| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345415 | A. BUILDING _____ B. WING _____ | C 06/06/2025 |

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| PINEVILLE REHABILITATION AND LIVING CTR | 1010 LAKEVIEW DRIVE PINEVILLE, NC 28134 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted from 6/2/25 through 6/6/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 21Y311. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and complaint investigation survey was conducted from 6/2/25 through 6/6/25. Event ID # 21Y311. The following intakes were investigated: NC00230097, NC00228318, NC00227757, NC00227248, NC00226445, NC00225109, NC00224417, NC00223750, NC00222847, NC00222164, and NC00218779.<br><br>10 of the 53 complaint allegations resulted in deficiency. | F 000 | | |
| F 553 SS=D | Right to Participate in Planning Care<br>CFR(s): 483.10(c)(2)(3)<br><br>§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br>(iii) The right to be informed, in advance, of changes to the plan of care. | F 553 | | 6/29/25 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/28/2025 |

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| F 553 | Continued From page 1<br>(iv) The right to receive the services and/or items included in the plan of care.<br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-<br>(i) Facilitate the inclusion of the resident and/or resident representative.<br>(ii) Include an assessment of the resident's strengths and needs.<br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and resident representative interviews, the facility failed to conduct a care plan conference and offer the resident and resident representative the right to participate in the person-centered care planning process for 1 of 5 residents reviewed for care plans (Resident #346).<br><br>The findings included:<br><br>Resident #346 was admitted to the facility on 3/14/2024 and discharged on 4/8/2024.<br><br>Resident #346's care plan initiated on 3/17/2024 addressed the following areas: the risk for allergic response to fenofibrate, neosporin and gluten, ADL self-care performance deficit and required staff assistance to complete ADL tasks daily, deep vein thrombosis of the left popliteal vein and left posterior tibial vein related to impaired mobility and atrial fibrillation which required | F 553 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to conduct a care plan conference and offer resident #346 and resident representative the right to participate in the person-centered care planning process<br><br>Effective 6/23/2025 the Administrator educated Social Services on informing the residents and resident representatives of participating in the care planning process.<br><br>Resident #346 discharged on 4/8/2024.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice; | |

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| F 553 | Continued From page 2<br>anticoagulant therapy, full code status, moderate risk for falls, indwelling foley catheter due to urinary retention, bowel incontinence but was at risk for constipation due to decreased mobility and medication side effects, right hip fracture requiring surgical repair after a fall at home in her bathtub and pain associated with the fracture, nutritional risk factors related to a mechanically altered diet for dysphagia, gluten free restriction, and a history of protein calorie malnutrition, and Stage IV pressure wounds of the left ischium and left elbow, unstageable wounds to both heels, and deep tissue injuries to both the left and right lateral ankles and was at risk for further skin breakdown.<br><br>The admission Minimum Data Set (MDS) assessment dated 3/18/2024 indicated Resident #346 was cognitively intact. As Resident #346 discharged to another skilled nursing facility, an MDS assessment was completed for discharge with return not anticipated.<br><br>A review of Resident #346's electronic medical record revealed no documentation that a care plan conference had been held during Resident #346's stay at the facility.<br><br>On 6/3/2025 at 6:00 PM a telephone interview with the Resident Representative revealed on the day of admission, Resident #346 and the Resident Representative were told that a care plan conference would be held on 3/15/2024 at 11:00 AM in Resident #346's room. The resident representative stated she arrived for the conference and waited in the room with Resident #346, but no staff ever came to the room. The Resident Representative stated she inquired about the conference at the nurse's station but | F 553 | All residents have the potential to be affected by the alleged deficiency.<br><br>Effective 6/27/2025 Social Services audited 30 days of care plan meetings to ensure care plan conference was conducted and the resident and resident representative was notified. No negative findings.<br><br>Effective 6/27/2025 Social Service will ensure that all residents and the residents representatives are notified to participate in the care plan process.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 6/23/2025, Administrator educated Social Services on notifying the residents and resident representative of the care plan meeting and the right to participate in the care plan process.<br>Effective 6/27/2025 any newly hired Social Service that has not been educated will not be allowed to work until receive education in- person or via telephone by Administrator and/or designee.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Administrator will audit 3 care plan meetings weekly x 12 weeks to ensure resident and resident representatives are notified of care plan meeting. | |

