TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RVEY 'ED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE 345282 B. WING 03/15/2 NAME OF PROVIDER OR SUPPLIER B. WING 03/15/2 CLEVELAND PINES 1404 N LAFAYETTE STREET STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY CC F 550 Resident Rights/Exercise of Rights SS=D CFR(s): 483.10(a) (1)(2)(b)(1)(2) F 550 4/1 Ş483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. F 550 \$43.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and Image: Communication with and access to person graining each resident's individuality. The facility must protect and Image: Communication with and access to person grain the environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and Image: Communication with and access to person grain the addingon the	(X5) (X5) COMPLETION
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resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	
promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	
her quality of life, recognizing each resident's individuality. The facility must protect and	
promote the rights of the resident.	
§483.10(a)(2) The facility must provide equal	
access to quality care regardless of diagnosis,	
severity of condition, or payment source. A facility	
must establish and maintain identical policies and	
practices regarding transfer, discharge, and the	
provision of services under the State plan for all	
residents regardless of payment source.	
§483.10(b) Exercise of Rights.	l
The resident has the right to exercise his or her	ſ
rights as a resident of the facility and as a citizen	
or resident of the United States.	
§483.10(b)(1) The facility must ensure that the	ſ
resident can exercise his or her rights without	ſ
interference, coercion, discrimination, or reprisal	ſ
from the facility.	l
	l
§483.10(b)(2) The resident has the right to be	ſ
free of interference, coercion, discrimination, and	ſ
reprisal from the facility in exercising his or her rights and to be supported by the facility in the	l
	DATE

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.

04/04/2018

PRINTED: 04/16/2018

						O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED	
		345282	B. WING		0;	C 03/15/2018	
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
CLEVELA				1404 N LAFAYETTE STREET			
CLEVELA	ND FINES			SHELBY, NC 28150			
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 550	Continued From page	e 1	F 55	50			
	exercise of his or her subpart.	rights as required under this					
	by: Based on observatio and staff interviews th the dignity of a reside care for a resident (R dignity and respect. The findings included Resident #7 was adm 08/08/13 with diagnos Parkinson's disease, panic disorder, anxiet Review of Resident # dated 09/13/17 revea adequate vision with understands, and an	ns, record review, resident ne facility failed to maintain ent by providing incontinence resident #7) reviewed for : hitted to the facility on ses which included degenerative joint disease, ty and others. ?7's comprehensive MDS filed the resident had glasses, understood, assessment by the facility of fily decision making. The		Preparation and/or execution of of Correction does not constitut admission or agreement by the the truth of the facts alleged or conclusions set forth in this stat deficiencies. The Plan of Correc prepared and/or executed solely it is required by the provisions of and State law. F550 SS=D The plan of correcting the speci deficiency. The plan should add processes that lead to the defic cited: During the complaint survey end	e provider of ement of ction is y because of Federal frederal		
	extensive assistance toileting and persona incontinent of bowel a Review of Resident #	of one with dressing, I hygiene and was frequently		3/15/18, a surveyor interviewed #7 and determined that nurse a to perform a basic nurse aide sl providing timely incontinence ca Resident #7 was interviewed by Director of Nursing to ensure co	Resident ides failed kill of are. / the		
	assistance of 2 with b assistance of one wit personal hygiene.	bed mobility, extensive h dressing, toileting and		were addressed. All nursing sta provided education regarding de of assigned duties.	aff were elegation		
	revealed she was car goal was for the resid ability to assist in dail	7's care plan dated 03/15/18 re planned for ADL. The lent to maintain current y care through the next		The procedure for implementing acceptable plan of correction fo specific deficiency cited:	r the		
	review. Interventions assistance of one for	dressing, toileting and		Facility Educator provided inser nursing staff and nursing assist			

Facility ID: 923107

If continuation sheet Page 2 of 31

PRINTED: 04/16/2018

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,	E CONSTRUCTION	(X3) DATE	
NU PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		345282	B. WING	C 03/15/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	15/2010
				1404 N LAFAYETTE STREET		
CLEVELA	ND PINES			SHELBY, NC 28150		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 550	Continued From page	- 2	F 550			
	personal hygiene and		1 000	expectation to provide timely incon	tinence	
				care. Any staff members who do no		
	An interview was con	ducted with Resident #7 on		receive the training by the specified		
	03/15/18 at 10:26 AM	 Resident #7 stated she 		(due to FMLA, leave, etc.) will be re		
		was enough staff at the		to complete training prior to workin	ga	
		her. She stated she had		scheduled shift.		
	-	the staff to put her on the				
	bedpan or help her to	She stated when she had		The monitoring procedure to ensur the plan of correction is effective an		
		humiliated" because she		specific deficiency cited remains co		
		pan in time to prevent an		and/or in compliance with the regul		
	accident. She stated			requirements:		
		d often come in and turn the				
	light off and then say	they would be back but it		To evaluate compliance with reside	ents	
		an hour before they came		receiving timely incontinence care,		
	-	as too late she had already		Director of Nursing or designee wil		
		e stated she knew she		conduct resident interviews weekly		
		use she timed it by her		10% of the interviewable residents		
		stated she had seen her NA nat was when she came in to		weeks. At the conclusion of 4 week conduct resident interviews bi-wee		
		ir. Resident #7 stated the		six weeks, with 10% of the intervie	-	
	- ·	e much more respectful		residents. Any identified issues will		
		e facility about 5 years ago		addressed through the progressive		
		and stated maybe it was		discipline process. Results of the		
	because they were se			monitoring will be shared with the		
				Administrator and Director of Nursi	ng on a	
	An interview with Nur			weekly basis and with QAPI month	ly.	
		revealed she typically			,	
		#12 stated when they		The title of the person responsible		
		mpossible to give all the		implementing the acceptable plan of correction.	JI	
		continence rounds every 2 fed and turned and get				
		two assists up for the day.		The Director of Nursing will be		
	She stated they were			responsible for oversight for this pla	an of	
	-	clock out on time. NA #12		correction. Date certain 4/12/18.		
	stated that Resident	#7 had wet her brief and had				
	bowel movement bef	-				
		hroom or waiting for the				
	bedpan. NA #12 stat	ed they had been told if a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLE C NAME OF PROVIDER OR SUPPLIER 345282 B. WING 03/15 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1404 N LAFAYETTE STREET SHELBY, NC 28150 5 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION 1	04/16/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1404 N LAFAYETTE STREET 1404 N LAFAYETTE STREET CLEVELAND PINES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION E F 550 Continued From page 3 resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7 F 550 F 550	SURVEY ETED
1404 N LAFAYETTE STREET SHELBY, NC 28150 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 3 resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7 F 550	5/2018
CLEVELAND PINES SHELBY, NC 28150 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 3 resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7 F 550	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 3 resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7 F 550	
resident was wet and they could not change her before their shift was over they were to leave her for the next shift and clock out on time and she stated this too had happened to Resident #7	(X5) COMPLETION DATE
	4/12/18
SS=E CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive	-

