 15	Continued From page		{F 2	Z I}			
		quite often slid to the left side			the 14 residents mentioned above.		
		ould have to straighten him			Resident #1 had a 24-inch-long x		
	1	d that Resident #1 was a			4-inch-wide transfer handle attached to		
	1 -	ld scoot from the middle of			his bed which was not assessed by sta		
		de of the bed. NA #2 also			to determine if it was a physical restrair The assessment as we described here		
		Resident #1 had swallowing advised to keep the head of			examines all bed devices, including	#1	
	_	#2 stated that on 02/16/17			transfer handles, to determine if they w	ere	
		5 PM-5:30 PM they were in			restraints based upon the resident□s□		
		NA #1 had taken Resident			individualized assessment. Where they		
	_	to assist him with the meal.			were determined to be a restraint the		
		nediately NA #1 came			resident MDS and care plan was updat	ed	
		dining room and stated "he			appropriately.		
	_	ated that all the staff jumped					
	_	nt #1's room. NA #2 stated			As of 3/8/17 and going forward, any		
	_ ·	d Resident #2's rooms she			device determined to be ineffective or a	ì	
	could tell "he was dea	ad, there was no movement,			safety issue by IDT (Interdisciplinary		
	he was limp, and his	face was completely white."			Team) shall be removed; the resident w	vill	
	NA #2 stated that Res	sident #1's bed was in low			then be assessed by the IDT		
	position and the head	d of the bed was elevated			(Interdisciplinary Team) for an alternative	ve	
	between 45 and 90 d	egrees and Resident #1's			intervention. Resident care plans will b	e	
	chin was "hooked" or	n the transfers handle with			updated accordingly by the IDT and dir	ect	
		mattress and the handle.			care staff will be informed via the care		
		sident #1's body was lying			guide. All nursing staff have been train		
	1 -	cept his head which was			on this by 3/9/17. Any nursing staff wh		
		sfer handle. NA #2 stated the			was not present for training or are PRN		
		Resident #1's neck under			will not be allowed to return to work and		
		ne larynx area) and stated			patient care until this training has been		
	1	r the head of the bed to			completed by them.		
		from the transfer handle. NA			 B		
		ney removed Resident #1			Resident #1 s bed did not malfunction		
		dle there was a red area on			nor have a device failure; therefore, it v	/as	
	I .	in (pointed to larynx area)			not necessary to take the bed out of	b	
	where the transfer ha	шие паи вееп.			service. The bed is not currently in use	υy	
	Intoniow with Nurse	#1 on 02/27/17 of 2:24 DM			any resident and will be assessed for		
		#1 on 02/27/17 at 3:24 PM			accessory needs prior to placement of		
	I .	s the nurse taking care of 6/17. Nurse #1 stated she			resident; transfer handles were remove from the bed on 3/1/17.	:u	
	Nesident#1 011 02/10	n i i . inuise # i sidleu siie	1				1

arrived for her shift at 3:00 PM and got report and

All residents in the facility with a bed

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR NO	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTE		(X3) DATE COMP	
						R-	-C
		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREETA	DDRESS, CITY, STATE, ZIP CODE		
DINEVILL	DELIABILITATION AND	LIVING CTD		1010 LAK	EVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CIR		PINEVIL	LE, NC 28134		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 221}	Continued From page	s 8	(E.3)	241			
11 22 15	· -		{F 2	- 1			
		on cart and then walked			essory or physical restraint were	£	
		check on her patients. Nurse			essed using the Initial Assessment	TOT	
		time Resident #1 was in his		I	of Physical Restraint tool by I/Nursing Management team		
	•	nd the head of the bed was his "normal self." Nurse #1			udes ADON, Nursing Supervisor, a	and	
	she had come up the				S coordinators) by 3/9/2017. This	and	
		ound 4:30 PM and again			ded the following elements: 1)		
	•	t #1 and he was he was		I	essing each bed accessory based		
		#1 stated that after she			the resident s individualized		
		ation pass she had gone		1 -	lent assessment to determine		
		o wait for the dinner tray so		whet	ther it constitutes a restraint for the	at	
	she could assist resid	lents with the meal. Nurse		resid	lent; 2) ensuring that all residents	with	
	#1 stated that at appr	oximately 5:15 PM NA #1		any a	assistive device have been coded	on	
	took Resident #1's tra	ay to his room to assist him		the N	MDS as having a potential restrain	t; 3)	
		#1 stated that immediately		ensu	ıring that all residents with a restra	aint	
	_	back to the dining room		I	e the MDS coded as such; 4) ensu	•	
		rse #1 stated that all the staff			fety assessment for all such reside	ents	
		Resident #1's room. Nurse		I	mpleted and documented; 5)		
		around the side of the bed			iring a physician order and/or		
		lying on the floor parallel to		1	sician/therapy order is in place for		
		firmly between the transfer between the transfer handle			device and 6) ensuring the clinical	al	
		rse #1 stated that she had		I	rd contains documentation of a ical condition warranting the use c	,f	
		A to get some help because		I	ical condition warranting the use c i device.	′'	
		to do. Nurse #1 stated that		30011	407100.		
		Resident #1 had expired with		A ph	ysician order for every resident wi	th a	
		d a Do Not Resuscitate			accessory or physical restraint wa		
	•	DON advised them to place			ined by nursing management tear		
	•	he bed and perform post			17 that includes use of	,	
		#1 also stated that they had		devid	ce/accessory or physical restraint	and	
	to lower the head of t	he bed to remove Resident		prese	ence of medical symptom/condition	n	
		andle. Nurse #1 stated she			evice/accessory to assist with		
		ice provider, the family, and			ecting the resident□s safety, and h	nelp	
	the physician that Re	sident #1 had expired.			esident attain the highest level of		
					er physical or psychological		
		on 02/27/17 at 4:39 PM			being.		
		tinely cared for Resident #1		I	esidents in the facility with a bed		
	and on 02/16/17 at ap	oproximately 3:45 PM she		acce	essory or physical restraint care pla	an	

had provided incontinent care to Resident #1. NA

shall be reviewed and updated by IDT by

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE COMP	SURVEY
						l R	-c
		345415	B. WING _			1	14/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				101	0 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	LIVING CTR		PIN	IEVILLE, NC 28134		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 221}	Continued From page	e 9	{F 22	21}			
, ,		she entered his room he was	(- 1	3/9/17 to reflect use of bed		
		he left side of the bed and			accessory/restraint.		
	1	him near the middle of the					
		ng care and repositioning			A modification MDS (Minimum Data S	et)	
	Resident #1 she had	raised the head of his bed			will be completed by MDS (Minimum I		
	and ensured the bed	was in low position and left			Set) team by 3/9/17 to reflect the use	of	
		ed that Resident #1 favored			bed accessory/restraint, and the MDS		
		d and generally about 3			(Minimum Data Set) restraint informati		
		she would have to go in and			will be transferred to the resident ☐s ca	ire	
	l .	#1 near the middle of the bed			plan.		
		scoot back to the left side.			A QAPI (Quality Assurance Performant		
		ely he would rest his head on nat was attached to his bed			Improvement) subcommittee was form this committee consulted with the Med		
		throw his legs off the side of			Director on 3/1/17 and again on 3/9/17		
	the bed. NA #3 state	_			regarding all required components of t		
		PM the staff was in the dining			Credible Allegation, and the citations		
		taken Resident #1's tray to			issued by North Carolina Department	of	
		n with the meal. NA #3			Health. The subcommittee consists of		
	stated that immediate	ely NA #1 came running back			Administrator, DON (Director of Nursir	ıg),	
		nd stated "Resident #1 is			ADON (Assistant Director of Nursing),		
		ımped up and ran to his			MDS (Minimum Data Set) Coordinator		
		hat when she entered his			The Subcommittee shall meet monthly		
		Resident #1 was dead, she			and as needed x 3 months to ensure		
		ale and white in color. NA #3			Credible Allegation, 2567 (upon receip		
		body was lying on the floor is chin was between the			and Plan of Correction is followed and facility is in compliance.	trie	
		his neck between the			lacility is in compliance.		
		ess. NA #3 stated that there			Identification of other residents:		
	was a red line where				All residents with bed accessories		
		inder his chin (pointed to			determined to be a restraint based upo	on	
		had to lower the head of the			their individualized assessment are at		
	bed to remove Resid	ent #1 from the transfer			for this alleged deficient practice.		