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| F 553 | Continued From page 3<br>was told no one knew about the conference as their system was down. The care plan conference was not rescheduled with the resident or resident representative. The Resident Representative indicated later she asked various staff members if the conference had been held but never received any updates or progress reports. The Resident Representative stated she only discovered there was a care plan document dated 3/17/2024 outlining focus areas, goals and interventions after she requested Resident #346's medical record after Resident #346 discharged on 4/8/2024.<br><br>On 6/5/2025 at 10:06 AM an interview with Social Worker #1 revealed she was responsible for the care plan conference invitations and meeting schedule based on a list provided to her by the MDS Coordinator. She recalled Resident #346 and thought the conference had been held with the Resident Representative. Social Worker #1 was unable to locate any documentation in the electronic medical record that the care plan conference had been held. She was unable to provide any documentation that discussions regarding care planning had been conducted with Resident #346 or her resident representative. Social Worker #1 indicated that documentation of the completed care plan conference in the electronic medical record was at times completed by nursing and at other times by her. She was not sure why documentation of the care plan conference had not been completed for Resident #346. There was not a clear process in place which determined if nursing or social work would document the completed care plan conference once held.<br><br>On 6/5/2025 at 2:47 PM an interview with the | F 553 | Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.<br>Completion date: 6/29/2025 | |

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| F 553 | Continued From page 4<br>Director of Nursing (DON) indicated that social services was responsible for arranging the care plan conferences based on a list provided by the MDS Coordinator. The DON stated the care plan process should include a progress note that the conference was held and document who attended. She stated sometimes the Social Worker would document the conference and at other times nursing would document under an Interdisciplinary Team (IDT) note. There was not a clear process to determine if nursing or social work took the responsibility to document in the electronic medical record after a completed care conference. The DON was unable to locate documentation that a care plan conference had been held for Resident #346 or that Resident #346 or the resident representative had participated in the care plan process. She did not know why there was not documentation in the electronic medical record.<br><br>On 6/6/2025 at 11:34 AM an interview with the Administrator revealed that a resident and the resident representative had the right to participate in the care plan conference if they chose to do so and the care plan conference should be documented in the electronic medical record (EMR). She did not know why Resident #346 had no documentation in the EMR reflecting that a care plan conference had been held and that Resident #346 and the resident representative had participated in the planning. | F 553 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status. | F 641 | | 6/29/25 |

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| F 641 | Continued From page 5<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge location (Resident #345) and respiratory treatment (Resident #147) for 2 of 19 residents reviewed for accuracy of assessment.<br><br>The findings included:<br><br>1. Resident #345 was admitted to the facility on 3/7/2025. | F 641 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to accurately code the Minimum Data Set for resident #345 and resident #147.<br><br>The facility modified resident #345 to reflect discharge as “discharge home with home health” on discharge assessment | |