Facility ID: 923107

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345282	B. WING				C 15/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
CLEVELA	ND PINES				404 N LAFAYETTE STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T				DN SHOULD BE COMPL DE APPROPRIATE DA		
F 676	assessment of a resider resident's needs and provide the necessary ensure that a residen daily living do not dim of the individual's clin that such diminution wincludes the facility er §483.24(a)(1) A resid treatment and service or her ability to carry of living, including those of this section §483.24(b) Activities of the facility must prov accordance with para activities of daily living §483.24(b)(1) Hygien grooming, and oral ca §483.24(b)(2) Mobility including walking, §483.24(b)(3) Elimina §483.24(b)(4) Dining- snacks, §483.24(b)(5) Commu (i) Speech, (ii) Language, (iii) Other functional c This REQUIREMENT by: Based on observatio	dent and consistent with the choices, the facility must y care and services to t's abilities in activities of iinish unless circumstances ical condition demonstrate was unavoidable. This nsuring that: ent is given the appropriate es to maintain or improve his out the activities of daily specified in paragraph (b) of daily living. ide care and services in graph (a) for the following g: e -bathing, dressing, are, y-transfer and ambulation, ation-toileting, eating, including meals and	F	676	F676 SS=E			

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PRINTED: 04/16/2018

		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDIN	G		
		345282	B. WING			C
		545262		STREET ADDRESS, CITY, STATE, ZIP		/15/2018
NAME OF PR	ROVIDER OR SUPPLIER			1404 N LAFAYETTE STREET	CODE	
CLEVELA	ND PINES			SHELBY, NC 28150		
						1
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 676	Continued From page	e 5	F 6	76		
		dent (Resident #5), personal				
		lent (Resident #7), turning		The plan of correcting the	specific	
		ne resident (Resident #6),		deficiency. The plan shoul	•	
		are for four residents		processes that lead to the	deficiency	
	•	7, and #8) and assistance		cited:		
	5	resident (Resident #9)		During the second sint surry		
	reviewed for activities	s of daily living (ADL).		During the complaint surve 3/15/18, surveyors intervie	, ,	
	The findings included	4.		#5, #7, #6, #4, #8, and #9		
		-		that nurse aides failed to p		
	1. Resident #5 was a	admitted to the facility on		resident⊡s Activities of Da		
	10/16/2017 with diag	noses which included		(ADLs). Those ADLs inclu	ded the	
	diabetes mellitus, type2, depression, fibromyalgia,		following: assisting with sh			
	anxiety disorder and	others.		assisting with personal hy		
				with turning and positionin		
	Review of Resident #	Fo's comprehensive Data Set (MDS) dated		incontinence care; assista bathing. Resident #7, #5,		
		assessment by the facility		#9 were interviewed by th		
	of moderately impair	, ,		Nursing to ensure concern		
		e MDS also revealed		addressed. All nursing sta		
	Resident #5 required	I limited to extensive		provided education regard	ling delegation	
		ADL and required extensive		of assigned duties.		
	assistance of one wit	th bathing.				
	Review of Resident #	#5's Care Area Assessment		The procedure for implement	enting the	
		ADL dated 10/27/17 revealed		acceptable plan of correct	-	
		the facility following a		specific deficiency cited:		
	hospitalization for we	eakness and sudden				
		alert and able to verbalize		Facility Educator provided		
		weak. Resident #5 currently		nursing staff and nursing a		
	-	ssistance from staff with bed		expectation to assist with		
	mobility, toileting and	sfers and dressing. Resident		bathing, personal hygiene positioning, and provide tir		
		aff assistance with ADL care		incontinence care. Any sta	-	
	due to her chronic m			who do not receive the tra		
	weakness.			specified date (due to FMI		
				will be required to complet	-	
		#5's care plan dated 02/09/18		to working a scheduled sh		
		re planned for ADL. The			iit.	

Facility ID: 923107

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345282 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1404 N LAFAYETTE STREET **CLEVELAND PINES** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 676 Continued From page 6 F 676 goal was for the resident to maintain her current The monitoring procedure to ensure that ability to assist in daily care through the next the plan of correction is effective and that review date. The interventions included extensive specific deficiency cited remains corrected assistance for bathing and others. and/or in compliance with the regulatory requirements; An interview was conducted with Resident #5 on 03/15/18 at 10:13 AM. Resident #5 stated she To evaluate compliance with residents had started washing herself off in the mornings receiving assistance with showers, because the staff had not had time to assist her bathing, personal hygiene, turning and with getting a shower. The resident stated it felt positioning and timely incontinence care, really good to get a shower but the staff don't Director of Nursing or designee will have time to help her get one. She stated she conduct resident interviews weekly, with had never refused a shower. 10% of the interviewable residents, for 4 weeks. At the conclusion of 4 weeks, will Review of a bath report for 03/01/18 through conduct resident interviews bi-weekly for 03/15/18 revealed Resident #5 had missed her six weeks, with 10% of the interviewable shower on 03/08/18 and she had not refused her residents. Any identified issues will be shower. addressed through the progressive discipline process. Results of the monitoring will be shared with the An interview with Nurse Aide (NA) #12 on 03/15/18 at 2:55 PM revealed she typically Administrator and Director of Nursing on a worked first shift. NA #12 stated when they weekly basis and with QAPI monthly. worked short it was impossible to give all the showers, complete incontinence rounds every 2 The title of the person responsible for hours, get everyone fed and turned and get implementing the acceptable plan of residents that require two assists up for the day. correction. She stated they were not allowed to have overtime and had to clock out on time. The NA The Director of Nursing will be stated they had been told if a resident was wet responsible for oversight for this plan of correction. Date certain 4/12/18. and they could not change her before their shift was over they were to leave her for the next shift and clock out on time. An interview with Nurse #5 on 03/15/18 at 3:43 PM revealed she typically worked first shift. The nurse stated it was hard to get everything done on first shift. She stated staffing seemed to be determined by the census and not acuity of the residents. The nurse stated there were always

