STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to assess a resident ' s seating in order to provide a wheelchair, or other mobility device, that would meet his seating needs and allow him to spend time out of bed and out of his room as desired for 1 of 3 residents (Resident #4) and failed to provide water or other fluids within reach of a resident so he could self-hydrate at will for 1 of 3 residents (Resident #4). The findings included: 1. Resident #4 was admitted 3/10/16 and readmitted on 4/22/16 and 5/6/16 with cumulative diagnoses including muscular sclerosis, cerebral vascular accident (CVA), hemiplegia (left side), major depressive disorder, anxiety and hypertension. The Admission Minimum Data Set dated 5/13/16 indicated Resident #4 was cognitively intact, required extensive assistance of two people for transfers and had upper and lower limb range of motion impairment on one side. The Resident Care Guide initiated and created on 4/29/16 reveled the following care guidance Mechanical Sling size XXL revised 5/18/16; Geri-Chair, and " non-pharmacological behavior intervention: move from bed to chair " .	F 246	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center□s response to this Statement of Deficiencies does not denotes agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.	7/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 246	Continued From page 1 The Care Plan revealed Resident #4 had a plan of care for transferring related to physical limitations initiated and created on 4/29/16 and revised on 5/18/16 and an intervention dated 4/29/16 for mechanical lift with two person assistance. The Care Plan also included a plan of care for fall risk initiated and created on 4/29/16 and revised on 5/18/16 with an intervention dated 4/29/16 for " bed in lowest position. Geri chair who (sic) OOB (out of bed) " . There was also a plan of care initiated 5/18/16 for " requires assistance to restore / maintain maximum function of self-sufficiency for MOBILITY characterized by the following functions; positioning, locomotion/ambulation related to: admits non ambulatory, with generalized weakness and rt (right) sided hemiplegia due to CVA " . Interventions included " encourage resident to propel own wheelchair " ; this intervention was initiated and created on 5/18/16. A Social Worker note dated 5/2/16 revealed " resident tried to get up out of chair unassisted and fell on his face " . A Physical Therapy note dated 6/6/16 revealed " states he is not transferring into Geri-chair today. ' I can ' t stand that chair " . On 6/9/16 at 5:10 PM Nurse #3 was observed providing care to Resident #4. A wheelchair or Geri-chair was not observed in the room at that time. Resident #4 was interviewed with Nurse #3 present. He stated that there was no chair in the room because staff had not been getting him up. He added that he had gotten up in a Geri-chair in the past but that he did not like it because it was hard and uncomfortable. Resident #4 said that he wanted to get up in a wheel chair, not a Geri-chair, and said that he thought he would be able to mobilize a wheel chair on his own.	F 246	F 246 On 6/9/16, the director of nursing placed Resident #4's water where he could access it. On 6/13/16, Therapy assessed Resident #4 was for the appropriate chair, determining a Broda chair was most appropriate. On 6/22/16, a Broda chair was assigned to Resident #4. As of 6/22/16, Resident #4 has expressed no further concerns about Resident #4's chair or access to fluids being within reach. On 6/9/16 while making rounds, the department heads (administrator, DON, QI nurse, social worker, housekeeping supervisor, maintenance director, dietary manager, admissions director) and charge nurses placed 100% of residents' water pitchers and other fluids within reach of a resident so the resident could self-hydrate at will. On 7/1/16, the Rehab Manager completed a 100% audit of resident chairs to ensure the appropriateness of chair so the resident will be able to get out of bed daily and/or when requested. During the chair audit, the hall nurse made therapy referrals as needed. On 7/9/16, Therapy completed the chair screenings. As of 7/9/16, all residents have an appropriately assigned chair or mobility device that meets the resident's needs and allows the resident to spend time out of bed and out of their room as desired. On 6/9/16, the director of nursing and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 246	Continued From page 2 On 6/10/16 at 10:15 AM Occupational Therapist #1 was interviewed. She indicated that Resident #4 had not been tried in a wheelchair as yet and had only been up in a Geri-chair. She acknowledged that the resident did not like the Geri-chair and said it hurt his back and also said that he had slipped out of it. The OT stated that Resident #4 had some challenges with positioning and