		I that his bed was in the low					
		d of the bed was just as she			Measures for systemic change:		
		r rendering care. NA #3			Administrator and facility leadership te		
		removed Resident #1 from			(leadership team consists of Director of		
		they assisted the body back			Nursing, Assistant Director of Nursing		
	into bed and post mo	ortem care was provided.			Nursing supervisor, and Minimum Dat		
					Set Coordinators) in serviced by outside	иe	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		R-	C
		345415	B. WING _				14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	
				10	010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION ANI	D LIVING CTR		Р	INEVILLE, NC 28134		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 221}	Continued From pag	ne 10	{F 2	21}			
,		rector of Maintenance on	" -	,	Registered Nurse consultant on 3/8/17		
		M revealed that on 01/04/17			The training included: 1) the definition of		
		w bed for the facility. On			restraint as any device attached to or	, u	
		d arrived to the facility and on			adjacent to the resident which limits the	دِ	
		ne assembled the new bed			residents movement in or out of a bed		
		ransfer handles. The Director			based that on that residents individualia	zed	
	of Maintenance state	ed that the new bed had			assessment; 2) coding that resident⊡s		
	come with Transfer h	nandles and he attached			MDS (Minimum Data Set) for restraints		
	them to the bed per	the manufacturer instructions			where applicable; 3) conducting a safe		
	and once the bed wa	as assembled the bed was			assessment of the device for risk / ben	-	
	placed in an empty r	oom until someone needed			and least restrictive 4) ensuring an		
	the bed. The Directo	r of Maintenance stated that			appropriate physician or therapy order	is	
	at some point Reside	ent #1 needed a new bed and			in place for the device; and 5) ensuring	J	
	someone had grabbo	ed the bed with the Transfer			the clinical record reflects an underlying	g	
	handles on it and as	signed it to Resident #1. The			medical condition supporting the use of	f	
	Director of Maintena	nce stated he had no			the restraint. No nursing staff who was		
	_	ning Resident #1 to the bed			absent or PRN (pro re nata) staff will be		
		ndles. The Director of			allowed to return to the floor and reside	ent	
		to his knowledge the beds			care until this training has been		
	-	nd was not sure that there			completed.		
	was anything wrong	with the old bed.					
					Then, all nursing staff shall be in service		
		ospice nurse on 02/28/17 at			by Director of Nursing, Assistant Direct		
		hat she routinely visited			of Nursing, or Nurse Supervisor by 3/9		
		no involvement in assigning			on 1) the definition of a restraint as any	!	
		The hospice nurse stated			device attached to or adjacent to the		
	· ·	d handle any type of bed or ded for the resident. The			resident which limits the resident⊡s movement in or out of a bed based tha		
						۱	
		d that when she would visit, ually found him lying on his			on that resident □s individualized assessment; 2) coding that resident □s		
		d resting on the top upper rail			MDS (Minimum Data Set) for restraints		
		e. The hospice nurse stated			where applicable; 3) conducting a safe		
		e him closer to the middle of			assessment of the device for risk / ben	-	
		t #1 would wiggle back to the			and least restrictive 4) ensuring an	5.11	
		The hospice nurse stated she			appropriate physician or therapy order	is	
		h Resident #1's preferred			in place for the device; and 5) ensuring		
		s head on the transfer handle			the clinical record reflect and underlyin		
	ı ·	ve had any concerns she			medical condition supporting the use of	-	
		ately notified the facility staff.			the restraint. No nursing staff who was		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		l R	-C	
		345415	B. WING _				14/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		•	
DINEVILL	E DELIADII ITATION ANI	D LIVING CTD		10	010 LAKEVIEW DRIVE			
PINEVILL	E REHABILITATION ANI	D LIVING CTR		Р	INEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 221}	seemed to be comfor preferred the left side stated she had visite 02/15/17 and he was linterview with the Ce 02/28/17 at 11:22 AN out of work for medic returned to work at the central Supply clerk 12/08/16 Resident # on his bed and wher facility on 01/19/17 fon his bed. The Cen Resident #1 was a "the would pull himself ar bed a lot." Interview with Direct 02/28/17 at 12:04 Phy vacation when Reside participate in any type with his death or the found. The DON stated that at on 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 if for him." The DON s	tated that Resident #1 also artable and obviously be of bed. The hospice nurse and with Resident #1 on a his usual self. The entral Supply Clerk on and revealed that he had been cal reason from 12/08/16 and the facility on 01/19/2017. The stated that when he left on 1 had a different type of rail in he returned to work at the ne had the Transfer handles tral Supply clerk stated that fidgety person in bed and round to the left side of the corror of Nursing (DON) on and revealed that she was on the fide that the transfer handles that the person of the state of the corror of the corror of the state of the corror of the state of the corror of th	{F 2	21}	absent or PRN (pro re nata) staff will be allowed to return to the floor and reside care until this training has been completed. All nursing staff shall be in-serviced by Director of Nursing, Assistant Director Nursing, or Nurse Supervisor on completing Initial Assessment for Use of Physical Restraint and Side Rail Assessment prior to implementation of bed accessory to identify the least restrictive intervention by 3/9/17. No nursing staff who was absent or PRN (re nata) will be allowed to return to the floor and resident care until this training has been completed. Beginning on 3/8/17, nursing staff shall in serviced by Director of Nursing or Assistant Director of Nursing upon hire bed safety including the use of restrain Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Physical Restraint Reduction Evaluation Assessment for all residents with a bed accessory at least quarterly, annually, any significant change, or as needed a update care plan accordingly. Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Stail Assessment for all residents with a side rail at least quarterly, annually, with any significant change, or as needed a update care plan accordingly.	ent of pro be on ts. n with nd side h		
	_	d not recall for sure.			Beginning on 3/9/17, the facility shall			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		INSTRUCTION	(X3) DATE COMP	SURVEY
						R	-C
		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				1010	LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CTR		PINE	EVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 221}	Continued From page	<u>.</u> 12	{F 2	211			
()	, ,		ا ا	-	asidant had whan rasidant disabarasa	or	
		tinely cared for Resident #1			esident bed when resident discharges		
	·	oproximately 5:10 PM she mand when the trays arrived			s assigned a different bed. This will be		
		ent #1's tray down the hall to			nandled by maintenance as directed by nursing staff. Administrator provided	/	
		with the meal. NA #1			education/in-servicing on 3/9/17 to nur	eina	
		entered the room she saw			staff, maintenance staff, and reception	•	
		ere outside of the bed. NA #1			on procedure of notifying maintenance	31	
	_	to the bedside she saw			staff to remove all bed accessories from	n a	
	_	chin between the transfer			esident bed when resident discharges		
		between the handle and the			s assigned a different bed including we		
		urple in the area of his			ends. No nursing, maintenance staff or		
	1	larynx area). NA #1 stated "I			eceptionist who was absent or PRN (p		
		w that he was already dead,			e nata) will be allowed to return to the		
	•	ises, he was limp and very			loor and resident care until this training	1	
	_	he ran and told Nurse #1			nas been completed.	•	
		g him come now." When			·		
	asked to describe the	choking NA #1 replied "the			How corrective actions will be monitore	ed:	
	rail was in his neck, h	is neck was trapped in the		Т	The Director of Nursing, Assistant		
	rail, and he could not	get out of the rail." NA #1		[Director of Nursing, Nurse Manager,		
	stated that the head of	of the bed was elevated and		N	Maintenance Director, Assistant		
	we had to lay the hea	d of his bed flat to remove		N	Maintenance Director, and/or		
		handle. NA #1 stated that			Administrator will complete an audit to		
		esident #1 from the transfer			assure any accessory being added to a	1	
		eish/purplish bruise still			ped validating: the type of accessory		
	•	area (points to larynx area)			peing recommended, an Initial		
		ndle had been. NA #1 stated			assessment for use of Physical Restra	nt	
	· ·	ted to lower Resident #1 to			ool has been completed for the		
		ck to bed and perform post			accessory to determine restraint/ability		
	mortem care.				use, Physician order has been obtaine		
	On 00/00/47 1 4 60	ONA in a fallow we into			esident is aware of the accessory and		
		PM in a follow up interview			can verbalize understanding of the		
		she stated that the assist			accessory. This audit will be completed		
		e and physically impossible			ive (5) times a week for eight(8)weeks		
		k and the facility did not			all resident beds, including new admiss	IOII	
		handle a restraint or a side			and permanently discharged resident		
	rail. The Administrato				peds, to ensure that a bed accessory h	as	
		as Resident #1's body was			not been added to a bed without going		
	still present in the facility at the time, however she			ti	hrough the nursing assessment and		

used charts to simulate the scene. The

approval process, and then continue three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345415	B. WING				R-C 03/14/2017	
	ROVIDER OR SUPPLIER E REHABILITATION AND			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134			14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
{F 221}	In an interview with t 03/01/17 at 4:08 PM recall writing the order have the Transfer Ha The MD stated that have the transfer Ha for devices like that the and notify him if they or needed an order. recollection the MD s Resident #1 for any the device for his bed.	o provide the written ing the circumstances of the he Medical Director (MD) on revealed that he did not er for Resident #1 to have to andles but could not deny it. he did not assess the need he facility would handle that needed anything from him To his knowledge and stated he did not assess transfer handle or other	{F 2	21}	(3) times a week for eights (8) weeks, and one (1) time a month for a minimum 6 months and will continue until the Qual Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has maintain substantial compliance. The audits being completed for both F3 and F221, will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (1 time a week for twelve (12) months; the weekly meetings and reviews will then presented in the Monthly Medical Direct report for review and determinations. The Monthly Medical Director reports will be submitted to the Quality Assurance Performance Implementation (QAPI) for monthly review for twelve (12) months, making any necessary recommendation This process will allow multiple layers of Facility committees to have direct review and over-sight of bed accessories in us within the Facility for a minimum of twe (12) months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee review and determines that the facility has me and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director, Unit Management, Regional Clinical Director, Director of Social Services, Minimum Data Set	ity ined 323) ese be ctor che e or cons. of ew se elive		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345415	B. WING		R-C 03/14/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	03/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX		CTION (X5) DULD BE COMPLETION ROPRIATE DATE
{F 221}	Continued From pag	e 14	{F 22	1} (MDS) Coordinator, Culinary Service Director, Maintenance Director, Admissions Coordinator, and Act Director.	