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 04/16/2018

CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 04/16/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				SURVEY LETED
		345282	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEVELA	ND PINES				404 N LAFAYETTE STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 676	 3-4 times weekly. The for them to help the N much of their own worshe was aware all show were not done, reside hours and incontinence every 2 hours. She sight they could in caring for An interview with the a (ADON) and Director 03/815/18 at 3:32 PM residents to receive the 2. Resident #7 was ac 08/08/2013 with diagr Parkinson's disease, anxiety and others. Review of Resident #7 comprehensive MDS assessment by the far daily decision making Resident #7 required for personal hygiene. Review of Resident # dated 09/27/17 reveal assistance with dress hygiene. Review of Resident # revealed she was care goal was for the residability to assist in daily review date. The interview date. 	h the NAs and it happened e nurse stated it was hard IAs because they had so rk to do. The nurse stated owers and personal hygiene ents were not turned every 2 ce care was not provided tated the staff did the best or the residents. assistant Director of Nursing of Nursing (DON) on I revealed they expected heir showers as scheduled. dmitted to the facility on hoses which included degenerative joint disease, 7's most recent dated 09/13/17 revealed an cility of intact cognition for . The MDS also revealed extensive assistance of one	F	676			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345282	B. WING			_		C 15/2018
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
CLEVELA					1404 N LAFAYETTE STREE	ET		
					SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	03/15/18 at 10:35 AM was just now getting of the NA had been in to hurried through dress chair and left. Reside comb her hair when s they never comb her l to do due to her Parki joint disease. An interview with NA s revealed she was taki she had gotten her up wheelchair. NA #9 st Resident #7's hair and forgotten to do it while An interview with Nurs PM revealed she typic nurse stated it was had on first shift and some could take up to 3 or 3 staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for because they had so do. The nurse stated and personal hygiene were not turned every care was not provided the staff did the best t residents. An interview with the	ducted with Resident #7 on . Resident #7 stated she up for the day. She stated help her get dressed and ing her and got her up in the ent #7 stated the NA did not he got her up, and stated hair and it is difficult for her nson's and degenerative #9 on 03/15/18 at 2:34 PM ing care of Resident #7 and o for the day in her ated she had not combed d stated she just had e she was in the room. se #5 on 03/15/18 at 3:43 cally worked first shift. The ard to get everything done etimes medication pass 3 ½ hours. She stated determined by the census residents. The nurse stated Il-ins especially with the NAs imes weekly. The nurse them to help the NAs much of their own work to she was aware all showers were not done, residents 2 hours and incontinence d every 2 hours. She stated hey could in caring for the	F	670	5			
	(ADON) and Director	-						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/16/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING		_		C 15/2018
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				1404 N LAFAYETTE STRE	ET		
CLEVELA	ND PINES			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676		e 9 Issistance with their personal	F 676	3			
	04/07/17 with diagnos disc disease with neu	dmitted to the facility on ses which included cervical irologic compromise to lower ention, muscle weakness, ers.					
	dated 04/14/17 revea facility of intact cognit making. The MDS als	6's comprehensive MDS led an assessment by the tion for daily decision so revealed Resident #6 ssistance of two with bed					
	revealed she was car goal was for the resid 3 times weekly and for through the next revie extensive assistance	6's care plan dated 12/25/17 re planned for ADL. The lent to be out of bed at least or ADL needs to be met daily ew. Interventions included of 2 for bed mobility, mal hygiene and dressing					
	03/15/18 at 10:26 AM came in to turn her ur change her brief and during the day from n stated she usually ge about 2 hours a day e stated there was not e	ducted with Resident #6 on I. Resident #6 stated no one nless they came in to she stated she got very stiff ot moving. Resident #6 ts up out of the bed for except the weekends. She enough help at the facility on her up out of bed and by					

Facility ID: 923107

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			0.00			IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A. DOILDING			С
		345282	B. WING		0	3/15/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLEVELA	ND PINES			1404 N LAFAYETTE STREET SHELBY, NC 28150		
				PROVIDER'S PLAN OF COR	DECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 676	Continued From page	e 10	F 67	6		
	Monday she was very of bed.	y stiff from not getting up out				
	03/15/18 at 2:55 PM worked first shift. NA worked short it was in showers, complete in hours, get everyone f residents that require She stated they were overtime and had to o stated they had been and they could not ch was over they were to and clock out on time An interview with Nur PM revealed she typi	interview with Nurse Aide (NA) #12 on 15/18 at 2:55 PM revealed she typically ked first shift. NA #12 stated when they ked short it was impossible to give all the owers, complete incontinence rounds every 2 ars, get everyone fed and turned and get idents that require two assists up for the day. e stated they were not allowed to have ertime and had to clock out on time. The NA ted they had been told if a resident was wet at they could not change her before their shift is over they were to leave her for the next shift				
	on first shift and some could take up to 3 or staffing seemed to be and not acuity of the there were always ca and it happened 3-4 t	etimes medication pass 3 ½ hours. She stated e determined by the census residents. The nurse stated ill-ins especially with the NAs times weekly. The nurse				
	because they had so do. The nurse stated and personal hygiene were not turned every care was not provide	them to help the NAs much of their own work to I she was aware all showers e were not done, residents y 2 hours and incontinence d every 2 hours. She stated they could in caring for the				
	(ADON) and Director 03/15/18 at 3:32 PM	assistant Director of Nursing of Nursing (DON) on revealed they expected d and positioned timely and				