had variable sitting balance and due to this a standard chair might not be appropriate for him. She said there were other options like a Broda chair that had not been pursued as yet for the resident, and said she did not know why. The OT also said that there was one broad chair in the facility but someone else was already using it. She also acknowledged that appropriate seating for the resident could be ordered once the resident was assessed. On 6/10/16 at 2:07 PM NA #2 was interviewed. He stated that Resident #4 did not like getting up in the Geri-chair that therapy required him to sit in. When asked if he knew why the resident did not like the Geri-chair he stated " he just doesn ' t like sitting in it " . NA #2 also stated that it was hard for Resident #4 to get comfortable and that he was currently bedridden but that staff did encourage him to get up. On 6/10/16 at 4:20 PM the Director of Nursing was interviewed and indicated that it was her expectation that Therapy assess the resident for alternative wheelchair seating. 2. Resident #4 was admitted 3/10/16 and readmitted on 4/22/16 and 5/6/16 with cumulative diagnoses including muscular sclerosis, cerebral vascular accident (CVA), hemiplegia (left side), major depressive disorder, anxiety and hypertension. The Admission Minimum Data Set dated 5/13/16 indicated Resident #4 was cognitively intact,	F 246	restorative nurse initiated a 100% nursing staff retraining that resident□s' water pitchers have to be accessible to the resident at all times. This retraining was completed on 7/9/16. On 6/30/16, the director of nursing initiated an in-service related to ensuring the resident has an appropriate chair. On 7/9/16, this in-service was completed. All newly hired staff will be trained during orientation by the staff facilitator/ADON/DON regarding a) providing a wheelchair, or other mobility device, that meets the resident's seating needs and b) water or other fluids being placed within reach of the resident so the resident can self-hydrate at will. Beginning on 7/5/16, the DON or QI Nurse will complete the Seating audit tool monitoring provision of proper wheelchairs, or other mobility devices. The Seating audit tool will be completed 5x a week x 2 weeks, then weekly x 10 weeks and then monthly x 3 Months. The results of the completed Seating audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee (administrator, DON, ADON, QI nurse, MDS nurse, Medical Records, Social Worker, and Housekeeping Director) will review the audit results monthly x 3 months to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 246	Continued From page 3	F 246		

could eat with supervision and set up help and had upper and lower limb range of motion impairment on one side.
The Resident Care Guide initiated and created on 4/29/16 reveled the following care guidance: feeds self.
The Care Plan revealed Resident #4 had a plan of care for risk for falls initiated and created on 4/29/16 and revised on 5/18/16 with an intervention dated 4/29/16 for " keep commonly used items within easy reach " . The Care Plan also included a plan of care for the Resident ' s state of nourishment initiated and created on 5/18/16 with an intervention dated 5/18/16 for " set up tray and encourage consumption of meal " . There was also o plan of care for risk for skin breakdown initiated and created o 5/18/16 with an intervention dated 5/18/16 for " monitor nutritional intake and assist with feeding the resident whenever necessary " . There were no interventions specific to ensuring fluids were within easy reach.
A Resident Concern Form dated 4/29/16 was reviewed and revealed that a family member of Resident #4 had a concern that included no cups being available in the room and a concern that his " food tray was not set up and close enough to let resident feed himself " . The action taken regarding these concerns were 1) " Cups and water pitchers are in the rooms of all resident ' s that can have them GCA ' s (Geriatric Care Assistants) fill pitchers at the beginning of each shift " , 2) " Staff have been advised to make sure (Resident #4 ' s) tray is completely set up after taking the lid off all drinks are speared and straws inserted per resident ' s request and tray is also within reach " .
On 6/9/16 at 5:10 PM the resident ' s water pitcher, filled with ice water, and a stack of plastic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 246	Continued From page 4	F 246		

glasses was observed on at the sink counter in the resident ' s room. It was not on the resident ' s over bed table or within his reach.
On 6/9/16 at 5:30 PM Resident #4 was interviewed. He stated that the water pitcher was usually on his over bed table but someone moved it and never put it back. He also said that he was able to drink from a cup by himself but that he could not pour the water from the water pitcher.