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| F 641 | Continued From page 6<br>A review of a social service progress note dated 4/28/2025 at 4:57 PM stated Resident #345 had a planned discharge to home with home health services on 4/28/2025.<br><br>A review of the discharge MDS assessment dated 4/28/2025 revealed that the discharge status had been coded as discharge to home/community.<br><br>An interview on 6/5/2025 at 9:46 AM with the MDS Coordinator indicated she received a resident's discharge information through progress notes, discussions with the Social Worker or weekly utilization review meetings. She stated she routinely coded the discharge status as home/community when a resident discharged home. She was unable to provide an example of when it would be appropriate to use the home under the care of organized home health service organization category. The MDS Coordinator stated she saw the social service progress note documenting the home health services but since Resident #345 discharged home she thought home/community was the correct coding.<br><br>An interview on 6/5/2025 at 2:47 PM with the Director of Nursing (DON) indicated the MDS should be coded accurately. She was not sure why Resident #345's discharge MDS had been coded incorrectly.<br><br>An interview on 6/6/2025 at 11:34 AM with the Administrator revealed that the MDS should be coded accurately. She did not know why Resident #345's discharge status had been coded incorrectly.<br><br>2. A hospital referral form dated 10/25/24 revealed Resident #147 required continuous | F 641 | 4/28/2025 and retransmitted on 6/05/2025.<br><br>The facility modified resident #147 to reflect “oxygen” on admission assessment on 11/3/2024 and retransmitted on 6/23/2025.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>Effective 6/20/2025 Minimum Data Set Nurses reviewed 30 days of discharge residents to ensure accuracy of coding when discharging home with home health. Any negative findings were corrected.<br><br>Effective 6/24/2025 Minimum Data Set Nurses reviewed current residents with oxygen orders to ensure accuracy of coding oxygen. Any negative findings were corrected.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 6/13/2025, Regional MDS Consultant educated MDS nurses coding MDS assessment accurately.<br>Effective 6/29/2025 any newly hired MDS that has not been educated will not be allowed to work until receive education in-person or via telephone by Administrator and/or designee.<br>Indicate how the facility plans to monitor its performance to make sure that | |

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| F 641 | Continued From page 7<br>supplemental oxygen.<br><br>Resident #147 was admitted to the facility on 10/30/24 with a diagnosis of chronic obstructive pulmonary disease (COPD).<br><br>A nursing progress note dated 11/01/24 revealed Resident #147 required 3 liters of supplemental oxygen.<br><br>A review of the admission Minimum Data Set (MDS) assessment dated 11/03/24 revealed Resident #147 was coded for no oxygen therapy.<br><br>An interview on 6/5/2025 at 9:38 AM with the MDS Coordinator indicated she reviewed the residents progress notes and referral forms prior to completing the initial admission MDS. The interview revealed based on the referral form and the nursing progress notes Resident #147 had received supplemental oxygen from the time of his admission and should have been coded on his admission MDS. The MDS Coordinator stated she was responsible for completing the assessment and had just miscoded it by mistake.<br><br>An interview on 6/5/2025 at 2:29 PM with the Director of Nursing (DON) indicated the MDS should be coded accurately. She was not sure why Resident #147's admission MDS had been coded incorrectly.<br><br>An interview on 6/5/2025 at 10:34 AM with the Administrator revealed that the MDS should be coded accurately. She did not know why Resident #147's admission MDS had been coded incorrectly. | F 641 | solutions are sustained:<br>Administrator will audit 5 discharge assessments weekly x 12 weeks to ensure discharge assessments are coded accurately.<br>Administrator will audit 5 admission assessments weekly x 12 weeks to ensure residents on oxygen is coded accurately.<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 6/29/2025 | |
| F 658 SS=D | Services Provided Meet Professional Standards | F 658 | | 6/29/25 |

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| F 658 | Continued From page 8<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and resident and staff interviews, the facility failed to ensure Resident #9 swallowed all of her prescribed medications before leaving Resident #9's room for 1 of 1 resident reviewed for medication storage (Resident #9).<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 3/7/2023 with diagnoses which included vascular dementia, cirrhosis of the liver and end stage renal disease.<br><br>The annual Minimum Data Set (MDS) assessment dated 2/23/2025 revealed Resident #9 was moderately cognitively impaired.<br><br>A physician order dated 05/27/2025 read; Lactulose 45 milliliters (ml) to be given twice daily by mouth for increased ammonia level due to cirrhosis of the liver.<br><br>There was not an assessment for medication self- administration documented in Resident #9's electronic medical record.<br><br>On 6/3/2025 at 8:50 AM, Resident #9 was observed sitting on the edge of her bed eating breakfast with her meal tray on her overbed table | F 658 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to ensure resident #9 swallowed all her prescribed medications before leaving resident #9 room. Nurse #1 returned to resident room and explained to the resident the medication that was in the medication cup and resident #9 took the medication.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>Effective 6/27/2025 license nurses were randomly observed passing medication and ensuring resident swallowed all medication before leaving room.<br><br>Effective 6/29/2025 Director of Nursing and/or designee conducted a competency checklist on all licensed nurses and medication aide. | |