Facility ID: 923107

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	0: 04/16/2018 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	-		LETED
	345282	B. WING				C 15/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CLEVELAND PINES			1404 N LAFAYETTE STRE SHELBY, NC 28150	ET		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 11/15/17 with diagnos congestive heart failur and others. Review of Resident #4 admission MDS dated assessment by the face daily decision making. Resident #4 required of with toileting and was and bladder. Review of Resident #4 dated 11/27/17 reveal assistance of 2 with to except eating. Review of Resident #4 revealed she was care urinary incontinence. resident to maintain or daily care through the included extensive assistance of 3/14/17 at 4:02 PM. was not enough staff a her. She stated she h changed and it is som she has had a bowel r has had to eat her me 	bed daily. Imitted to the facility on es which included re, arthritis, history of falls 4's comprehensive 11/22/17 revealed an cility of intact cognition for The MDS also revealed extensive assistance of 2 always incontinent of bowel 4's CAA summary for ADL ed she required extensive bileting and most ADL 4's care plan dated 11/30/17 e planned for ADL and for The goal was for the urrent ability to assist in next review. Interventions sistance for toileting and ducted with Resident #4 on Resident #4 stated there at the facility to take care of has to wait on them to get etimes uncomfortable when movement. She stated she al before with a dirty brief a not enough staff to change	F 67	6			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		SURVEY LETED	
		345282	B. WING _					C 15/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODI	E		
CLEVELA				14	04 N LAFAYETTE STREET			
OLLVLLA				Sł	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ŗ.	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 676	worked short it was in showers, complete in hours, get everyone for residents that require She stated they were overtime and had to o stated they had been and they could not ch was over they were to and clock out on time An interview with Nurs PM revealed she typic nurse stated it was had on first shift and some could take up to 3 or 3 staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for because they had so do. The nurse stated and personal hygiene were not turned every care was not provided the staff did the best t residents. An interview with the (ADON) and Director 03/15/18 at 3:32 PM r residents to receive in as needed.	se Aide (NA) #12 on revealed she typically #12 stated when they possible to give all the continence rounds every 2 ed and turned and get two assists up for the day. not allowed to have clock out on time. The NA told if a resident was wet ange her before their shift b leave her for the next shift cleave her for the next shift. Se #5 on 03/15/18 at 3:43 cally worked first shift. The ard to get everything done etimes medication pass 3 ½ hours. She stated determined by the census residents. The nurse stated ll-ins especially with the NAs imes weekly. The nurse them to help the NAs much of their own work to she was aware all showers were not done, residents 2 hours and incontinence d every 2 hours. She stated hey could in caring for the	F 6	76				
	5. Resident #6 was ad	dmitted to the facility on						

Facility ID: 923107

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING			_		C 15/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				1	404 N LAFAYETTE STREE	ET		
CLEVELA	ND PINES			s	SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	04/07/17 with diagnost disc disease with neu extremity, urinary refe chronic pain and other Review of Resident # dated 04/14/17 revea facility of intact cognit making. The MDS als required extensive as and was always incor Review of Resident # dated 04/20/17 revea assistance of 2 with d personal hygiene. Review of Resident # revealed she was car goal was for the resid 3 times weekly and for through the next revise extensive assistance toileting needs, perso and others. An interview was com 03/15/18 at 10:26 AM did not feel like there facility to take care of wait over 30 minutes get changed when sh her brief. Resident # uncomfortable to sit in stated she had somet while having stool in h not provide care until	ses which included cervical rologic compromise to lower ention, muscle weakness, ers. 6's comprehensive MDS led an assessment by the ion for daily decision so revealed Resident #6 sistance of one with toileting ntinent of bowel and bladder. 6's CAA summary for ADL led she required extensive tressing, toileting and 6's care plan dated 12/25/17 e planned for ADL. The ent to be out of bed at least or ADL needs to be met daily ew. Interventions included of 2 for bed mobility, nal hygiene and dressing ducted with Resident #6 on 1. Resident #6 stated she was enough staff at the her. She stated she had to and longer sometimes to e had a bowel movement in 6 stated it was n a brief with stool in it and times had to eat her meals ner brief because they could all the trays were passed knew how long she waited	F	676				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/16/2018 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING		_	(03/	; 15/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CLEVELA				1404 N LAFAYETTE STREE	ET		
CLEVELA	ND FINES			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	Continued From page	2 14	F 67	'6			
	worked short it was in showers, complete in hours, get everyone for residents that require She stated they were overtime and had to o stated they had been and they could not ch was over they were to and clock out on time An interview with Nurs PM revealed she typic nurse stated it was had on first shift and some could take up to 3 or 3 staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for because they had so do. The nurse stated and personal hygiene were not turned every care was not provided the staff did the best t residents. An interview with the s (ADON) and Director	revealed she typically #12 stated when they possible to give all the continence rounds every 2 ed and turned and get two assists up for the day. not allowed to have lock out on time. The NA told if a resident was wet ange her before their shift b leave her for the next shift colleave her for the next shift b leave her for the next shift. The ard to get everything done etimes medication pass 3 ½ hours. She stated determined by the census residents. The nurse stated ll-ins especially with the NAs imes weekly. The nurse them to help the NAs much of their own work to she was aware all showers were not done, residents of 2 hours. She stated hey could in caring for the assistant Director of Nursing					
	residents to receive ir as needed.	ncontinence care timely and					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING					C 15/2018
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				1	404 N LAFAYETTE STREE	г		
CLEVELA	ND PINES			5	SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 676	6. Resident #7 was at 08/08/13 with diagnos Parkinson's disease, panic disorder, anxiet Review of Resident #	dmitted to the facility on ses which included degenerative joint disease, y and others. 7's comprehensive MDS led an assessment by the	F	676				
	making. The MDS als required extensive as dressing, toileting and frequently incontinent	so revealed Resident #7						
	assistance of 2 with b	led she required extensive ed mobility, extensive n dressing, toileting and						
	revealed she was car goal was for the resid ability to assist in dail review. Interventions	dressing, toileting and						
	03/15/18 at 10:26 AM did not feel like there facility to take care of accidents waiting for to bedpan or help her to happened frequently. an accident she felt "H could not get the bed accident. She stated assistance they would	She stated when she had numiliated" because she pan in time to prevent an						