On 6/10/16 at 8:00 AM Resident #4 was observed in bed feeding himself with his right hand.
On 6/10/16 at 10:30 AM the resident ' s water pitcher, filled with ice, and a stack of plastic glasses was observed on at the sink counter in the resident ' s room. It was not on the resident ' s over bed table or within his reach. NA #2 was present and interviewed at this time and stated that the Geriatric Care Assistants (GCA) were responsible for filling the pitchers at the beginning of each shift. He added that if the pitcher had been there previously the GCA had probably filled it this morning and left the pitcher where it was instead of moving it to the over bed table. NA #2 then moved the water pitcher and several plastic cups to the resident ' s over bed table within reach of Resident #4. He did not fill a plastic cup with water for the resident.
On 6/10/16 at 4:15 PM the resident ' s room was observed with the Director of Nursing (DON). Resident #4 was in bed at this time. The water pitcher was on the resident ' s over bed table within his reach but there were no cups on the table. The DON stated that cups should also be on the over bed table for the resident and added that they may have been removed by the GCS when the lunch trays were cleared or in an effort to keep the area tidy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 281	Continued From page 5	F 281		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to obtain a physician's order for a physical restraint device (self-release seat belt restraint) for one of three residents reviewed for restraints (Resident #9). The findings included: Resident #9 was initially admitted to the facility on 12/17/15. Cumulative diagnoses included, in part, Alzheimer's disease, dementia, restlessness and agitation. An Admission Minimum Data Set (MDS) dated 1/29/16 indicated Resident #9 had short term and long term memory impairment and was severely impaired in cognition. No restraints were documented as having been used during the assessment period. A Physical restraint evaluation dated 3/4/16 indicated risks and benefits of a physical restraint was discussed with the responsible party on 3/4/16. A care plan dated 3/23/16 indicated the use/ application of a physical restraint device for prevention of injury to self or to others characterized by high risk for injury, falls, impaired mobility, physical aggression related to unsteady gait, anxiety, decreased/ poor safety awareness. Interventions: Discuss necessity of restraining device for resident with resident and family. Evaluate device for least restrictive, reduction and/or discontinuation per facility	F 281	F281 On 6/9/16, the hall nurse obtained an order for a self-releasing seat belt from resident #9's physician Dr. Arnold. On 6/9/16, the QI nurse completed a 100% audit of residents with restraints to ensure that orders for restraints were in place. 100% of residents with restraints had a physician's order for a physical restraint device, including Resident #9's 6/9/16 order. On 6/30/16, the Director of Nursing (DON) and Rehab Manager started 100% in-servicing of all RNs, LPNs, and 100% of rehab staff on what is considered a restraint and the need for an order before a physical restraint device is applied. On 7/9/16, the DON, QI nurse, staff facilitator, and/or rehab manager will complete this in-servicing. No employee will be allowed to complete a work shift without having the restraint in-service. The DON, QI nurse, staff facilitator, and/or rehab manager will provide restraint in-servicing to all new employees during new employee orientation.	7/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 281	Continued From page 6 protocol. Use self-release seat belt restraint (SRSBR) safety device when in scoot chair. Remove device during supervised activities and re-apply upon completion. A Quarterly MDS dated 4/30/16 indicated Resident #9 had short term and long term memory impairment and was severely impaired in cognition. During the assessment period, a trunk restraint was used less than daily. A review of physician's orders from February 2016 through present was conducted. There was not a physician's order for a self-release seat belt restraint device for Resident #9. On 6/8/16 at 4:40PM, Resident #9 was observed in her wheelchair with a self-release seat belt restraint secured around her waist area. She was making no attempt to release the seat belt restraint. On 6/8/16 at 4:43PM, an interview was conducted with Nurse #2. She stated a self-release seat belt restraint would be used for residents that were at great risk for falling or had fallen. She stated the resident would be assessed by the Quality Improvement (QI) nurse and