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| F 658 | Continued From page 9<br>positioned next to her bed. A medication cup containing a green liquid was observed sitting next to her breakfast tray. Resident #9 stated she did not know what the liquid was or where it had come from.<br><br>An interview on 6/3/2025 at 9:10 AM with Nurse #1 revealed she had administered Resident #9's medications that morning and she thought Resident #9 had taken all of the medications while she was in the room. Nurse #1 and this surveyor returned to Resident #9's room and during the interview Nurse #1 explained to Resident #9 that the medication was lactulose, and it reduced her ammonia level. Resident #9 took the medication. Nurse #1 stated she should have been sure Resident #9 had taken all of her medications before she left the room earlier that morning.<br><br>On 6/4/2025 at 3:05 PM an interview with the Assistant Director of Nursing (ADON) indicated that Nurse #1 should have stayed in the room until Resident #9 had taken all of her medications. No medications should have been left at the bedside.<br><br>On 6/5/2025 at 2:47 PM an interview with the Director of Nursing (DON) indicated Nurse #1 should have stayed with Resident #9 and watched while she took her medications. The DON said medication should not have been left with Resident #9. She was not sure why Nurse #1 had left Resident # 9's medication at the bedside.<br><br>On 6/6/2025 at 11:34 AM an interview with the Administrator revealed that Nurse #1 should have stayed with Resident #9 to observe her taking all of the medications administered. The | F 658 | Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 6/27/2025 Director of Nursing and/or designee will educate all license nurses and medication aides on ensuring that resident swallowed all medication before exiting the room.<br><br>Effective 6/27/2025 any license nurse and medication aide that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.<br><br>Effective 6/27/2025 all license nurses and medication aides including Agency nurse before their first assignment, will be educated in orientation, in person by Director of Nursing and/or designee on " ensuring resident swallows all medication before exiting the room”.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing will randomly audit 3 nurses or medication aides weekly x 12 weeks after medication administration to ensure there is no medication left in the room.<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Director of Nursing will review the results | |

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| F 658 | Continued From page 10<br>Administrator did not know why Nurse #1 had left medication unattended with the resident. | F 658 | of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 6/29/2025 | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review,and resident and staff interview, the facility failed to provide supervision for storage of smoking supplies (cigarettes/lighter) for 1 of 3 residents sampled for supervision to prevent accidents (Resident #31).<br><br>The findings included:<br><br>A review of the facility's Resident Smoking policy, dated October 2023, indicated any resident who was deemed safe to smoke independently will have their smoking materials secured by the facility, including lighters, cigarettes and e-cigarettes.<br><br>Resident #31 was admitted to the facility on 02/24/23 with diagnoses which included seizure disorder, anxiety and depression.<br><br>A review of Resident #31's care plan, revised on | F 689 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to provide supervision for storage of smoking supplies (cigarettes/lighter) for resident #31 for supervision to prevent accidents.<br><br>Resident #31 smoking material was removed on 6/5/2025 and secured on the medication cart.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>Effective 6/24/2025 the Social Service and/or designee reviewed current residents that are safe to smoke | 6/29/25 |

