STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUP COMPLET NAME OF PROVIDER OR SUPPLIER 345397 B. WING C SHORELAND HLTH CARE & RETIREME STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRICE SHORELAND HLTH CARE & RETIREME STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRICE C PRETX TAG EACH DEFICIENCY SUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PREEX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C F 623 SS=C Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) F 623 F 623 12 SS=C CFR(s): 483.15(c)(3)-(6)(8) F 623 F 623 12 I anguage and manner they understand. The facility musts send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. F 623 F 623 12 I (ii) Necord the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and Image and manner they understand. The facility must send a copy of the fortice to a representative of the Office of the State Long-Term Care Ombudsman. Image and manner they understand core discharge in the resident's medical record in <th></th> <th>-</th> <th></th> <th>S FOR MEDICARE & I</th> <th>CENTER</th>		-		S FOR MEDICARE & I	CENTER	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLET 345397 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE SHORELAND HLTH CARE & RETIREME STREET ADDRESS. CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EAch DEFICIENCY WIST BE PRECIDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE 0 F 623 Notice Requirements Before Transfer/Discharge F 623 F 623 12 SS=C CFR(s): 483.15(c)(3). Notice before transfer. Before a facility transfers or discharges a resident, the facility must- ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE 0 ID S483.15(c)(3). Notice before transfer. Before a facility transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. ID (II). Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and ID ID ID (III). Include in the notice the items described in paragraph						
345397 B. WING 12/06// NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472 WHITEVILLE, NC 28472 WHITEVILLE, NC 28472 (¢A) ID SUMMARY STATEMENT OF DEFICIENCIES (¢A) D (¢ACH OER/GUNY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S CORRECTIVE ACTION SHOULD BE CCRSS.REFERENCED To THE APPROPRIATE DEFICIENCY) SS=C CFR(5): 483.15(c)(3).01(6)(8) §483.15(c)(3).Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident'S representative(s) of the transfer or discharge and the reasons for the mansfer or discharge and the reasons for the mansfer or discharge and the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (ii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	TION NUMBER: A. BUILDING COMPLETED	ì, í				
200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472 (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX F 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		B. WING	345397			
SHORELAND HLTH CARE & RETIREME V(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 OERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERICIENCY ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the movie in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. III	STREET ADDRESS, CITY, STATE, ZIP CODE			ROVIDER OR SUPPLIER	NAME OF PR	
WHITEVILLE, NC 28472 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH OERCITWA EACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of the is section. §483.15(c)(4) Timing of the notice. Image: Colspan="2">WHITEVILLE, NC 28472	200 FLOWER-PRIDGEN DRIVE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCT TO THE APPROPRIATE DEFICIENCY) C F 623 Notice Requirements Before Transfer/Discharge SS=C F 623 F 623 12 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. F 623	WHITEVILLE, NC 28472		REME			
SS=C CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX	
 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of 	indication indication ier/Discharge F 623 r. ges a ent's discharge and and in a and. The ce to a cet o a tate iffer or record in f this section; lescribed in is (c)(4)(ii) and ansfer or on must be a before the d. s practicable iacility would j(1)(i)(C) of		Before Transfer/Discharge (6)(8) pefore transfer. ers or discharges a ust- and the resident's e transfer or discharge and ove in writing and in a t they understand. The opy of the notice to a Office of the State udsman. s for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in s section. of the notice. I in paragraphs (c)(4)(ii) and he notice of transfer or der this section must be least 30 days before the or discharged. de as soon as practicable tharge when- iduals in the facility would paragraph (c)(1)(i)(C) of	Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannee facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required un made by the facility ar resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under	F 623	
this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or TITLE (X0)	discharge, section; arge is edical needs, section; or		te transfer or discharge,)(i)(B) of this section; sfer or discharge is nt's urgent medical needs,)(i)(A) of this section; or	(C) The resident's heat allow a more immediat under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1		

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

TITLE

12/19/2018

PRINTED: 01/03/2019

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.