{F 278} SS=D	483.20(g)-(j) ASSES ACCURACY/COORI	SMENT DINATION/CERTIFIED	{F 27		3/21/17
	,,	ssments. The assessment ct the resident's status.			
	(h) Coordination A registered nurse m each assessment wit participation of health				
	(i) Certification (1) A registered nurs the assessment is co	e must sign and certify that ompleted.			
	• •	tho completes a portion of the given and certify the accuracy of sessment.			
	(j) Penalty for Falsific (1) Under Medicare a who willfully and kno	and Medicaid, an individual			
		al and false statement in a is subject to a civil money han \$1,000 for each			
	and false statement i	ndividual to certify a material in a resident assessment is bey penalty or not more than essment.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		R	-c
		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINEVII I I	E REHABILITATION AN	D LIVING CTP		10	010 LAKEVIEW DRIVE		
FINEVILLI	E REHABILITATION AN	D LIVING CTR		Р	INEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 278}	material and false st This REQUIREMEN by: Based on observati	ment does not constitute a atement. T is not met as evidenced on, record review and staff	{F 2	78}	F Tag 278 Assessment Accuracy		
	the quarterly minimureflect the use of a pservice for 1 of 3 res Resident #1's chin witwo bars of a Transfit ohis bedframe and the Transfer Handle resident was found,				/Coordination /Certified Corrective action that will be accomplished: Resident #1 received physician order of 11/22/16 for Supportive devices, positioning bars on both sides of bed for assistance with positioning and trunk control. Resident #1 received physicial clarification order on 12/6/16 that also	or n	
	nursing home failed use of a device that restraint and had the resident. On 2/16/1 lying on the left side beside the low bed variansfer Handle. With the staff, the resident.a.	to began on 01/30/17 when the to assess Resident #1 for the met the definition of a effect of restraining the 7, Resident #1 was found of his body on a fall mat with his head entrapped in the nen the resident was found by at was dead. See findings in			states for Supportive devices, positioni bars on both sides for assistance with positioning and trunk control. The positioning bars are the transfer handle on Resident #1 bed. The facility did not assess Resident #1 need for the transfer handles prior to adding them to the resident □s bed on 12/6/16 or while they were in use on hi bed from 12/06/16 to 2/16/17. Also, sta	es □s s	
	The facility provided Centers for Medicard acceptable allegatio 03/10/17. A revisit survey was determine the status Jeopardy. The facility for review of the follows:	the State Agency and the e and Medicaid with an of compliance (AOC) on conducted on 03/14/17 to of the ongoing Immediate ty provided documentation owing:			failed to assess the transfer handles as physical restraint on Resident #1□s quarterly MDS (Minimum Data Set) of 1/30/17. Resident #1 was found lying on his left side on the fall mat beside the low bed with his head on the transfer handle on 02/16/2017. Resident assessed by LPN (Licensed Practical Nurse) to be absential signs; resident was DNR (Do Not Resuscitate) and hospice and PCP (Primary Care Physician) immediately	. 7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345415	B. WING _			R- 03/1	-C 14/2017	
NAME OF P	ROVIDER OR SUPPLIER	L	- 	STREET ADDRESS, CITY, STATE, ZIP C	ODE	03/	14/2017	
				1010 LAKEVIEW DRIVE				
PINEVILL	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	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
{F 278}	Continued From page	e 16	{F 27	78}				
	of bed accessories, tl	he use of restraints, and the		notified. Death Certificate s	igned by			
	accurate coding of	the minimum data set		Medical Director on 03/06/2				
	(MDS).			cause of death: cardiac arre	est, heart			
	- Evidence of staff	in-servicing on the use of		failure, and hypertension.				
	bed accessories, the	use of restraints, and the						
	accurate coding of th			Facility MDS (Minimum Dat				
		of audits for the use of bed		Coordinator completed a m				
	accessories, the use			Resident #1 1/30/17 quarte	•			
	accurate coding of th	e MDS.		coding of P0100 on 3/9/17;	transmissio	n		
	0	landa bankan kandan di santan sant		was completed on 3/9/17.	t- O-t)			
		lents bed and enviroment		Facility MDS (Minimum Dat		_		
		taff present in the facility on III documentation to support		Coordinator completed a m Resident #1 1/30/17 quarte)		
	the AOC and interview	• •		(Minimum Data Set) for coo		n		
		ector of Nursing provided		on 3/1/17; transmission was				
		support corrective action by		3/9/17.	o completed			
		the immediate jeopardy at		G. S				
	-	pe and severity of (D)		100% audit of all residents	with bed			
		irm with potential for more		accessories/restraints last I	MDS			
	than minimal harm th	at is not immediate		completed by 3/9/17 by fac	ility MDS			
	jeopardy, while the fa	cility continues the process		(Minimum Data Set) Coord	inators on			
	of monitoring the imp	lementation of the corrective		appropriate coding. Audit w	as complete	∌d		
	action.			based upon results of the Ir				
				Assessment for Use of Phy				
	The findings included	i:		tool for each individual resid				
	4. 5			identified, all were modified				
		initially admitted to the		by 3/9/17 by facility MDS (N		ta		
		Resident #1's diagnoses mentia and heart failure.		Set) Coordinators to reflect		nd		
	moluucu vasculai del	nenua anu neart fallure.		accessory/restraint. This wafter the two (2) facility MD	-			
	A fall care plan undat	ed on 11/16/16 specified the		Data Set) Coordinators rec	•			
	resident was to have			education/in servicing from				
		ats on both sides of the bed		Clinical Reimbursement on				
	while in bed to avoid			appropriately coding MDS (Set) Section P0100.		ata		
	Review of the cumula	ative physician orders for						
	02/01/17 through 02/2	28/17 revealed that on		100% audit of all hospice re	esidents last			
	11/22/16 a physician'	s order was written for		MDS (Minimum Data Set) of	completed or	n		
	"positioning bars on b	ooth sides of bed for		3/1/17 by MDS (Minimum D	Data Set)			

CENTER	S FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	<u>7. 0936-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						R	-c
		345415	B. WING			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
50.50				10	010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	LIVING CTR		Р	INEVILLE, NC 28134		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 278}	Continued From page	e 17	{F 2	78}			
, ,		ioning and trunk control."		. 0,	Coordinators on appropriate coding; a	ıdit	
	-	medical record revealed no			was completed based upon review of a		
		symptom for use of the			resident physician orders to determine		
	_	did not reveal a side rail			resident is under hospice care. This wa		
		raint enabler decision tree.			completed after the two (2) facility MDS		
	In an interview with the	ne Medical Director (MD) on			(Minimum Data Set) Coordinators		
		the MD revealed that he did			received education/in-servicing from		
	not recall writing the	order for Resident #1 to			outside RN (Registered Nurse) consult	ant	
	have to have the Trai	nsfer Handles but could not			on 3/1/17 on appropriately coding MDS	3	
	deny it. The MD state	ed that he did not assess the			(Minimum Data Set) Section J1400.		
	need for devices like	that. The facility would					
	handle that assessme	ent and notify him if they			Identification of other residents:		
		n him or needed an order. To			All residents who have a bed		
	_	ecollected the MD stated he			accessory/restraint are at risk for this		
		ent #1 for any Transfer			alleged deficient practice.		