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING					C 15/2018
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				1	1404 N LAFAYETTE STREET	г		
CLEVELA	ND PINES			s	SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 676	back and by then it we had an accident. She waited an hour becau watch. Resident #7 s one time today and th get her up in her chai got her dressed and p not comb her hair. Re and NAs were much r came to the facility ab so much and stated n were so busy now. An interview with Nur 03/15/18 at 2:55 PM r worked first shift. NA worked short it was in showers, complete in hours, get everyone fir residents that require She stated they were overtime and had to o stated they had been and they could not ch was over they were to and clock out on time An interview with Nur PM revealed she typic nurse stated it was had on first shift and some could take up to 3 or staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for	an hour before they came as too late she had already e stated she knew she se she timed it by her stated she had seen her NA hat was when she came in to r. She stated she quickly but her in her chair and did esident #7 stated the nurses more respectful when she bout 5 years ago but now not haybe it was because they se Aide (NA) #12 on revealed she typically #12 stated when they npossible to give all the continence rounds every 2 ed and turned and get two assists up for the day. not allowed to have clock out on time. The NA told if a resident was wet ange her before their shift o leave her for the next shift o leave her for the next shift. se #5 on 03/15/18 at 3:43 cally worked first shift. The ard to get everything done etimes medication pass 3 ½ hours. She stated o determined by the census residents. The nurse stated ll-ins especially with the NAs imes weekly. The nurse	F	676				

Facility ID: 923107

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/16/2018 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE : COMPI	SURVEY LETED
		345282	B. WING			03/1	; 15/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE	E, ZIP CODE		
<u>.</u>			14	04 N LAFAYETTE STREET			
CLEVELA	ND PINES		SI	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 676	and personal hygiene were not turned every care was not provided the staff did the best t residents. An interview with the (ADON) and Director 03/15/18 at 3:32 PM n residents to receive in as needed. 7. Resident #8 was an 06/19/17 with diagnos mellitus, type 2, scolid apnea, paraplegia and Review of Resident # dated 08/31/17 revea facility of intact cognit making. The MDS als required extensive as dressing, toileting and always incontinent of Review of Resident # dated 09/14/17 revea assistance of one with personal hygiene. Review of Resident # revealed she was car goal was for Resident ability to assist in dail review. Interventions assistance with toileti assistance with dress	she was aware all showers were not done, residents 2 hours and incontinence d every 2 hours. She stated hey could in caring for the assistant Director of Nursing of Nursing (DON) on revealed they expected noontinence care timely and dmitted to the facility on ses which included diabetes bis, obstructive sleep d others. 8's comprehensive MDS led an assessment by the ion for daily decision so revealed Resident #8 sistance of one with d personal hygiene and was bowel and bladder. 8's CAA summary for ADL led she required extensive n dressing, toileting and 8's care plan dated 03/04/18 e planned for ADL. The t #8 to maintain current y care through the next included frequently offer	F 676				

Facility ID: 923107

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/16/2018 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING		_	03/ ⁻	; 15/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1,	404 N LAFAYETTE STREE	ET		
CLEVELA	ND PINES		s	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	Continued From page others.	9 18	F 676				
	03/15/18 at 11:27 AM facility needed more f her calls because she still took 30 minutes of brief changed. Resid for water and to be ch while to get assistance by the clock on the wa "once in a blue moon her" but not as a rule. An interview with Nur- 03/15/18 at 2:55 PM r worked first shift. NA worked short it was in showers, complete in- hours, get everyone for residents that require She stated they were overtime and had to of stated they had been and they could not ch was over they were to and clock out on time An interview with Nur- PM revealed she typic nurse stated it was had	se Aide (NA) #12 on revealed she typically #12 stated when they npossible to give all the continence rounds every 2 ed and turned and get two assists up for the day. not allowed to have clock out on time. The NA told if a resident was wet ange her before their shift b leave her for the next shift					
	staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for	3 ½ hours. She stated determined by the census residents. The nurse stated Il-ins especially with the NAs imes weekly. The nurse them to help the NAs much of their own work to					

Facility ID: 923107

If continuation sheet Page 19 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345282	B. WING				C / 15/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEVELA	ND PINES				1404 N LAFAYETTE STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 676	 do. The nurse stated and personal hygiene were not turned every care was not provided the staff did the best for residents. An interview with the (ADON) and Director 03/15/18 at 3:32 PM or residents to receive in as needed. 8. Resident #9 was an 02/23/18 with diagnos hypertension, right tib ramus fracture and ot Review of Resident # dated 03/02/18 revea facility of intact cognit making. The MDS alsextensive assistance supervision of one with hygiene and limited a transfers and was alw bladder. Review of Resident # dated 03/14/18 revea assistance of one with functional limitations of Review of Resident # 02/23/18 revealed sho bladder and bowel co continence level will to maintained to improve 	she was aware all showers were not done, residents 2 hours and incontinence devery 2 hours. She stated they could in caring for the assistant Director of Nursing of Nursing (DON) on revealed they expected nontinence care timely and dmitted to the facility on ses which included ha fracture and left pubic hers. 9's comprehensive MDS led an assessment by the ion for daily decision so revealed she required of one with toileting, th bed mobility and personal ssistance of one with vays continent of bowel and 9's CAA summary for ADL led she required extensive n toileting due to her resulting from her fractures. 9's interim care plan dated e was care planned for ntinence with the goal of be optimal as evidenced by ed bowel/urinary function novements every 3 days.	F	670	6		