Electronically Signed

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345397	B. WING			C 12/06/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHORELA	AND HLTH CARE & RETIR	REME			00 FLOWER-PRIDGEN DRIVE VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	 (E) A resident has not days. §483.15(c)(5) Contennotice specified in parmust include the follor (i) The reason for transferred or discharr (iii) The location to what transferred or discharr (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombody (vi) For nursing facility and developmental disabilities, the mailinn telephone number of the protection and add developmental disabilities, the mailing C of the Developmental disabilities and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dise email address and tele agency responsible for advocacy of individual 	t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; inch the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ils with a mental disorder e Protection and Advocacy uals Act.	F	623			

Facility ID: 923452

If continuation sheet Page 2 of 8

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345397	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
SHORELAND HLTH CARE & RETIREME					00 FLOWER-PRIDGEN DRIVE VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	If the information in the effecting the transfer of must update the recip as practicable once the becomes available. §483.15(c)(8) Notice is in the case of facility of the administrator of the written notification price to the State Survey As State Long-Term Care the facility, and the rewell as the plan for the relocation of the resident and/or the resident and/or the resident and/or the registent and/or	<pre>ine notice changes prior to or discharge, the facility bients of the notice as soon he updated information</pre> in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate ents, as required at § is not met as evidenced ew and staff interviews the a written letter to the sponsible party (RP) for the t's transfer to the hospital viewed for transfers 7). : priginally admitted to the had a diagnosis of dent (stroke) and Alzheimer ' record revealed Resident o the hospital on 10/21//18. AM the Social Worker stated d not send a letter to the	F	623	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correctio constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 1. Corrective action for affected residents. For resident #47, the resident returned the facility on 10/26/2018 and resided there until her death on 12/11/2018. For resident #17, the resident returned to t facility on 10/06/2018 and remains in the f	al ken on to or he	

Facility ID: 923452

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345397	B. WING _		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		·
SHORE	AND HLTH CARE & RETI	REME	200 FLOWER-PRIDGEN DRIVE		
UNUXEL/				WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C PROVIDER'S PLAN O C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 623	On 12/5/18 at 10:23 J in an interview she se ombudsman at the en Administrator further RP by phone but she needed to be sent to them of the reason fo 2. Resident # 17 was 12/4/18 with diagnost Cerebral Palsy, Diab Disc. Disorder. A review her clinical m 17 was discharged to On 12/5/18 at 10:15 J in an interview she di resident or the RP wh transferred to the hos On 12/5/18 at 10:23 J in an interview she se ombudsman at the en Administrator further RP by phone but she	AM the Administrator stated ent a list of transfers to the nd of each month. The stated the facility notified the was not aware a letter the resident/RP to notify or the transfer. admitted to the facility on es of Spinal Stenosis, etes Mellitus and Cervical record revealed Resident # the hospital on 10/2/18. AM the Social Worker stated id not send a letter to the nen a resident was spital or another facility. AM the Administrator stated ent a list of transfers to the nd of each month. The stated the facility notified the was not aware a letter the resident/RP to notify	F 6	 facility at this time. For rewas given a late notice of her own RP. Corrective action for the potential to be affected deficient practice. All residents with a facility or discharge have the potential discharges for to identify facility initiated discharges. For those resiwith a facility initiated transfer/diswas given in writing to the resident representative if twere no longer currently a This was completed on Data Staff Development Coorditime, part time, and as new Social Worker, Business Cand Administration. In-ser completed on or before 12 on Topics included: The new Transfer/Disform. When to initiate the Transfer/Discharge notice Follow up to be comp Social Worker within 72 htransfer of a resident to the fact the transfer of a resident to the fact the transfer of a resident form. 	transfer. She is residents with d by the alleged initiated transfer ential to be ficient practice. Social Worker the past 30 days transfers or idents identified sfer or charge notice resident or those residents at the facility. ecember 19th . provided by the nator to all full eded Nurses, Office Manager, vice will be 2/24/18. started scharge notice