the use of a self-release seat belt restraint would be determined by the QI nurse and the physician. Nurse #2 stated a physician's order would be written for the self-release seat belt restraint. She stated Resident #9 could release her seat belt but rarely released the self-release seat belt restraint on command. On 6/9/16 at 10:34AM, Resident #9 was observed in a wheelchair with a self-release seat belt restraint secured around her waist area. On 6/9/16 at 10:35AM, Nurse #1 stated a self-release seat belt restraint was used for Resident #9 because she was at a high risk for falls and would try and get up unassisted. On 6/9/16 at 10:45AM, an interview was	F 281	The assistant director of nursing (ADON), DON, staff facilitator and/or QI Nurse will monitor all residents to ensure that all residents that have a physical restraint device have a physician order and consent and assessment as ordered. The use of physical restraint devices will be monitored by the DON, ADON, QI nurse, staff facilitator, and/or rehab manager using the Restraint audit tool 5x/week for 2 weeks then weekly for 10 weeks then monthly for three months. The DON, ADON, or QI nurse will present the Restraint audit tool findings to the QI Committee (administrator, DON, ADON, QI nurse, staff facilitator, MDS nurse, rehab manager, social worker, maintenance supervisor, admissions coordinator, dietary manager). The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 281	Continued From page 7 conducted with NA#1 who stated a self-release seat belt restraint was used for Resident #9 due to her high risk for falling. NA#1 said Resident #9 had been able to release the seat belt restraint herself until recently. She said Resident #9 wore the self-release seat belt restraint most of the time. On 6/9/16 at 3:59PM, an interview was conducted with the Director of Nursing who stated she could not find a physician's order for the self-release seat belt restraint for Resident #9 and stated she expected a physician's order to be written when a self-release seat belt restraint was used for a resident.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview the facility failed to provide incontinent care to a dependent resident for 1 of 3 residents (Resident # 3). The findings included: Resident #3 was admitted 9/8/08 and had cumulative diagnoses including anxiety, bipolar disorder, dementia, hyperlipidemia, osteoarthritis, hypertension and diverticulosis. The Quarterly Minimum Data Set (MDS) assessment dated 4/1/16 revealed Resident #3 was cognitively impaired and required extensive assistance of 2 staff for toileting and was always	F 312	F 312 On 5/27/16, the assigned medication aide/nursing assistant provided incontinent care to dependent Resident #3. On 5/27/16, the director of nursing (DON), QI nurse, and hall nurses performed a 100% audit of all residents for incontinent care for that day shift. Any resident needing incontinent care was immediately	7/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 312	Continued From page 8 incontinent of bowel and bladder. The MDS also indicated that the resident had not refused care. Review of the Care Plan revealed a plan of care initiated and created on 1/15/14 and revised on 2/13/16 for " at risk for recurrent UTI ' s (urinary tract infections) " with interventions including: encourage appropriate hygiene techniques. Assist/provide peri-care as indicated " initiated and created on 1/15/14. There was also a plan of care for ineffective coping and refusal of baths and showers revised on 2/13/16; the plan of care did not indicate that the resident refused incontinent care. The staff assignment sheet for 5/27/16 was reviewed. Nursing Assistant #3 (NA #3) and Nursing Assistant #4 (NA #4) were assigned to the hall that Resident #3 ' s room was on that day for the 7:00 AM - 3:00 PM shift. Med Aide #2 was assigned to pass medications. On 6/9/16 at 10:15 AM Resident #3 was observed in bed with the head of her bed raised approximately 75 degrees. She was asked if she was comfortable or in need of incontinent care but did not understand the question. Med Aide #2 then entered the room and asked the resident if she needed anything and she indicated she did not. Med Aide #2 was interviewed at this time and stated that he had never come on shift and found the resident soaking wet, or through her briefs, as if she had not received incontinent care on the previous shift but that as a Med Aide he passes medications and did not have an assignment for providing personal care. When asked, he said that he had heard of one incident when Resident #3 had not received incontinent care during the morning and was found by a family member who was upset about