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PRINTED: 04/16/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345282	B. WING					C 15/2018
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
				14	404 N LAFAYETTE STREET			
CLEVELA	ND PINES			S	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI		(X5) COMPLETION DATE
F 676	Continued From page elimination status and protocol as needed and continence status and An interview was con- 03/15/18 at 1:31 PM. was at the facility for the accident and surgery during the day the face but night shift was "te her roommate waited longer for assistance stated that she had tift wall. Resident #9 stated the weekends and thi and 03/11/18) and the (03/03/18 and 03/04/7 neglected. Resident # before they received to Saturday 03/10/18 and the room prior to them Resident #9 stated sh getting washed up an AM or so before she a in their basins to wash occupational therapis their basins so they co for therapy. On Sund stated it was hours af trays were picked up water on Sunday so t all day. She stated sh out in the hallway and not answer the lights two of the NAs say "th were beeping in the h	e 20 d bowel management ind monitor for decline in d others. ducted with Resident #9 on Resident #9 stated she rehab following a car on her right leg. She stated cility seemed to be staffed ok rrible." She stated she and sometimes for an hour or to the bathroom. She med it by the clock on the ted it was even worse on s past weekend (03/10/18 e previous weekend 18) she felt they were #9 stated it was 9:30 AM their breakfast trays on id had not seen anyone in n bringing in their tray. ne did not receive help with d on Saturday it was 11:15 and her roommate got water		676				
	and rinsed before she	e could use it again and t flush the toilet after her						

Facility ID: 923107

If continuation sheet Page 21 of 31

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/16/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345282	B. WING			03/	C 15/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
CLEVELA	ND PINES			1404 N LAFAYETTE STRE SHELBY, NC 28150	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	roommate uses it and every time she goes t she would be nervous her, especially on the just was not enough s the residents. An interview with Nurs 03/15/18 at 2:55 PM r worked first shift. NA worked short it was in showers, complete int hours, get everyone for residents that require She stated they were overtime and had to o stated they had been and they could not ch was over they were to and clock out on time An interview with Nurs PM revealed she typic nurse stated it was had on first shift and some could take up to 3 or 3 staffing seemed to be and not acuity of the r there were always cal and it happened 3-4 t stated it was hard for because they had so do. The nurse stated and personal hygiene were not turned every care was not provideo	she has to flush it almost o use it. Resident #9 stated if something happened to weekend because there staff at the facility to care for see Aide (NA) #12 on revealed she typically #12 stated when they npossible to give all the continence rounds every 2 ed and turned and get two assists up for the day. not allowed to have clock out on time. The NA told if a resident was wet ange her before their shift to leave her for the next shift b leave her for the next shift. Se #5 on 03/15/18 at 3:43 cally worked first shift. The ard to get everything done etimes medication pass 3 ½ hours. She stated determined by the census residents. The nurse stated Il-ins especially with the NAs imes weekly. The nurse	F 67	76			

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		MEDICAID SERVICES				38-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURV COMPLETE	
		345282	B. WING		C 03/15/2	018
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COI		010
CLEVELA	ND PINES			N LAFAYETTE STREET ELBY, NC 28150		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COM E APPROPRIATE	(X5) MPLETIO DATE
F 676	An interview with the (ADON) and Director 03/15/18 at 3:32 PM	assistant Director of Nursing	F 676			
F 725 SS=E	§483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and a	(2) Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest	F 725		4/12	2/18
	well-being of each res resident assessments and considering the r diagnoses of the facil	mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility assessment required				
	by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not				
	designate a licensed nurse on each tour of	section, the facility must nurse to serve as a charge				

Facility ID: 923107

If continuation sheet Page 23 of 31

		MEDICAID SERVICES			OMB NO. 0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SU COMPLE	
		345282	B. WING		C 03/15	/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEVELA	ND PINES			1404 N LAFAYETTE STREET SHELBY, NC 28150		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 725	Continued From page	23	F 72	5		
	and staff interviews, t	he facility failed to provide		SS=E		
	(Resident #5), persor (Resident #7), turning done (Resident #6) a	dents reviewed.		The plan of correcting the specific deficiency. The plan should addres processes that lead to the deficience cited: During the complaint survey ending 3/15/18, surveyors interviewed Res #5, #7, #6, #4, #8, and #9 and determined for the specific deficiency of the specific deficed deficiency of the specific deficiency	cy J sident	
	interviews, the facility for one resident (Res for one resident (Res positioning for one re incontinence care for #4, 6, 7, and 8) and a one resident (Resider activities of daily living 2. Cross refer to tag F observations, record interviews the facility	reviews, resident and staff failed to provide showers ident #5), personal hygiene ident #7), turning and sident (Resident #6), four residents (Residents assistance with bathing for nts #9) reviewed for g (ADL). F0550. Based on review, resident and staff failed to maintain the dignity		that nurse aides failed to perform resident □ s Activities of Daily Living (ADLs). Those ADLs included the following: assisting with showers; assisting with personal hygiene; as with turning and positioning; provid incontinence care; assistance with bathing. Resident #7, #5, #6, #4, # #9 were interviewed by the Directo Nursing to ensure concerns were addressed. All nursing staff were p education regarding delegation of assigned duties.	sisting e timely 8 and r of	
	of a resident by provi	ding timely incontinence esident #7) reviewed for		The procedure for implementing the acceptable plan of correction for the specific deficiency cited:		
	revealed she had wor time and enjoyed taki She stated there was to get all the work don hour rounds could no were lucky to get 2 ro had not been able to especially the ones th	on 03/14/18 at 6:30 AM rked at the facility for some ing care of the residents. not enough time in the shift ne. NA #1 stated the every 2 t ever be done and they bunds done. She stated they get early risers up and nat took 2 to get them up ot enough staff. She stated		At the facility, a Hiring/Job Fair is scheduled on 4/10/18 with assistant from Human Resources and Contin Care Senior Leadership. In addition are recruitments efforts amongst lo community colleges for nurses and nursing assistants. The facility will offering staff incentives for individu- in gaps, as new staff are onboarde facility also engaged with the Carol	nuing n, there cal be al filling d. The	