Event ID: RM5011

Facility ID: 923452

If continuation sheet Page 4 of 8

STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345397	B. WING			C 2/06/2018
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP		
SHORELAND HLTH CARE & RETIREME				200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 623	Continued From pag	e 4	F 62	 acute care. This information has been the standard orientation trarequired in-service refresh all identified staff and will be the Quality Assurance produthat the change has been and the compliance were have have have and the compliance were have have have have have have have hav	aining and in the er courses for be reviewed by cess to verify sustained. onitoring ger will monitor ischarge notice inthly x 3 /Discharge . Monitoring will initiated re the orm was esident or eports will be uality he Administrator initiated as vill be monitored ram reviewed at nce Meeting. attended by the Nursing, MDS alth Information	
F 658 SS=D		leet Professional Standards)(i)	F 65		managor	12/24/18
	The services provide	rehensive Care Plans of or arranged by the facility, omprehensive care plan,				

Facility ID: 923452

If continuation sheet Page 5 of 8

	-	D HUMAN SERVICES				FORM	APPROVED
			(X2) MULT			(X3) DATE	0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			LETED
			A. DOILDII	<u> </u>			C
		345397	B. WING				06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	200 FLOWER-PRIDGEN DRIVE		
SHORELA	ND HLTH CARE & RETIR	REME		V	WHITEVILLE, NC 28472		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG			IAG		DEFICIENCY)		
F 658	Continued From page	9 5	Fe	358			
	must-						
	(i) Meet professional	standards of quality.					
	This REQUIREMENT	is not met as evidenced					
	by:						
		ew and staff interviews, the			The statements made on this plan of		
		physician orders resulting in			correction are not an admission to and	do	
		oses for 1 of 6 residents			not constitute an agreement with the alleged deficiencies.		
	reviewed for medicati	ons (Resident #36).			To remain in compliance with all federa	1	
	Findings included:				and state regulations the facility has ta		
					or will take the actions set forth in this	-	
	Resident #38 had bee	en admitted on 6/18/14. Her			plan of correction. The plan of correction	on	
	diagnoses included a				constitutes the facility s allegation of		
	depressive disorder, p				compliance such that all alleged		
		e heart disease, heart			deficiencies cited have been or will be		
	and dementia.	ctive pulmonary disease			corrected by the dates indicated. F658		
					1. For resident #38, The corrective		
	A physician order date	ed 5/24/18 for Alprazolam			action is as follows: On October 4th		
		et by mouth two times a day			prescription was received by provider,		
	and give two tablets a				pharmacy filled medication and resider	nt	
					started receiving medication on 10/4/18	3 at	
		recent Minimum Data Set			9PM.		
		ed she had mild cognitive					
	impairment. She had	ted to be on Hospice care.			2. Corrective action for residents with	,	
		ted to be on hospice care.			the potential to be affected by the alleg		
	A prescription written	by a Nurse Practitioner (NP)			deficient practice.		
		azolam 0.5 mg; give one					
	tablet twice a day, dis	pense 60 tablets, with 5			All current residents receiving narcotic		
	refills.				medications have the potential to be		
	Desides 1 //00 t				affected by the alleged deficient practic	e.	
		plan, most recently updated			Beginning on December 12, 2018, the	o.d	
	on 10/3/18, indicated medications and a dia	-			Nursing Department Mangers complete an audit of all current residents	eu	
	Interventions included				physician orders to identify which		
	medications ordered I				residents have orders for narcotic		
					medications. Once residents were		
	A review of Resident	#38 ' s October 2018			identified, the Nursing Department		

