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	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pineville Rehabilitation and Living Center	1010 Lakeview Drive Pineville, NC 28134

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included: Resident #346 was admitted to the facility on [DATE] and discharged on 4/8/2024. 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 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. The admission Minimum Data Set (MDS) assessment dated [DATE] 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. 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. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. On 6/5/2025 at 2:47 PM an interview with the 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. 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. A hospital referral form dated 10/25/24 revealed Resident #147 required continuous supplemental oxygen. Resident #147 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). A nursing progress note dated 11/01/24 revealed Resident #147 required 3 liters of supplemental oxygen. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #147 was coded for no oxygen therapy. 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. 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. 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. 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. The findings included: 1. Resident #345 was admitted to the facility on [DATE]. 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. A review of the discharge MDS assessment dated [DATE] revealed that the discharge status had been coded as discharge to home/community. 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included: Resident #9 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, cirrhosis of the liver and end stage renal disease. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was moderately cognitively impaired. 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. There was not an assessment for medication self- administration documented in Resident #9's electronic medical record. 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 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. 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. 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. 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. 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 Administrator did not know why Nurse #1 had left medication unattended with the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included: 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. Resident #31 was admitted to the facility on [DATE] with diagnoses which included seizure disorder, anxiety and depression. A review of Resident #31's care plan, revised on 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. A safe smoking assessment dated [DATE] revealed Resident #31 was a safe smoker, and the facility stored his smoking materials. A review of Resident #31's quarterly Minimum Data Set (MDS) dated [DATE] 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. 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. 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. An observation was conducted of Resident #31 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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 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 allowed to keep his own smoking supplies in his room. 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 ([NAME] Hall Medication Storage Room) reviewed for medication storage. The findings included: An observation of the [NAME] 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. 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. 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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). The findings included: Review of the facility's policy and procedure entitled Hand Hygiene and dated October 2021 read in part: 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: a. Immediately before touching a resident. b. Before performing an aseptic task c. After contact with blood, body fluids, or contaminated surfaces. d. After touching a resident e. After touching the resident's environment f. Before moving from working on a soiled body site to a clean body site on the same resident; and g. Immediately after glove removal. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. 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. 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.