	Handle or other devic	ce for his bed.			All residents who are under hospice ca are at risk for this alleged deficient	re	
	Observations on 02/2	27/17 at 10:00 AM and again			practice.		
	on 02/28/17 at 10:00	AM made of Resident #1's					
	bed revealed a bed the	hat was approximately 80			Measures for systemic change:		
	_	ained a Transfer Handle on			In-service by Director of Clinical		
		The Transfer Handle was			Reimbursement on 3/7/17 to the facility	/□s	
		hes from the top of the bed			two (2) MDS (Minimum Data Set)		
	_	a pillow in line with the			Coordinators on appropriately coding of		
		ne Transfer Handle was a tall			MDS (Minimum Data Set) Section P0		
		red 4 inches wide by 24			including definition of Physical Restrair		
	-	erpendicular to the bed.			which is defined as any manual metho		
		andle was attached to the			physical or mechanical device, materia		
		Il bar created a 90 degree			or equipment attached or adjacent to the		
		ss. The Transfer Handle			resident □s body that the individual car		
	was attached to the b				remove easily which restricts freedom movement or normal access to one □s	ال	
	removed.	ctions and was not easily			body (e.g. leg restraints, arm restraints		
	removeu.				hand mitts, soft tires or vests, lap	,	
	Interview with the Ce	ntral Supply Clerk on			cushions, and lap trays the resident		
		I revealed that he had been			cannot remove easily).		
		08/16 and returned to work			damot formove easily).		
		Central Supply Clerk stated			If a device is coded as a restraint on		
		12/08/16 Resident #1 had a			Section P0100, a CAA (Care Area		

OLIVILIV	O T OIT MEDIO, TILE &	WEDIO/ ND OLIVIOLO					2. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD			R	k-C
		345415	B. WING			03/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIMEN/II I I	- DELLA DIL ITATIONI AND	ALIMINO CER		10	010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CIR		Р	INEVILLE, NC 28134		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 278}	Continued From page	e 18	{F 2	:78}			
	· -	n his bed and when he		-,	Assessment) and Care Plan shall be		
		ne facility on 01/19/17 he had			implemented.		
	the Transfer Handles				In-service by outside RN consultant on	I	
					3/1/17 to the two (2) facility MDS		
	Review of Resident #	t1's most recent quarterly			(Minimum Data Set) Coordinators		
	minimum data set (M	DS) dated 01/30/17			received education/in-servicing from		
		nt #1 had long and short			outside RN (Registered Nurse) consult		
	, ,	ns and was moderately			on 3/1/17 on appropriately coding MDS	3	
		cision making. The MDS also			(Minimum Data Set) Section J1400		
		nt #1 required extensive			including definition of condition or chro	nic	
		rson for bed mobility and			disease that may result in a life		
	required extensive as	r. The MDS further revealed			expectancy of less than 6 (six) months If Section J1400 is coded on resident□		
		no falls since the prior			MDS (Minimum Data Set), a CAA (Car		
		d no physical restraint			Area Assessment) and Care Plan shall		
		ual method or physical or			implemented.		
	mechanical device, m				p.seear		
		to the resident's body that			How corrective actions will be monitore	ed:	
	the individual cannot				A nurse manager will conduct random		
	restricts freedom of n	novement or normal access			audits of 10 MDS□s (Minimum Data Se	et)	
	to one's body) was us	sed in bed or chair.			to ensure coding of J1400 and P0100		
					appropriate. This audit will be complete		
		lurse on 03/01/17 at 10:30			five (5) times a week for eight (8) week	S,	
		had completed the MDS			three (3) times a week for eights (8)		
		esident #1 and she had not			weeks, one (1) time a week for four (4)	1	
		traint because Resident #1 nt. The MDS nurse stated			weeks, and one (1) time a month for a minimum 6 months and will continue up	ntil	
		he only had Transfers			the Quality Assurance/ Performance	Hui	
		ere used for positioning but			Improvement (QAPI) committee review	IC.	
	were not a restraint.	cre used for positioning but			and determines that the facility has me		
	word not a restraint.				and maintained substantial compliance		
	Interview with Nurse	#1 on 02/27/17 at 3:24 PM			Sample S		
		s the nurse taking care of			The Quality Assurance Performance		
		6/17. Nurse #1 stated that at			Improvement committee participation		
	approximately 5:15 P	M NA #1 requested her			includes, but is not limited to,		
	assistance. Nurse #1	stated she walked around			Administrator, Director of Nursing,		
		nd Resident #1 was laying on			Medical Director, Unit Management,		
		e bed with his chin firmly			Director of Social Services, Minimum D		
	between the Transfer	Handle vertical rails and his			Set (MDS) Coordinator, Regional Clinic	cal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
							-C	
		345415	B. WING _			03/	14/2017	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
DINEVII I I	E REHABILITATION AND	LIVING CTP		10	110 LAKEVIEW DRIVE			
PINEVILLI	E REHABILITATION AND	LIVING CIR		PI	INEVILLE, NC 28134			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SI			(X5) COMPLETION DATE	
{F 278}	neck was between the mattress. Nurse #1 st Resident #1 had expi had a Do Not Resusce #1 also stated that the the bed to remove Rehandle. Interview with the Directory of the Dolon Stated that was a "busy body" in the other devices that The DON stated that was able to pull a devening" out of the post The DON stated that different types of bed best for Resident #1 'Handle that attached sturdier and better for she believed that Resent Handle a couple of mestated that residents assessed using the sin the electronic medi were assessed using decision tree also loce The DON stated that Transfer Handle a resent On 02/28/17 at 4:20 Feed Administrator she stated was 4 inches wide an get your head stuck as	e Transfer Handle and the ated that she confirmed red with no respiration and itate order in place. Nurse ey had to lower the head of esident #1 from the Transfer ector of Nursing (DON) on stated that Resident #1 the bed and would pull on they had in place for him. at one point Resident #1 rice called a "Halo Safety that secured it to the bed. They had tried several is to find what would work but we felt like the Transfer to the bed frame was him." The DON stated that sident #1 got the Transfer onths ago. The DON also with side rails were de rail assessment located cal record and other devices the restraint enabler ated in the medical record. They did not consider the straint for Resident #1.	{F 2'	78}	Director, Culinary Services Director, Maintenance Director, Admissions Coordinator, and Activity Director.			
	with side rails were as side rail assessment	r stated that all residents ssessed for safety using the document located in the cord and that other devices						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345415	B. WING			R-C	
	ROVIDER OR SUPPLIER E REHABILITATION AN			STREET ADDRESS, CITY, STATE, ZIP COL 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134)3/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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}	decision tree. The A always try to use the possible and they be was appropriate for Administrator stated Resident #1 was use. The Administrator w jeopardy on 03/06/1 1.b. Review of a doc Palliative care Certif Statement" that was read in part, "I have beneficiary's clinical that the beneficiary expectancy of six m illness runs its norm was signed by the h 01/04/17. The certifi 04/17/17. Review of Resident minimum data set (N revealed that Reside term memory proble impaired for daily derevealed that Reside services, but did not had a life expectance (section J1400 of the Interview with the M 10:30 AM revealed the MDS on Resident # was receiving hospic assessment period.	g the restraint enabler dministrator stated that they eleast restrictive device elieved the Transfer Handle Resident #1. The that the Transfer Handle for ed for positioning. as notified of immediate 7 at 11:39 AM. cument titled, "Hospice and ication/Recertification found in the medical record reviewed the above circumstances and I certify s terminally ill with a life onths or less if the terminal al course." The document ospice medical director on cation period was 01/18/17 to #1's most recent quarterly MDS) dated 01/30/17 ent #1 had long and short ms and was moderately ecision making. The MDS also ent #1 received hospice indicate that Resident #1 y of less than 6 months to live en MDS). DS Nurse on 03/01/17 at that she had completed the 1 dated 01/30/17 and that he	{F 27	8}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7.1. 50.125.			R	-C
		345415	B. WING			03/	14/2017
	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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 278} {F 323} SS=D	the physician wrote a 6 months or less to live that it was very rare for MDS in section J, been frame how long some. In a follow up interview the MDS nurse confirmation have reflected that Research expectancy of less that the MDS to be complete the MDS to be complete resident status. 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVIOLATION (d) Accidents. The facility must ensure (2) Each resident receand assistance devices (n) - Bed Rails. The fappropriate alternative bed rail. If a bed or simust ensure correct in maintenance of bed rails to the following elements.	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." If w on 03/01/17 at 11:28 AM, med the assessment should esident #1 had a life an 6 months to live. If of Nursing (DON) on evealed that she expected eted accurately to reflect the eted accurately to reflect the sas is possible; and every adequate supervision es to prevent accidents. If accility must attempt to use es prior to installing a side or de rail is used, the facility installation, use, and earls, including but not limited ents. Inter the other than the provision of the rail is used, the facility installation, use, and earls, including but not limited ents.	{F 2				3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING) DATE SURVEY COMPLETED
		345415	B. WING			R-C 03/14/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	I)E	03/14/2017
DINEVILL	E REHABILITATION AND	A LIVING CTP		1010 LAKEVIEW DRIVE		
FINEVILLI	E REHABILITATION AND	LIVING CIR		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 323}	Continued From page	e 22	{F 32	:3}		
	(2) Review the risks a	and benefits of bed rails with				
	the resident or reside	ent representative and obtain				
	informed consent price	or to installation.				