Facility ID: 923452

If continuation sheet Page 6 of 8

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION		ATE SURVEY OMPLETED
	CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING			
		245207				С
		345397	B. WING			12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE			
SHORELA	ND HLTH CARE & RETI	REME		200 FLOWER-PRIDGEN DRIVE		
				WHITEVILLE, NC 28472		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	e 6	F 65	8		
	10	ation record (MAR) revealed	1 00	Mangers audited the currer	nt supply on	
		one tablet to be given at 9		hand for those narcotics to		
		given at 5 PM and two		identified resident had an a		
		total of four tablets daily.		on hand. For those residen		
				have an adequate supply o		
	Review of the Octobe	er 2018 MAR also revealed		pharmacy or MD were notif		
	Resident #38 had no	t received any doses of		refill or hard script to obtain		
		18 at 9 PM, 10/3/18 at 9 AM,		addition to this, the Nursing		
)/4/18 at 9 AM or 5 PM.		Mangers compared the phy	, I	
				to the current narcotic drug		
	On 12/04/18 at 9:13	AM an interview with Nurse		ensure accuracy. This proc		
	#1 was conducted. S	he stated she had cared for		completed on December 14	4, 2018 by	
	Resident #38 during	the time Resident #38 had		SDC and DON.		
	been out of alprazola	m. The nurse stated she had				
	been unsure why the	ere had been a delay in		3. Systemic changes		
	receiving the Alprazo	lam from the pharmacy or a				
	new prescription from	n the physician.		In-service education was p	rovided by the	
				Staff Development Coordin	ator to all full	
	On 12/04/18 at 3:34	PM an interview with the		time, part time, and as need	ded Nurses.	
	Hospice nurse was c	onducted. The nurse stated		This in-service will be comp	pleted on or	
	the facility had run sh	nort of the medication		before 12/24/18. Topics inc	luded:	
		d changed, the pharmacy				
		ablets and the facility nurses		" Auditing narcotics for r	efill needs	
		ing the medication three		every Tuesday.		
	times a day as previo	ously ordered.		" How to obtain a hard s		
				narcotic refills and who to c		
		AM a telephone interview		" How to avoid residents	s missing doses	
		chnician (PT) who managed		of ordered mediations.		
	the narcotic prescript					
		ucted. She stated when a		This information has been i		
		s presented, it canceled the		the standard orientation tra		
		s of the same medication.		required in-service refreshe		
		otion had been received on		all nurses and will be review	•	
		m 0.5 mg one tablet twice a		Quality Assurance process	•	
		ted Resident #38 had been		the change has been susta	ineu.	
		and because of this, only 15			aitoriac	
	-	were dispensed at a time. So		4. Quality Assurance mor	nitoring	
		order, and only 15 days of d at a time, 30 tablets had		procedure.		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		C		
		345397	B. WING		12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SHORELA	SHORELAND HLTH CARE & RETIREME			200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO		
F 658	been refilled on 9/24/ had been administeri 2, they ran out of mer refill time. On 12/05/18 at 9:41 / Resident #38 's phys physician stated the f may have why there receiving a new prese #38 had not suffered and had no adverse of doses of the Alprazol On 12/05/18 at 2:57 f Director of Nursing (I DON stated the Nurs written the prescription realized Resident #38 of the Alprazolam. The discrepancy had bee physician had been of prescription had been of prescription had been of prescription had been of prescription for reside facility because of ind when she had received reviewed the MAR ar Alprazolam 0.5 mg to had written a prescription stated if staff had ale	AM an interview with the constant of the practition of the fax requests had been a delay in cription. He stated Resident any withdrawal symptoms outcome from missing six am. PM an interview with the CON) was conducted. The e Practitioner (NP) had on on 9/12/18 and had not 8 also took a bedtime dose the DON stated when the n realized, Resident #38 's contacted and the n corrected. AM an interview with the NP stated she did not regularly 8 but had been helping the climate weather. She stated ed the request for a new ent #38 's Alprazolam, she	F 65		y of monthly ailability oring will ons to hand ports uality inistrator d as nonitored iewed at eting. ed by the , MDS rmation		

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