Facility ID: 923107

	S FOR MEDICARE &					O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	E SURVEY IPLETED
			A. BUILDING	3		
		345282	B. WING			C
		545262		STREET ADDRESS, CITY, STATE, ZIP CODE	03	8/15/2018
NAME OF PI	ROVIDER OR SUPPLIER					
CLEVELA	ND PINES			1404 N LAFAYETTE STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 AP DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 725	Continued From pag	e 24	F 72	.5		
		t done and had to be passed		HealthCare System resource tea	am to	
		NA #1 stated in addition to		provide immediate support for o		
	the patient care they	had to put up stock, and		positions when available.	-	
	change everyone's w	vater pitchers.				
				Human Resources has reduced		
		rse #1 on 03/14/18 at 6:47		turnaround process from hire da		
		d worked at the facility for a		date. This was accomplished by		
		een asked to come in early		increasing new employee orient		
		to work over when someone urse stated staffing was		weekly. In addition, a weekly rec call will be conducted with Huma		
		d fluctuated based on		Resources and Continuing Care		
		the stated the nurses are		Leadership.	Cernor	
		eir work done but they really				
		help the NAs because of all		In an effort to promote teamworl	k and	
		e residents. Nurse #1 stated		pride in the workplace, on 4/13/		
	the nurses sometime	es have to clock out and stay		Employee Appreciation Day has	been	
	over to get their work	done when it is hectic and		scheduled. In addition, on 4/18/	18 and	
		ends. Nurse #1 stated there		4/20/18, Employee Forum sessi		
		A positions and some nurse		scheduled to provide opportuniti		
	-	they did not have enough		staff to be informed about staffin	-	
	help currently to take	e care of the residents.		and to gain their ideas about init		
		an 02/14/18 at 7:00 AM		promote teamwork and pride in	the	
		on 03/14/18 at 7:00 AM orked at the facility for some		workplace.		
		had worked short for some		The monitoring procedure to en	sure that	
		y could not get baths and		the plan of correction is effective		
		ad to give residents a quick		specific deficiency cited remains		
		ted they had to get the stock		and/or in compliance with the re		
	put up at night and w	vere usually only able to do 2		requirements:		
		nce care and that really was				
	not often enough for	some residents.		To evaluate compliance with res		
	,			receiving assistance with showe		
		on 03/14/18 at 7:12 AM		bathing, personal hygiene, turni		
		orked at the facility for a short		positioning and timely incontiner		
		commonly work short on		Director of Nursing or designee		
		ed she is rarely able to get all nd was only able to get 2 out		conduct resident interviews wee 10% of the interviewable resider		
		iu was uniy able to get 2 out				
	of 3 done last night a	and doesn't ever have time to		weeks. At the conclusion of 4 we	aake will	

Facility ID: 923107

If continuation sheet Page 25 of 31

		· /	PLE CONSTRUCTION	(X3) DATE S COMPL				
IND PLAN OF			A. BUILDING	G	COMPL			
345282		B. WING			, 5/2018			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE				
CLEVELAND PINES				1404 N LAFAYETTE STREET SHELBY, NC 28150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AP DEFICIENCY) DEFICIENCY)			ON SHOULD BE HE APPROPRIATE	D BE COMPLETION			
F 725	past 2 weekends had they worked short ain did not seem to be a call in to work. Interview with Nurses revealed she had wor time and typically wor some on 2nd shift an weekends. She state work done when she the day and evening everything done with admissions and disch they used to have sup with admissions and disch they out on the halls. get all your work done are not done because can't have overtime. one NA on each side it is hard for them to h not get done. Interview with Nurses revealed she had wor and typically worked was able to get her w stated that staffing wa acuity and that night s and one NA on each #3 stated there were	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 ast 2 weekends had been bad. NA #3 stated hey worked short almost every night and there id not seem to be a back-up plan for when NAs all in to work. Therview with Nurse #2 on 03/14/18 at 7:24 AM evealed she had worked at the facility for a short me and typically worked 3rd shift but worked ome on 2nd shift and 12 hour shifts on the veekends. She stated she was able to get her work done when she worked night shift but during he day and evening shift it was hard to get worything done with physician orders and dimissions and discharges. Nurse #2 stated hey used to have supervisors that would help with admissions and orders but their positions ad been eliminated. She stated they usually try o have a weekend supervisor but lately she has and to work a cart and that leaves no one extra to lelp out on the halls. On weekends it is hard to set all your work done and sometimes treatments in en Ad on each side because if the nurse is busy is hard for them to help the NA and care does to get done. Therview with Nurse #3 on 03/14/18 at 7:38 AM evealed she had worked at the facility for a while ind typically worked night shift. She stated she was able to get her work done but barely. She tated that staffing was not done by resident ind one NA on each hall and that was it. Nurse as stated there were open NA and nurse positions and there was not enough staff at the		 25 six weeks, with 10% of the residents. Any identified iss addressed through the prog discipline process. Results monitoring will be shared w Administrator and Director of weekly basis and with QAP The title of the person response implementing the acceptable correction. The Administrator will be re oversight for this plan of concertain 4/12/18. 	ues will be gressive of the ith the of Nursing on a I monthly. onsible for le plan of sponsible for			
	-	#4 on 03/14/18 at 8:00 AM						