it but he could not recall further details at that time. On 6/9/16 at 11:30 AM a family member of	F 312	provided incontinent care. On 6/30/16, the administrator, DON, and/or QI nurse initiated retraining for 100% nursing staff (RNs, LPNs, CNAs), including weekend and PRN staff, on providing incontinent care in a timely manner. The DON, assistant director of nursing (ADON), QI nurse, and/or staff facilitator will be complete the incontinent care retraining with the nursing staff on 7/9/16. No nursing staff will be allowed to complete a work shift until having the incontinent care retraining. The DON, QI nurse, and/or staff facilitator will train, during orientation, all newly hired nursing staff on providing incontinent care to a dependent resident in a timely manner. On 6/10/16 the DON, QI nurse, and hall nurses completed 100 % of the residents to ensure all residents received incontinent care in a timely manner. The DON/QI/Administrator will audit Incontinence care, including all shifts and weekends, utilizing the Resident Incontinence Care Audit tool. The audits will be completed 5x weekly for 2 weeks, then weekly x 10 weeks then monthly x3. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The DON will present the audit results to the QI Committee (administrator, DON, ADON, QI nurse, staff facilitator, MDS nurse, rehab manager, social worker, maintenance supervisor, admissions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 312	Continued From page 9 Resident #3 (Family Member #1) was interviewed. He stated that on 5/27/16 he came to the facility and at approximately 10:45 AM found Resident #3 in cold urine soaked briefs through to the linens on her bed. He added that he spoke to Nursing Assistant # 3 (NA #3) on the hall and she told him she did not know she was assigned to the resident, and had not provided incontinent care to the resident yet, as the hall was split between herself and another NA. The family member also said that there had been a similar occurrence on 5/14/16 but another family member had been present. On 6/9/16 at 2:00 PM Nursing Assistant #3 was interviewed. NA #3 stated that she had worked on 5/27/16 on 1st shift (7:00 AM - 3:00 PM) and recalled the incident when Family Member #1 came in and found the resident in bed with wet briefs on 5/27/16. She stated that she was splitting several rooms on the hall that day (including Resident #3 ' s room) with another staff member and they had not yet decided who would have Resident #3. NA #3 also indicated that she focused first on the residents she was specifically assigned to and had not provided incontinent care to Resident #3 before Family Member #1 arrived, sometime just before 11:00 AM. NA #3 stated that another family member (Family Member #2) usually came in after lunch but on 5/27/16 a family member (Family Member #1) arrived earlier than expected and was upset that the resident was wet and not up yet. NA #3 said that " we " would have gone in to provide care to Resident #3 at about 11:00 AM. On 6/10/16 at 1:42 PN Nursing Assistant #4 (NA #4) was interviewed. She stated that she recalled an incident on 5/14/16 when Family Member #2 came in before 10:30 which was earlier than usual and found Resident #3 wet and not up yet.	F 312	coordinator, dietary manager)monthly x 6 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 312	Continued From page 10 NA #4 said Family Member #2 was very upset but she (NA #4) had already provided incontinent care to Resident #3 before breakfast. In regards to the incident on 5/27/16 NA #4 stated that she wasn ' t involved in it and wasn ' t aware of it at the time but did hear about it after the fact. Although she worked on Resident #3 ' s hall on the 7:00 AM - 3:00 PM shift (1st shift) on 5/27/16 she did not recall the specific events of that day. Med Aide #2 was re-interviewed on 6/10/16 at 3:00 PM. He stated he recalled working on Resident #3 ' s hall on 5/27/16 on 1st shift and that the two Nursing Assistants on the hall (NA #3 and NA #4) would have become aware they were splitting the assignment when they came on that morning and initialed the assignment sheet. He stated that when Family Member #1 came in he was upset about Resident #3 being wet. Med Aide #2 also said that he went ahead and provided incontinent care to Resident #3 at that time as the NA ' s were busy and he wanted to take care of it. He stated that Resident #3 was a heavy wetter and therefore used inserts in her briefs that the family had approved. He acknowledged that when he changed Resident #3 ' s brief it was very wet and the pad had to be changed as well, since it was damp. NA #3 indicated he thought NA #3 had provided incontinent care to Resident #3 before breakfast but that if she said she didn ' t that she must not have. On 6/20/16 at 4:20 PM the Director of Nursing (DON) was interviewed. She indicated she expected staff to check for incontinence and provided need incontinent care more fequently than every 4 hours.