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| F 689 | Continued From page 11<br>02/22/24, revealed he was an unsupervised smoker. The goal was for Resident #31 to not suffer injury from unsafe smoking practices through the review date. Interventions included the residents smoking supplies to be stored with the nurse.<br><br>A safe smoking assessment dated 03/11/25 revealed Resident #31 was a safe smoker, and the facility stored his smoking materials.<br><br>A review of Resident #31's quarterly Minimum Data Set (MDS) dated 03/25/25 revealed the resident was cognitively intact and independent for most activities of daily living (ADL). The MDS indicated Resident #31 utilized a wheelchair for mobility.<br><br>An observation and interview were conducted with Resident #31 on 06/02/25 at 12:45 PM. Resident #31 was observed with a lighter and one pack of cigarettes in the left pocket of his backpack located on the back of his wheelchair. Resident #31 stated he was an unsupervised smoker and had always kept his smoking supplies because he was trustworthy. He stated no staff member had asked him to keep his supplies at the nurse's station and that he was familiar with the smoking policy because he had signed the smoking agreement when he admitted into the facility.<br><br>An observation was conducted of Resident #31 on 06/03/25 at 11:31 AM. Resident #31 was observed with a lighter and one pack of cigarettes in the left pocket of his backpack located on the back of his wheelchair.<br><br>An observation was conducted of Resident #31 | F 689 | independently to identify that no smoking materials are in the rooms and that it is secured on the medication cart. No negative findings.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 6/27/2025 Director of Nursing and/or designee educated current license nurses and medication aides on the smoking policy and storage of smoking materials.<br><br>Effective 6/27/2025 any License Nurses and medication aides that have not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.<br><br>Effective 6/27/2025 all License Nurses and medication aides including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on smoking policy "ensuring that resident smoking materials are secured on the medication cart."<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit 4 resident rooms to ensure no smoking material is present and it's | |

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| F 689 | Continued From page 12<br>on 06/03/25 at 1:38 PM. Resident #31 was observed with a lighter and one pack of cigarettes in the left pocket of his backpack located on the back of his wheelchair.<br><br>On 06/03/25 at 12:22 PM an interview was conducted with Nurse #1. During the interview she stated she was new to the facility and had just started working in the building that morning at 7:00 AM. Nurse #1 stated residents in the facility that were deemed unsupervised smokers were allowed to go out and smoke at the designated smoking area. She stated typically the cigarettes were kept in the nurse's medication cart however she stated she did not have any cigarettes in the cart on that day. The interview revealed she was not sure who the unsupervised smoker was or where they kept their smoking supplies.<br><br>On 06/03/25 at 12:27 PM an interview was conducted with Nurse Aide (NA)#1. During the interview she stated she frequently worked with Resident #31 and that he was an unsupervised smoker. NA #1 stated the resident kept his own supplies (cigarette/lighter) so he could go to the smoking area whenever he wanted to. The facility had never had any issues or incident in which his smoking materials would be taken from him. NA #1 stated Resident #31 had kept his cigarettes and lighter in his room for as long as she could remember.<br><br>On 06/03/25 at 12:39 PM an interview was conducted with NA #2. During the interview she stated she had worked in the facility for one year and typically worked with Resident #31. She stated Resident #31 would go outside to smoke whenever he wanted to, not at certain times. NA #2 stated Resident #31 kept his own cigarettes | F 689 | secured on the medication cart weekly X 12 weeks.<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 6/29/2025 | |

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| F 689 | Continued From page 13 | F 689 | | |

and lighter in his room. She did not know of any incidents or issues that had resulted from him keeping his own cigarettes. All the other residents had to ask for their supplies. NA #2 stated Resident #31 was the only resident in the facility that kept his own smoking supplies.

On 06/04/25 at 10:07 AM an interview was conducted with Nurse #2. During the interview she stated she was responsible for Resident #31 on 06/04/25 and did not have his smoking supplies on the medication cart. She stated Resident #31 was the only resident that was allowed to keep his own smoking materials because he was deemed a safe smoker.