	(3) Ensure that the be	ed's dimensions are				
		sident's size and weight.				
		Γ is not met as evidenced				
	by:					
		ons, staff interviews, and		F Tag 323 Free Of Accident		
		cility failed to identify a		Hazards/Supervision/Devices	;	
		n accident hazard for 1 of 1				
		t1) that resulted in a resident		Corrective action that will be		
		in a Transfer Handle and		accomplished:		
	when found by staff v	vas dead.		Resident #1 received physicia 11/22/16 for Supportive device		
	Immediate Jeonardy	began on 02/16/17 when		positioning bars on both sides		
		entrapped in the Transfer		assistance with positioning ar		
		ched to his bed. When		control. Resident #1 received		
	Resident #1 was four	nd he was lying on his left		clarification order on 12/6/16		
	side on the fall mat b	eside the low bed with his		states for Supportive devices	, positioning	
	head entrapped in the	e transfer bar and was dead.		bars on both sides for assista	ince with	
				positioning and trunk control.		
	The immediate jeopa	rdy is present and on-going.		positioning bars are the trans on Resident #1□s bed.	fer handles	
		the State Agency and the				
		and Medicaid with an		The facility did not assess Re		
	acceptable allegation	of compliance (AOC) on		need for the transfer handles	-	
	03/10/17.			adding them to the resident□		
				12/6/16 or while they were in		
	•	conducted on 03/14/17 to		bed from 12/06/16 to 2/16/17		
		of the ongoing Immediate		Resident #1 was found lying		
	for review of the follo	y provided documentation		side on the fall mat beside the		
	ioi review of the follo	wii ig.		with his head on the transfer 02/16/2017. Resident assess		
	- Systematic chan	ges implemented on the use		(Licensed Practical Nurse) to		
		he use of restraints, and the		vital signs; resident was DNR		
	accurate coding of	the minimum data set		Resuscitate) and hospice and		
	(MDS).	and minimidity data dot		(Primary Care Physician) imn		
	, ,	f in-servicing on the use of		notified. Death Certificate sign	-	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		_	-C	
		345415	B. WING				-	
NAME OF D	ROVIDER OR SUPPLIER	343413	B: 11:110	C.	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2017	
NAME OF PI	ROVIDER OR SUPPLIER							
PINEVILLI	E REHABILITATION AN	D LIVING CTR			010 LAKEVIEW DRIVE			
				Р	INEVILLE, NC 28134		T.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 pag	ne 23	{F 3	231				
(,		e use of restraints, and the	, ,	20,	Medical Director on 03/06/2017 states			
	accurate coding of the				cause of death: cardiac arrest, heart			
	_	of audits for the use of bed			failure, and hypertension.			
		e of restraints and the			landre, and hypertension.			
	accurate coding of the				The Director of Clinical Operations			
					reviewed the Bed Safety policy educat	ion		
	Observations of resi	dents bed and enviroment			with the ADON (Assistant Director of			
	and interviews with	staff present in the facility on			Nursing) via telephone on 02/16/17. The	ne		
		all documentation to support			ADON (Assistant Director of Nursing) t			
	the AOC and intervie	ews with the facility's			educated the Unit Manager on the Bed			
	Administrator and D	irector of Nursing provided			Safety policy on 2/16/17. The ADON			
	sufficient evidence to	o support corrective action by			(Assistant Director of Nursing) and Uni	t		
	,	e the immediate jeopardy at			Manager then immediately reviewed a	I		
		ope and severity of (D)			resident beds in the facility for use of			
	· ·	arm with potential for more			physical restraints, including all bed ra			
	than minimal harm the				and assistive devices/bed accessories			
		acility continues the process			including but not limited to side rails ar			
		plementation of the corrective			halo bed rails to validate devices in use			
	action.				and any immediate concerns for safety			
	The Circuit and its about	- d.			No immediate concerns were noted			
	The Findings include	ea:			including no unacceptable spacing	4:ام		
	Povious of facility as	licy titled "Bed Safety" revised			between rail and mattress during the a			
	, , ,	d in part, To try to prevent			on the evening of 02/16/17; this review was conducted by staff making direct			
		the beds and related			observations of each resident □s bed a	nd		
	-	g frame, mattress, side rails,			the assistive device/restraint which wa			
	, , , ,	rd, and bed accessories), the			place on the bed. This was repeated			
		the following approaches:			3/8/17 after the training by the outside			
		afety measure for residents			consultant was completed. That training	ng		
	-	itified as having a higher than			is described below.	J		
		ncluding entrapment (e.g.,						
		s, restlessness, etc.)			On 2/28/17, Director of Operations			
		•			conducted education/in-servicing to			
	Resident #1 was init	tially admitted to the facility on			nursing management team (i.e. Directo	r		
	12/03/04 and expire	d in the facility on 02/16/17.			of Nursing, Assistant Director of Nursir	ıg,		
	Resident #1's diagno	oses included blindness,			Nurse Supervisor) on use of the Device	Э		
	cerebrovascular acc	sident, right sided			Decision Tree. The Device Decision Tr	ee		
		esis, vascular dementia,			reviews the device ordered, if device			
	history of convulsion	ne heart failure, and major			prevents resident from performing an			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	_		l R	-C
		345415	B. WING _				14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		•
DIMEN/III		ALIMANO OTO		10	010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	LIVING CIR		Р	INEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 323}	Continued From page depressive disorder. Review of Resident # comprehensive minir 10/30/16 revealed the short term memory p impaired for daily deceiver identified on the revealed that Reside assistance of 1 staff required extensive as for transfers. The MDR Resident #1 was 72 in pounds. No falls were MDS. The MDS also received hospice serphysical restraint was was in the bed. A fall care plan update resident was to have positioning and fall me while in bed to avoid the cumula 02/01/17 through 02/11/22/16 a physician "positioning bars on the facility was unaborder. Review of a nurse's report of the positioning bars on the facility was unaborder.	#1's most recent num data set (MDS) dated at Resident #1 had long and roblems and was moderately cision making. No behaviors a MDS. The MDS further int #1 required extensive member for bed mobility and assistance of 2 staff members and seistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance of 2 staff members assistance of 3 staff members assistance of 2 staff members assistance	{F 3	23}		of nall re as n n ol. se nt tate le sed re l, ello out	
	was elevated betwee	v position and head of bed n 45 and 90 degrees. otified. Family was notified			Residents with assistive devices on the beds, such as side rails and halos, we safety-checked by nursing management	re	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDII			l R	-C
		345415	B. WING				14/2017
NAME OF P	ROVIDER OR SUPPLIER	0.000	<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2017
TO UNE OF TH	NOVIDER OR COLL FIER				110 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CTR			INEVILLE, NC 28134		
					<u> </u>		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 323}	Continued From page	e 25	{F 3:	23}			
,		otified." The note was signed	(, 0,	_0,	team (Director of Nursing, Assistant		
	by Nurse #1.	office. The flote was signed			Director of Nursing, Nurse Supervisor)	on	
	by Italioo ii I.				2/17/17 and again on 3/8/17 with any		
	Observations on 02/2	27/17 at 10:00 AM and again			need for adjusting or repair completed		
		AM made of Resident #1's			immediately. The safety check included	t	
	bed revealed a bed the	nat was approximately 80			ensuring that no gaps existed that coul	d	
	inches long and conta	ained a Transfer Handle on			cause entrapment from being caught		
	each side of the bed.	The transfer handle was			between the mattress and bed accessor	ory	
		hes from the top of the bed			or in the bed accessory itself with no		
		a pillow in line with the			immediate concerns noted. The		
		transfer handle was a 24			resident □s bed accessory & devices		
	-	ide by 24 inches tall metal			including the halos, were assessed to		
		icular to the bed. When			determine if they meet the definition of	а	
		bar created 90 degree angle le transfer handle was			restraint by the nursing management		
		rame per the manufacture			team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor).		