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345282		345282	B. WING			_	C 03/15/2018	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				1	404 N LAFAYETTE STREE	T		
CLEVELA	ND PINES			s	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	and stated she was us work done on her shift staffing pattern for nig NAs but should be 6 M worked short for some for them to get everytt only 4 of them. She sig get showers done and gotten up because mo and there is just not e Interview with NA #4 of revealed she had wor time and stated she ty #4 stated they had wo and when they did the the showers done, tur every 2 hours or provi 2 hours. She stated t incontinence rounds of they worked short. No several NA positions of anyone in a while. Sha asked to stay over to in early due to call-ins was short they would (RA) to work on the has services were not pro- had been pulled a lot Interview with NA #5 of revealed she had wor time and typically wor she had been asked to over due to call-ins. So coming in early 4-5 da they were not able to	e 26 ked at the facility for a while sually able to get all her t. She stated the current tht shift was 4 nurses and 4 NAs. She stated they had e time and it makes it hard hing done when there is stated they are not able to d early risers are not always ost of them require 2 assists nough help to get them up. on 03/14/18 at 11:53 AM ked at the facility for some /pically worked 1st shift. NA orked short for some time ey were not able to get all n and position residents ide incontinence care every hey were lucky to get 2 done on everybody when A #4 stated there were open but they had not hired he stated she had been help the next shift and come a. NA #4 stated if the floor pull the Restorative Aid all and then restorative vided. She stated the RA lately to work the floor. on 03/14/18 at 12:13 PM ked at the facility for a long ks 1st shift. NA #5 stated o come in early and work She stated she had been ays a week. NA #5 stated get everybody up in the lining room so some of the	F	725				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/16/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345282		B. WING	B. WING			C 15/2018	
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CLEVELAND PINES			1	404 N LAFAYETTE STRE	ET		
				SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	She stated if they are put her on the hall wit restorative was not do residents. Interview with NA #6 of had worked at the fact typically work 1st shift always able to get all do not get all the show to do every 2 hour incosaid it was hard to get on the hall at meal time room. Interview with NA #7 of revealed she had work they could not get all the show to get on the hall at meal time room. Interview with NA #7 of revealed she had work they could not get all they were showers of they could not get all they were showers of the nurses do not help constantly going off of the RA is often pulled assignment because of residents do not get residents do not ge	heir breakfast in their room. short they pull the RA and h an assignment and then one that day for the on 03/14/18 revealed she ility for a short time and the work assigned done and wers done and are not able ontinence rounds. NA #6 the work assigned bare not able ontinence rounds. NA #6 the verything done plus trays he and helping in the dining on 03/14/18 at 4:18 PM ked at the facility for a short ked 2nd shift. NA #7 stated the showers done especially requiring 2 assists because help. She stated they had baths instead of showers. been called to work extra some in early. She stated to the floor to take an of call-ins and then the estorative services and frequently and especially on on 03/14/18 at 4:49 PM ked at the facility for some ked 2nd shift. She stated	F 725		DEFICIENCY)		
	weekends. She state	ays short staffed on the d they were not always able showers done, residents					

Facility ID: 923107

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/16/2018 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
345282			B. WING		_	03/15/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CLEVELAND PINES				1404 N LAFAYETTE STRE SHELBY, NC 28150	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	as was expected of the An interview with NA is revealed he had worked and 03/04/18. NA #1 and more hectic that we showers given on 1st and trays on the floor residents. An interview with NA is revealed she had work time and typically wor she had worked the we 03/04/18 and had not She stated she only of because she had so re of and stated a few me twice but most only of stated trays were late fall because there we feed. She stated there that complained about An interview with NA is revealed she had work time and typically wor she had worked the we 03/04/18 and had not showers that day. NA rounds for incontinent residents but had not stated there were so is day they had to be rule	 the care done every 2 hours item. #10 on 03/15/18 at 2:44 PM ed at the facility for a short the weekend of 03/03/18 0 stated it was a lot busier weekend and there were no shift, weights were not done were late getting to the #11 on 03/15/18 at 2:53 PM ked at the facility for a short ked 1st shift. She stated veekend of 03/03/18 and given any showers that day. iid 1 incontinence round nany residents to take care ay have been checked nee during the shift. NA #11 getting to residents on the re so many residents to e were a lot of family there t the care that weekend. #13 on 03/15/18 at 3:05 PM ked at the facility for a short ked 2nd shift. She stated veekend of 03/03/18 and been able to do any A#13 stated she had done 2 ce care on most of the done any weights. She many residents to feed that shed to feed everyone and it was late in the evening 	F 72	5			

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	-	D HUMAN SERVICES				FORM	028 0201	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
345282			B. WING		_	C 03/15/2018		
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
<u>.</u>			1	404 N LAFAYETTE STRE	ET			
CLEVELAND PINES			s	HELBY, NC 28150				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 725	revealed she had work time and had worked and 03/04/18. She st give one shower that 2 incontinence rounds She stated there were floor that had to be fe done that weekend. Shad fallen on Saturda NAs were taking resid An interview with NA is revealed he had work time and typically wor had worked the week 03/04/18 and it was h especially Saturday. showers on Saturday done and was able to incontinence care. He his residents fed and residents to the dining fallen. He stated they because she constam not able to ambulate of An interview on 03/15 Assistant Director of N Director of Nursing (D staffing assistant who the schedule and prin stated the staffing assistant of not schedule to get not schedule to get not schedule to get not	#14 on 03/15/18 at 3:17 PM ked at the facility for some the weekend of 03/03/18 ated she only had time to day and was able to only get s done on the residents. e several residents on the d and there were no weights She stated that a resident y during 2nd shift while the lents to the dining room. #15 on 03/15/18 at 3:24 PM ed at the facility for a short ked 2nd shift. He stated he end of 03/03/18 and ectic that weekend and He stated he had two and was able to get them get 2 rounds done for e stated he was able to get while taking some of the g room another resident had y had to watch this resident tly tried to get up and was	F 725					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/16/2018 1 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
345282		B. WING			C 03/15/2018			
NAME OF PROVIDER OR SUPPLIER				STREET AD	DRESS, CITY, STATE, ZIP CODE	•		
				1404 N LA	FAYETTE STREET			
CLEVELAND PINES				SHELBY,	NC 28150			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 725	according to census a fluctuates with census have nurses that are thave NAs on call. The that no one had comp workload or the numb been assigned to take the weekend of 03/03 "perfect storm." She member die, one wer gallstones, one was a just returning from FM residents and there w stated they had not hab but she nor the ADON rate was. The DON s interviews when they lately. She stated the doing rounds and out a NA always over her make adjustments to ADON and DON state for nurses and NAs b open positions they h stated they had not have stated they have not have not have stated they have not hav	and acuity and staffing s. The DON stated they on-call for call-ins but do not e ADON and DON stated blained to them about their per of residents they have e care of. The DON stated /18 and 03/04/18 was the stated they had a staff	F 7.	25				

Facility ID: 923107

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