On 06/04/25 at 10:31 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated the facility did not have a lot of residents who smoked and only had two residents that were independent smokers. The DON stated the two independent smokers would retrieve their smoking materials from the Nurse on the hall and go in/out of the facility to the smoking area as they wished. All smoking supplies were stored on the medication cart and the resident had to sign the smoking materials out and back in as they reentered the building. She stated it was part of the resident's smoking agreement that they signed at admission. The DON stated she was unaware of any resident in the building that had their own smoking materials on them and was unaware about Resident #31. The DON stated staff received education several months prior for a facility wide education and upon hire regarding the smoking practices/policy of the facility. She stated the nurses along with Resident #31 should be following the facility smoking policy and he should not have been

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| F 689 | Continued From page 14<br>allowed to keep his own smoking supplies in his room.<br><br>On 06/05/25 at 10:40 AM an interview was conducted with the Administrator. During the interview she stated Resident #31 signed a smoking agreement upon his admission into the facility. However, it was hard to keep up with him because he was known to hide his smoking supplies and curse at staff if they tried to keep them locked in the nurse's cart. | F 689 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can | F 761 | | 6/29/25 |

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| F 761 | Continued From page 15<br>be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to label an open vial of Tuberculin Purified Protein Derivative (PPD) medication observed in 1of 2 medication storage rooms (Polk Hall Medication Storage Room) reviewed for medication storage.<br><br>The findings included:<br><br>An observation of the Polk Hall medication storage room with Nurse #1 on 06/04/25 at 7:40 AM revealed an open multi-use vial of Tuberculin Purified Protein Derivative, Diluted Aplisol Exp: 2026/8, was opened and not labeled with open date.<br><br>An interview with Nurse #1 on 06/04/25 at 7:40 AM revealed the Tuberculin medication vial should have been labeled with an open date and the expiration date on box should have been circled. Nurse #1 stated the vials were labeled with open date because Tuberculin medication vials were only good for 30 days after they were opened. Nurse #1 stated she was not sure why the vial was not dated; she had not used the vial.<br><br>An interview with the Assistant Director of Nursing (ADON) on 06/04/25 at 7:50 AM revealed the opened Tuberculin medication vial should have been labeled with an open date and discarded 30 days after the open date. The ADON stated Tuberculin medication vials were used so often and emptied before the 30 days of opening, the nurses probably forgot to label the vial with the open date. The ADON stated that she checked the medications in the refrigerator on day shift | F 761 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to label an open vial of Tuberculin Purified Protein Derivative (PPD) medication.<br><br>Tuberculin was discarded properly on 6/4/2025.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>Effective 6/27/2025 pharmacy consultant audited medication carts and medication rooms, any unlabeled or expired medication were removed and discarded properly.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 6/27/2025 Director of Nursing and/or designee will educate License Nurses on ensuring all TB medications are dated when opened.<br>Effective 6/27/2025 any License Nurses that have not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee. | |

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| F 761 | Continued From page 16<br>and unit manager checked on night shift. The ADON reported she had not completed medication refrigerator checks for the day and discarded the unlabeled open Tuberculin medication vial when it was brought to her attention by Nurse #1. | F 761 | Effective 6/29/2025 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on “ensuring all TB medications are dated when opened.”<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit medication carts and medication storage to ensure Tuberculin medications when open are dated properly weekly x 12 weeks.<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 6/29/2025 | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at | F 880 | | 6/29/25 |

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| F 880 | Continued From page 17<br>a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | F 880 | | |

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| F 880 | Continued From page 18<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when Nurse #2 did not doff her gloves, perform hand hygiene and don clean gloves prior to applying wound treatment and a clean dressing and before moving to a second wound on Resident #14. The deficient practice occurred for 1 of 4 staff members observed for infection control practices (Nurse #2).<br><br>The findings included:<br><br>Review of the facility's policy and procedure entitled Hand Hygiene and dated October 2021 read in part:<br>Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:<br><br>a. Immediately before touching a resident.<br>b. Before performing an aseptic task<br>c. After contact with blood, body fluids, or | F 880 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 6/03/2025 an observation was made of Nurse #2 did not doffing her gloves, perform hand hygiene and donning clean gloves prior to applying wound treatment, a clean dressing and before moving to the second wound on Resident #14.<br><br>Effective 6/03/2025 the Director of Nursing educated Nurse #2 on doffing gloves between each wound care and performing proper hand hygiene.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>All residents have the potential to be affected by the alleged deficiency. | |