	instructions.	ame per the manufacture			This task was completed after		
	mondono.				Administrator and nursing leadership		
	Interview with Nursin	g Assistant (NA) #2 on			team (leadership team consists of		
		revealed that she routinely			Director of Nursing, Assistant Director	of	
		t #1 and Resident #1 quite			Nursing, Nursing supervisor, and		
		ide of the bed and she would			Minimum Data Set Coordinators) were	in -	
	have to straighten hir	n back up. NA #2 stated that			serviced by outside RN consultant on		
		ousy body" and would scoot			3/8/17. The training included: 1) the		
	from the middle of the	e bed to that left side of the			definition of a restraint as any device		
		ed that because Resident #1			attached to or adjacent to the resident		
	_	s they had been advised to			which limits the residents movement in		
	· •	bed elevated. NA #2 stated			out of a bed based that on that residen		
		pproximately 5:15 PM-5:30			individualized assessment; 2) coding the	iat	
		dining room and NA #1 had			resident S MDS for restraints where		
		ray to his room to assist him stated that immediately NA			applicable; 3) conducting a safety assessment of the device for risk / ben	ofit	
		k into the dining room and			and least restrictive 4) ensuring an	SIIL	
		." NA #2 stated that all the			appropriate physician or therapy order	is	
	_	an to Resident #1's room.			in place for the device; and 5) ensuring		
		en she entered Resident			the clinical record reflects an underlying		
		I tell "he was dead, there			medical condition supporting the use o	- 1	
		e was limp, and his face was			the restraint. If they did, the MDS		
		A #2 stated that Resident			(Minimum Data Set) for that resident w	as	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIMENTILL	DELIABILITATION AND	LINANO CED		1	010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CIR		Р	INEVILLE, NC 28134		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
{F 323}	Continued From page		{F 3	323}			
	bed was elevated bet and Resident #1's chi transfers handle with mattress and the han Resident #1's body wexcept his head which transfer handle. NA # against Resident #1's (pointed to the larynx had to lower the head Resident #1 from the stated that after they the transfer handle th neck under his chin (pwhere the transfer ha Interview with Nurse revealed that she was Resident #1 on 02/16 arrived for her shift at counted the medication down the hallway to complete #1 stated that at that bed in low position ar elevated and was his stated she had come	dle. NA #2 stated that as lying parallel to the bed n was "hooked" on the 2 stated the bar was tight neck under his chin area) and stated that they I of the bed to remove transfer handle. NA #2 removed Resident #1 from ere was a red area on his pointed to larynx area)			coded appropriately, and the care plan updated to reflect same by the MDS (Minimum Data Set) Coordinators. Thi was completed by 3/9/17. On 2/17/17, an assessment was performed by the Interdisciplinary Team on each resident with any assistive device, including side rails and halos. Based on that assessment, fourteen (1 residents based upon their current abilities and conditions were determine to be appropriate for change to alternat less restrictive bed accessory, such as assist bars or halos and those devices were ordered on 2/17/17 by the maintenance department for installation upon delivery. Delivery is expected by 03/10/17. On 3/8/17 after training by ar outside consultant (as described herein the IDT (Interdisciplinary Team) again assessed and reviewed each resident use of any bed accessory including but not limited to side rails and halos. Bed accessory is defined as any item e.g. fixtures such as handrails, grab bars, a devices/equipment such as transfer lifts canes, and wheelchairs, etc. that is use	s 4) d tive n n n), s : nd s,	
	looked in on Resident alive and well. Nurse completed her medical into the dining room to she could assist reside #1 stated that at approper took Resident #1's trawith the meal. Nurse NA #1 came running	t #1 and he was he was #1 stated that after she ation pass she had gone o wait for the dinner trays so lents with the meal. Nurse oximately 5:15 PM NA #1 by to his room to assist him #1 stated that immediately back to the dining room rse #1 stated that all the staff			by, or in the care of a resident to promo supplement, or enhance the resident supplement of use on 03/08/17 included a review of the resident supplement clinical record, staff interviews regarding how /if resident use the accessory, and resident observation was performed by a licensed nurse. The has resulted in the removal of assistive devices for all but 12 residents. As of	ote, s ne sed n nis	
ORM CMS-256		Resident #1's room. Nurse	12	Fai	3/8/17, upon arrival, any assistive device		t Page 27 of 39

OLIVILIV	O T OIT MEDIO TITE &	MEDIO/ ND OLIVIOLO				OIVID IT	3. 0000 000 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		345415	B. WING			03/	/14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
50.50				10	010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	LIVING CTR		Р	INEVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 323}	Continued From page	e 27	{F 3	323}			
,		around the side of the bed	, ,		will be assessed by nursing manageme	≥nt	
		laying on the floor parallel to			team (Director of Nursing, Assistant	,11t	
		firmly between the transfer			Director of Nursing, Nurse Supervisor,	all	
		between the transfer handle			whom received training by outside		
	and the mattress. Nu	urse #1 stated that she had			consultant on 3/8/17 using the		
	summoned the ADO	N because she had no idea			pre-restraint assessment tool to		
	what to do. Nurse #1	stated that she did confirm			determine if device is a restraint based		
	that Resident #1 had	expired with no respiration			upon the resident□s individualized		
	and had a Do Not Re	suscitate order in place. The			assessment. If they are restraints, the		
		to place Resident #1 back in			MDS (Minimum Data Set) will be coded	Ł	
		post mortem care. Nurse #1			accordingly and the care plan updated		
		had to lower the head of the			MDS (Minimum Data Set) Coordinators		
		ent #1 from the transfer			This will include the alternative devices	tor	
		ted she had notified the			the 14 residents mentioned above.		
	that Resident #1 had	family, and the physician			Resident #1 had a 24-inch-long x 4-inch-wide transfer handle attached to		
	that Resident #1 had	expired.			his bed which was not assessed by sta		
	Interview with NA #3	on 02/27/17 at 4:39 PM			to determine if it was a physical restrain		
		tinely cared for Resident #1			The assessment as we described here		
		pproximately 3:45 PM she			examines all bed devices, including		
	1	nent care to Resident #1. NA			transfer handles, to determine if they w	ere	
		she entered his room he was			restraints based upon the resident □s □		
	lying on his side on the	ne left side of the bed and			individualized assessment. Where they		
	she had to reposition	him near the middle of the			were determined to be a restraint the		
	bed and after providir	ng care and repositioning			resident MDS and care plan was update	ed	
		raised the head of his bed			appropriately.		
		was in low position and left					
		ed that Resident #1 favored			As of 3/8/17 and going forward, any		
		d and generally about 3			device determined to be ineffective or a	3	
	-	she would have to go in and			safety issue by IDT (Interdisciplinary	vill	
	-	1 near the middle of the bed scoot to the left side. NA #2			Team) shall be removed; the resident we then be assessed by the IDT	V111	
	-	vould rest his head on the			(Interdisciplinary Team) for an alternati	VA	
	-	vould rest his head on the			intervention. Resident care plans will be		
		w his legs off the side of the			updated accordingly by the IDT and dir		
	bed. NA #3 stated that				care staff will be informed via the care		
		M the staff was in the dining			guide. All nursing staff have been train	ied	
		taken Resident #1's tray to			on this by 3/9/17. Any nursing staff wh		
		n with the meal. NA #3			was not present for training or are PRN		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345415	B. WING			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	010 LAKEVIEW DRIVE		
PINEVILL	E REHABILITATION AND	LIVING CTR		P	PINEVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 323}	Continued From page	e 28	{F 3	323}			'
		ely NA #1 came running back		٠,	will not be allowed to return to work and	d	
	to the dining room and stated "Resident #1 is				patient care until this training has been	-	
		mped up and ran to his			completed by them.		
		nat when she entered his					
	room she could tell R	esident #1 was dead, she			Resident #1 □s bed did not malfunction		
	stated he was very pa	ale and white in color. NA #3			nor have a device failure; therefore, it v	vas	
	stated Resident #1's	body was lying on the floor			not necessary to take the bed out of		
		s chin was between the			service. The bed is not currently in use	by	
	transfer handles with				any resident and will be assessed for		
		ess. NA #3 stated that there			accessory needs prior to placement of		
	was a red line where				resident; transfer handles were remove	: d	
		nder his chin (pointed to			from the bed on 3/1/17.		
		had to lower the head of the			All residents in the facility with a bed		
		ent #1 from the transfer that his bed was in the low			accessory or physical restraint were	for	
		I of the bed was just as she			assessed using the Initial Assessment Use of Physical Restraint tool by	101	
	had left it earlier after				DON/Nursing Management team		
	Tidd for it carrier after	rendering date.			(includes ADON, Nursing Supervisor, a	ind	
	Interview with the Dire	ector of Maintenance on			MDS coordinators) by 3/9/2017. This		
		I revealed that on 01/04/17			included the following elements: 1)		
		v bed for the facility. On			assessing each bed accessory based		
		I arrived to the facility and on			upon the resident individualized		
		e assembled the new bed			resident assessment to determine		
	which included the Tr	ansfer handle. The Director			whether it constitutes a restraint for tha	ıt	
	of Maintenance state	d that the new bed had			resident; 2) ensuring that all residents v	with	
	come with Transfer ha	andles and he attached			any assistive device have been coded	on	
	them to the bed per tl	ne manufacturer instructions			the MDS as having a potential restraint	:; 3)	
	and once the bed was	s assembled the bed was			ensuring that all residents with a restra	int	
	1	oom until someone needed			have the MDS coded as such; 4) ensur		
		of Maintenance stated that			a safety assessment for all such reside	nts	
	· ·	nt #1 needed a new bed and			is completed and documented; 5)		
		d the bed with the Transfer			ensuring a physician order and/or		
		igned it to Resident #1. The			physician/therapy order is in place for		
	Director of Maintenan				such device and 6) ensuring the clinica	ıl	
	_	ning Resident #1 to the bed			record contains documentation of a		
	with the Transfer Han				medical condition warranting the use of	Į.	
