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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345111 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>01/23/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Penick Village |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>401 East Rhode Island Avenue<br>Southern Pines, NC 28387 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009</b></p> <p>Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 1 of 5 residents (Resident #19) reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>Resident #19 was admitted to the facility on [DATE].</p> <p>A review of Resident #19's physician orders revealed an order dated 9/4/24 for Lantus insulin (a long acting injectable medication to control blood sugar) 10 units subcutaneously (injected with a needle beneath the skin) daily at bedtime.</p> <p>A review of Resident #19's Medication Administration Record for December 2024 revealed documentation Resident #19 received Lantus insulin 10 units subcutaneously at bedtime on 12/6/24, 12/7/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24 and 12/12/24.</p> <p>A review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed documentation she received insulin injections on 4 of the 7 day look-back period days of the assessment.</p> <p>On 1/23/25 at 11:41 AM in an interview the MDS Nurse indicated she completed the medication section of Resident #19's MDS assessment dated [DATE]. She stated the look-back period for the assessment would have been from 12/6/24 through 12/12/24. She reported she could see documentation on Resident #19's MAR that Resident #19 received insulin injections on all 7 of the look-back days. The MDS Nurse stated she missed this when coding Resident #19's 12/12/24 MDS assessment. She reported this was an oversight on her part and she would correct it.</p> <p>On 1/23/25 at 11:51 AM in an interview the Director of Nursing confirmed Resident #19 received insulin injections on all 7 of the look-back period days of her 12/12/24 quarterly MDS assessment. She stated Resident #19's MDS assessment should have accurately reflected the number of days she received insulin injections.</p> <p>On 1/23/25 at 12:00 PM an interview with the Administrator indicated MDS assessments should accurately reflect the medication a resident received.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| NAME OF PROVIDER OR SUPPLIER<br><br>Penick Village   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>401 East Rhode Island Avenue<br>Southern Pines, NC 28387 |  |
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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37468</p> <p>Based on record review and staff interviews the facility failed to have an active order for hospice for 1 of 2 residents reviewed for hospice care. (Resident #3)</p> <p>Findings included:</p> <p>Resident #3 was admitted to the facility on [DATE].</p> <p>Review of physician orders revealed on 1/10/24 Resident #3 was ordered to have hospice consult and care. This order was discontinued on 8/8/24 by Nurse #3.</p> <p>During an interview on 1/22/25 at 4:49 PM Nurse #3 stated she must have incorrectly discontinued the hospice order for Resident #3 by accident in August 2024. Resident #3 had no break in her hospice care and was still currently receiving hospice care.</p> <p>Review of Resident #3's Hospice Certification dated 1/11/24 revealed Resident #3's hospice election date was 1/11/24.</p> <p>Review of Resident #3's Minimum Data Set assessment dated [DATE] revealed the resident was assessed to be receiving hospice services.</p> <p>Review of Resident #3's care plan dated 1/10/25 revealed Resident #3 was care planned to receive hospice services.</p> <p>During an interview on 1/22/25 at 4:45 PM Nurse #2 stated Resident #3 was on hospice and had been on hospice a long time. Resident #3 and any resident on hospice should have an active order for hospice. She stated Resident #3 was currently receiving hospice care and did not have any breaks in her hospice care since January 2024 but could not find an active order for hospice care in the health record.</p> <p>During an interview on 1/22/25 at 4:37 PM the Director of Nursing stated there was no active hospice order in Resident #3's medical record and there should be an active order for hospice. She stated the floor nurse was responsible for entering the hospice order and she could not find it. There was no break in Resident #3's hospice care.</p> <p>During an interview on 1/22/25 at 4:44 PM the Administrator stated there should be an active order for hospice if a resident was admitted to hospice.</p> |   |  |