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| F 880 | Continued From page 19<br>contaminated surfaces.<br>d. After touching a resident<br>e. After touching the resident's environment<br>f. Before moving from working on a soiled body site to a clean body site on the same resident; and<br>g. Immediately after glove removal.<br><br>A wound observation was made on 06/03/25 at 3:08 PM on Resident #14 with Nurse #2 and the Infection Preventionist. Nurse #2 and the Infection Preventionist donned a clean gown and clean gloves. The Infection Preventionist stood on the resident's right side and held the resident over in a turned position so Nurse #2 could complete the dressing change. Nurse #2 then removed the old dressings from two wounds located on the residents lower back and sacrum. Nurse #2 placed the two soiled dressings into the trash can. Nurse #2 doffed her gloves, sanitized her hands, donned clean gloves and cleaned the wound to Resident #14's lower back. While wearing the same gloves Nurse #2 applied petroleum and silver alginate to the wound bed and covered the wound with a dry dressing. She then proceeded to move to the next wound located on Resident #14's sacrum without doffing her gloves and sanitizing her hands. Nurse #2 cleaned the wound bed to the sacrum, applied petroleum and silver alginate to the wound bed. A dry dressing was placed on the wound with tape to secure the dressing. She then doffed her gloves and sanitized her hands.<br><br>An interview conducted on 06/04/25 at 10:24 AM with Nurse #2 revealed she was aware that she had not sanitized her hands and changed her gloves between the dressing changes on Resident #14's lower back and sacrum. She | F 880 | Effective 6/27/2025 Director of Nursing and/or designee observed all current nurses on donning, doffing gloves between each wound care and performing proper hand hygiene after doffing gloves. Any negative findings were corrected immediately.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 6/27/2025 Director of Nursing and/or designee will educate current license nurses on donning and doffing between wound care and performing proper hand hygiene.<br><br>Effective 6/27/2025 any license nurse that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee.<br><br>Effective 6/27/2025 all license nurses including Agency nurse before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on " donning and doffing, performing proper hand hygiene between each wound care."<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Director of Nursing will audit three designated staff members weekly x 4 weeks, then bi-weekly x 4 weeks, then | |

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| F 880 | Continued From page 20<br>stated the resident had a total of 6 wounds and she had just gotten nervous and missed changing gloves and sanitizing between the first and second wound, however she corrected her mistake on the next dressing change she completed on the same resident. Nurse #2 stated she had received ongoing education on infection control and dressing changes, that it was just a mistake.<br><br>An interview conducted on 06/04/25 at 2:55 PM with the Infection Preventionist (IP) revealed she had observed the errors made by Nurse #2 during wound care. She stated her expectation was that she would sanitize her hands and change gloves every time she moved from a dirty area to clean area and with any new wound, she was applying a dressing to. She stated the residents lower back was one wound and the sacrum wound was a second wound, she further stated they had to be treated as two separate areas. The IP stated staff received education on infection control annually and multiple times during the year.<br><br>An interview on 06/04/25 at 11:03 AM with the Director of Nursing (DON) revealed she was aware of Nurse #2's errors during wound care and said she had been provided with additional education 06/03/24 regarding doffing and donning and sanitizing in between wound care. The DON stated it was her expectation for Nurse #2 to follow infection control best practices to avoid introducing microorganisms into the wounds.<br><br>An interview on 06/05/25 at 10:40 AM with the Administrator revealed she would expect Nurse #2 to follow the Hand Hygiene policy for wound care. | F 880 | monthly x 1 month.<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 6/29/2025 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345415 | A. BUILDING _____ B. WING _____ | C 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PINEVILLE REHABILITATION AND LIVING CTR** | **1010 LAKEVIEW DRIVE PINEVILLE, NC 28134** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
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