		o his knowledge the beds			such device.		
	were just switched ar	nd was not sure that there			A physician order for every resident wit	h a	
	: vvaa anviiillu vviollu V	VIIII IIIG UIU UGU.	1		T A DITABLE OF THE TOT CALL A LEGICIENT MIL		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345415	B. WING _			03/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BILLEY (1) 1				1	010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CTR		P	PINEVILLE, NC 28134		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 323}	Continued From page	e 29	{F 3	23}			
				ĺ	bed accessory or physical restraint was	s	
	Interview with the hos	spice nurse on 02/28/17 at			obtained by nursing management team		
		at she routinely visited			3/9/17 that includes use of	- ,	
		no involvement in assigning			device/accessory or physical restraint a	and	
		. The hospice nurse stated			presence of medical symptom/conditio		
		visit Resident #1 was usually			for device/accessory to assist with		
	found him lying on his	s left side with his head			protecting the resident □s safety, and h	elp	
	resting on the top upp				the resident attain the highest level of		
		nurse stated that she would			his/her physical or psychological		
		ne middle of the bed but			well-being.		
		iggle back to the left side of					
	•	nurse stated she had no			All residents in the facility with a bed		
		ent #1's preferred position of			accessory or physical restraint care pla		
	_	ne transfer handle and if she			shall be reviewed and updated by IDT 3/9/17 to reflect use of bed	by	
		concerns she would have the facility staff. The hospice			accessory/restraint.		
	·	sident #1 also seemed to be			accessory/restraint.		
		ously preferred the left side			A modification MDS (Minimum Data Se	2†)	
		nurse stated she had visited			will be completed by MDS (Minimum D	•	
	•	02/15/17 and he was his			Set) team by 3/9/17 to reflect the use of		
	usual self.				bed accessory/restraint, and the MDS		
					(Minimum Data Set) restraint information	on	
	Interview with NA #1	on 02/28/17 at 3:39 PM			will be transferred to the resident □s ca	re	
		tinely cared for Resident #1			plan.		
	,	oproximately 5:10 PM she			A QAPI (Quality Assurance Performance)		
	_	m and when the trays arrived			Improvement) subcommittee was form		
		ent #1's tray down the hall to			this committee consulted with the Medi		
		n with the meal. NA #1			Director on 3/1/17 and again on 3/9/17		
		entered the room she saw			regarding all required components of the	те	
	_	ere outside of the bed. Nurse			Credible Allegation, and the citations		
	_	of to the bedside she saw			issued by North Carolina Department of		
		chin between the transfer between the handle and the			Health. The subcommittee consists of Administrator, DON (Director of Nursin		
		ourple in the area of his neck			ADON (Assistant Director of Nursing),	y <i>)</i> ,	
		ed to larynx area). NA #1			MDS (Minimum Data Set) Coordinators	s	
		but I knew that he was			The Subcommittee shall meet monthly		
		s making no noises, he was			and as needed x 3 months to ensure t		
	_	NA #1 stated she ran and			Credible Allegation, 2567 (upon receip		
		e rail is choking him come			and Plan of Correction is followed and		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345415	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	0.0.1.0			TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	14/2017
	10115211 011 001 1 2.2.1				010 LAKEVIEW DRIVE		
PINEVILLI	E REHABILITATION AND	LIVING CTR			INEVILLE, NC 28134		
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 323}	Continued From page	e 30	{F 3	23}			
		describe the choking NA #1 nhis neck, his neck was			facility is in compliance.		
		d he could not get out of the			F Tag 323 focuses on accident/hazards		
		at the head of the bed was			As reflected above, the assessment we		
		to lay the head of his bed			have described includes assessing not		
		om the transfer handle. Na			is the least restrictive and poses any	er it	
		was blueish/purplish bruise			safety concerns.		
		me area (points to larynx					
	area) where the trans	sfer handle had been.			Identification of other residents:		
	On 02/28/17 at 4:20 PM In an interview with the				All residents with bed accessories		
					determined to be a restraint based upo		
					for this alleged deficient practice.	IISK	
	Administrator she stated that the assist rail was 4 inches wide and physically impossible to get your head stuck. The Administrator stated she had not re-enacted the scene as Resident #1's body was				ioi uno anogea aonoiem praesioe.		
					Measures for systemic change:		
	still present in the fac	sility at the time, however she			Administrator and facility leadership tea		
	used charts to simula				(leadership team consists of Director o	f	
	Administrator failed to				Nursing, Assistant Director of Nursing,		
	incident.	ing the circumstances of the					
	incluent.				Registered Nurse consultant on 3/8/17		
	The Administrator wa	s notified of Immediate			The training included: 1) the definition		
	Jeopardy on 02/28/17	7 at 4:20 PM.			restraint as any device attached to or	TY, STATE, ZIP CODE VE 134 DER'S PLAN OF CORRECTION DORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) Impliance. Uses on accident/hazards. Soove, the assessment we dincludes assessing not e is a restraint but whether it extrictive and poses any ins. In other residents: With bed accessories be a restraint based upon lized assessment are at risk dideficient practice. Systemic change: and facility leadership team farm consists of Director of extrant Director of Nursing, visor, and Minimum Data fors) in serviced by outside forse consultant on 3/8/17. Cluded: 1) the definition of a by device attached to or for resident which limits the former in or out of a bed find that resident is individualized by coding that resident is for the device for risk / benefit fictive 4) ensuring an formit is a device; and 5) ensuring ford reflects an underlying formit is a device; and 5) ensuring ford reflects an underlying formit is a device; and 5) ensuring ford reflects an underlying formit is a device; and 5) ensuring formit is a device; and 5) ensurin	
					adjacent to the resident which limits the	Э	
					residents movement in or out of a bed		
					where applicable; 3) conducting a safe		
					assessment of the device for risk / ben	•	
					and least restrictive 4) ensuring an		
					appropriate physician or therapy order		
					in place for the device; and 5) ensuring		
					the clinical record reflects an underlying	•	
					medical condition supporting the use o		
					allowed to return to the floor and reside		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	(>	(3) DATE SURVEY COMPLETED	
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		345415	B. WING _			03/14/2017	_
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEVILL	E REHABILITATION AND	LIVING CTR	1010 LAKEVIEW DRIVE				
				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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	٧
{F 323}	Continued From page	e 31	{F 32	care until this training has been completed. Then, all nursing staff shall be in by Director of Nursing, Assistant of Nursing, or Nurse Supervisor on 1) the definition of a restraint device attached to or adjacent to resident which limits the resident movement in or out of a bed base on that resident care until this has been completed. Beginning on 3/8/17, nursing staff shall be in-serviced in the restrictive intervention by 3/8/17 nursing staff who was absent or re nata) will be allowed to return floor and resident care until this has been completed. Beginning on 3/8/17, nursing staff shall per intervention by 3/8/17, nursing staff or out or out of the per intervention in the per intervention in the per intervention in the per intervention by 3/8/17 nursing staff who was absent or re nata) will be allowed to return floor and resident care until this has been completed.	n serviced at Director of by 3/9/1 t as any to the ont □s sed that d dent □s sestraints as a safety sk / benefit an y order is ensuring nederlying e use of who was aff will be d resident of use of attorn of ast 7. No r PRN (pronto the straining	t t	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(>	(3) DATE SURVEY COMPLETED	
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		345415	B. WING _			03/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
PINEVILL	E REHABILITATION AN	D LIVING CTR		1010 LAKEVIEW DRIVE			
				PINEVILLE, NC 28134			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 323}	Continued From page	e 32	{F 32	in serviced by Director of N Assistant Director of Nursin bed safety including the use Beginning on 3/8/17, the ID (Interdisciplinary Team) will Physical Restraint Reduction Assessment for all resident accessory at least quarterly any significant change, or a update care plan according Beginning on 3/8/17, the ID (Interdisciplinary Team) will Rail Assessment for all resistide rail at least quarterly, a any significant change, or a update care plan according Beginning on 3/9/17, the faremove all bed accessories resident bed when resident is assigned a different bed handled by maintenance as nursing staff. Administrator education/in-servicing on 3 staff, maintenance staff, and on procedure of notifying mostaff to remove all bed accessed to resident bed when resident is assigned a different bed ends. No nursing, maintenance receptionist who was abservental will be allowed to refloor and resident care until has been completed. How corrective actions will The Director of Nursing, As	ng upon hire of e of restraints. OT I complete on Evaluation its with a bed by, annually, with a needed and gly. OT I complete Sidiatents with a complete sidiatents with a complete sidiatents with a complete sidiatents with a complete sidiatent of the sidiate	th did the did	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	
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NAME OF D	ROVIDER OR SUPPLIER	345415	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2017
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PINEVILL	E REHABILITATION AND	LIVING CTR		PINEVILLE, NC 28134		
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{F 323}	Continued From page	÷ 33	{F 3	Director of Nursing, and/or Nurse Manager will complete an audit to ass any accessory being added to a bed validating: the type of accessory being recommended, an Initial assessment use of Physical Restraint tool has bee completed for the accessory to detern restraint/ability to use, Physician order been obtained, resident is aware of the accessory and can verbalize understanding of the accessory. This audit will be completed five (5) times a week for eight(8) weeks on all resident beds, including new admission and permanently discharged resident beds ensure that a bed accessory has not be added to a bed without going through nursing assessment and approval process, and then continue three (3) that a week for eights (8) weeks, one (1) time a month for a minimum 6 months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has maintal substantial compliance. The audits being completed for both F and F221 will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (time a week for twelve (12) months; the weekly meetings and reviews will ther presented in the Monthly Medical Director reports will be submitted to the Quality Assurance Performance Implementation (QAPI) of the presented Implementation (QAPI)	of for n nine has e has e has t t s, to been the simes me has be ctor The be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER E REHABILITATION AND		b. wine _	S1 10	TREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKEVIEW DRIVE INEVILLE, NC 28134	03/	14/2017
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{F 323}	RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practice.	TE/ACCURATE/ACCESSIB In accepted professional less, the facility must bords on each resident that ented;	{F 3		monthly review for twelve (12) months, making any necessary recommendatio. This process will allow multiple layers of Facility committees to have direct review and over-sight of bed accessories in us within the Facility for a minimum of twe (12) months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee review and determines that the facility has me and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director of Nursing, Medical Director, Unit Management, Regional Clinical Services Director, Director of Social Services, Minimum Director, Maintenance Director, Admissions Coordinator, and Activity Director.	of w se lve s t	3/21/17

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING		X3) DATE SURVEY COMPLETED				
		345415	B. WING			R-C 03/14/2017	,
	ROVIDER OR SUPPLIER E REHABILITATION AND	LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP COD 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134	' E	30.1.1.2011	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLE DATE	TION
{F 514}	Continued From page	e 35	{F 51	4}			
	(iv) Systematically or	ganized					
	(5) The medical recor	rd must contain-					
	(i) Sufficient informati	on to identify the resident;					
	(ii) A record of the res	sident's assessments;					
	(iii) The comprehensi provided;	ve plan of care and services					
	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;						
	(v) Physician's, nurse professional's progre	s, and other licensed so notes; and					
	services reports as re This REQUIREMENT	ogy and other diagnostic equired under §483.50. is not met as evidenced					
	facility failed to provid	iew, and staff interviews the le complete documentation for 1 of 1 resident (Resident		F Tag 514 Res Records □ complete/accurate/accessible Corrective action that will be accomplished:			
	The findings included	:		Resident #1 medical record w on 2/17/17 after Resident #1 v			
	PM read, "Resident wat 5:15 PM. Skin color lying on his left side. bed in low position arbetween 45 and 90 d notified. Resident famphysician was notified.	rote dated 02/16/17 at 11:12 vas observed not breathing r was pale, resident was Floor mats were in place, and head of bed elevated egrees. Hospice nurse hily notified and the d." Signed by Nurse #1.		lying on his left side on the fall the low bed with his head on the handle on 02/16/2017. Reside by LPN (Licensed Practical Nabsent of vital signs; resident (Do Not Resuscitate) and hos PCP (Primary Care Physician immediately notified. Death Caigned by Medical Director on	Il mat besic the transfe ent assesse urse) to be was DNR spice and) ertificate	r ed	

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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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		345415	B. WING				14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	1-1/2017
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PINEVILL	E REHABILITATION AND	LIVING CTR			INEVILLE, NC 28134		
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{F 514}	Continued From page	- 36	(F 5	141			
(,	medical record about		יי	ן ידיי	states cause of death: cardiac arrest,		
	Theulcal record about	tills event.			heart failure, and hypertension.		
	Interview with Nurse:	#1 on 02/27/17 at 3:24 PM			ricart failure, and hypertension.		
		s the nurse taking care of			100% of all residents nursing notes of		
	Resident #1 on 02/16/17 and that she wrote the				residents involved in a significant even	t	
	nurse's note dated 02	2/16/17 at 11:12 PM. Nurse			within the last 30 (thirty) days were		
	#1 stated that at appr	oximately 5:15 PM on			reviewed by the Director of Nursing by		
	02/16/17 she was sur	mmoned to Resident #1's			reading the nursing notes to ensure the	ere	
	room because he was reportedly choking. Nurse				is complete documentation of the incid		
	#1 stated she walked around the side of the bed				by 3/9/17. The review by the Director of		
	and Resident #1 was lying on the floor parallel to				Nursing showed all significant events h		
	the bed with his chin firmly between the transfer				complete documentation. This audit to	ok	
		between the transfer handle			place after the Director of Clinical		
		rse #1 stated that she had ursing Assistant (NA) to get			Operations in - serviced the Director of Nursing, Assistant Director of Nursing,		
		she had no idea what to do.			and Nurse Manager on 3/9/17 on		
	Nurse #1 stated that				completing documentation in the		
	I .	red with no respirations and			resident □s medical record on all		
		citate order in place. Nurse			observations and care provided to the		
		as told by the Assistant			resident, or any changes in the residen	ıt⊡s	
	Director of Nursing (ADON) to only document that they found him unresponsive and to not				medical or mental condition.		
		is found or any details of the			Identification of other residents:		
		ed, "I documented what she			All residents are at risk for this alleged		
	told me to document."				deficient practice.		
	Interview with the AD	ON on 02/27/17 at 11:50 AM			Measures for systemic change:		
		s summoned to Resident			Director of Clinical Operations in -		
	#1's room by staff and				serviced the Director of Nursing, Assist		
	I .	he was informed by Nurse			Director of Nursing, and Nurse Manage		
		vas a hospice patient with a			on 3/9/17 on completing documentation	n in	
		order in place and he had			the resident s medical record on all		
	expired. The ADON s				observations and care provided to the	st⊐o.	
	"concerns" with the w	-			resident, or any changes in the residen medical or mental condition.	แ⊔ร	
	positioned and she re	ADON stated she did not			Director of Nursing and Assistant Direc	etor	
		staff what to document.			of Nursing in-serviced all nursing staff		
	Toodii instructing the s	stan what to document.			3/9/17 on completing documentation in		
	Interview with the Adı	ministrator on 02/27/17 at			the resident s medical record on all		
						,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245445	B. WING			1	-C	
NAME OF D	POVIDED OD SLIDDI IED	345415	B. WING _	STI	PEET ADDRESS CITY STATE 7ID CODE	03/	14/2017	
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 DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	OULD BE COMPLETION		
{F 514}	the staff had notified that they were being and what not to char that the individual wh employee what to do action and was instru	nat during the investigation the Director of Operations instructed as to what to chart t. The Administrator stated no allegedly instructed the ocument was given corrective acted that she could not do ee was free to document	{F 5	114}	observations and care provided to the resident, or any changes in the resident medical or mental condition. No nursing staff who was absent or PRN (pro rent staff will be allowed to return to the floor and resident care until this in-servicing has been completed. How corrective actions will be monitored. The Director of Nursing, Assistant Director of Nursing, and/or Nurse Manager will review 10 random clinical records for documentation of any significant event to assure the clinical record contains complete documentation the resident smedical record on all observations and care provided to the resident, or any changes in the resident medical or mental condition. This audit be completed five (5) times a week for eight weeks (8), five (5) times a week for eight (8) weeks, three (3) times a week four (4) weeks, and one (1) time a mon for a minimum 6 months and will continuntil the Quality Assurance/ Performant Improvement (QAPI) committee review and determines that the facility has maintained substantial compliance. The audits being completed for both F3 and F221 will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (1 time a week for twelve (12) months; the weekly meetings and reviews will then presented in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Director reports will be reviewed in the Monthly Medical Direct	g ata) or ed: on tts will or of for oth oue ce ss 323) ese be ctor ine		

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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		
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{F 514}	Continued From page	ge 38	{F 514	submitted to the Quality Assurance/Performance Implee (QAPI) for monthly review for to months, making any necessary recommendations. This proces multiple layers of Facility comm have direct review and over-sig accessories in use within the F minimum of twelve (12) months continue until the Quality Assur Performance Improvement (QA committee reviews and determ the facility has met and maintal substantial compliance. The Quality Assurance Perform Improvement committee partice includes, but is not limited to, Administrator, Director of Nursi Medical Director, Unit Manager Regional Clinical Services Director Director of Social Services, Mir Set (MDS) Coordinator, Culina Director, Maintenance Director Admissions Coordinator, and A Director.	twelve (12 y y ss will allo mittees to ght of bed acility for is and will irrance/API) nines that ained mance sipation sing, extern, nimum Daary Servicer,	eta