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		7/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 329	Continued From page 11 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain and give medications according to physician ' s orders for a period of 4 days for 1 of 3 residents (Resident #4) reviewed for unnecessary medications. The findings included: Resident #4 was admitted 3/10/16 and readmitted on 4/22/16 and 5/6/16 with cumulative diagnoses including muscular sclerosis, cerebral vascular accident (CVA), hemiplegia (left side), major	F 329	F- 329 On 06/10/2016, resident # 9 was immediately assessed by the director of nursing (DON) with no negative findings. On 06/10/16 the director of nursing (DON) and quality improvement (QI) nurse initiated in- servicing for all RNs, LPNs, and medication aides on having ordered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 329	Continued From page 12 depressive disorder, anxiety and hypertension. The Admission Minimum Data Set (MDS) dated 5/13/16 indicated Resident #4 was cognitively intact, and was taking antianxiety medication and scheduled pain medication. The MDS also revealed that Resident #4 had frequent pain that made it hard to sleep at night and limited his day to day activities. According to the MDS Resident #4 rated his pain as 6 on a 0-10 scale. Review of the Physician Orders dated 5/6/16 revealed admission orders including: " Lyrica 150 mg (milligrams) orally tid (three times a day) " (a medication used to treat nerve and muscle pain) and " Klonopin 1 mg po (by mouth) qid (four times a day) " (an antianxiety medication). Review of the Nurses Notes for 5/6/16 revealed Resident #4 was readmitted by 1 PM on 5/6/16. Review of the Medication Administration Record (MAR) for May 2016 revealed that all three daily doses of Lyrica and all four daily doses of Klonapin were documented as not given for 4 days from 5/7/16 through 5/10/16. Resident #4 also missed his 4:00 PM and 8:00 PM doses of Lyrica on 5/6/16 and his 6:00 PM dose of Klonapin on 5/6/16. The Care Plan revealed Resident #4 had a plan of care for pain initiated and created on 5/18/16 with interventions that included: " administer pain medication as per MD (Medical Doctor) orders " . There was also a plan of care for ineffective coping initiated and created 5/18/15 with interventions that included " administer medications as per MD orders " . On 6/10/16 at 11:00 AM the Pharmacy was called. The Pharmacy Manager was interviewed and stated that the resident ' s Lyrica and Klonapin was delivered to the facility with the 5/11/16 delivery as the hard script (hand written	F 329	medications on hand. On 7/9/16, the DON, QI nurse, and staff facilitator will complete this Unnecessary Drugs- Having Ordered Medication on Hand in-service with the RNs, LPNs, and medication aides, to include weekend and PRN staff. No RN, LPN, or medication aide will be allowed to begin a work shift without completing this in-service. The DON, QI nurse, or staff facilitator will train all newly hired RNs, LPNs, and medication aides during new employee orientation. On 07/08/16, the DON, QI nurse, staff facilitator, treatment nurse, resident care coordinators, and hall nurses, completed a 100% audit comparing medication administration records (MARs) and treatment administration records (TARs) to medications in the medication carts and treatment carts to ensure ordered medications are available to administer as ordered, to include Resident #4's Lyrica and Klonapin medication. All prescribed medications will be available by 07/09/16. Beginning 07/09/16, the DON, ADON, QI nurse, staff facilitator, consultants and/or resident care coordinators will audit the availability of medications compared the MARs and TARs utilizing the Medication Availability Audit tool. The audits will be completed 5x weekly for 2 weeks, then weekly x 10 weeks then monthly x3. The results of the completed audit tool will be reviewed weekly by the Administrator. The DON will present the results of the Medication Availability Audits to the QI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 329	Continued From page 13 prescription) that was required for controlled substances like Lyrica and Klonapin arrived at the pharmacy 5/9/16. On 6/10/16 at 11:45 AM the Physician was interviewed. He stated that 4 or 5 days without having Lyrica or Klonapin as ordered was a concern. He added that the facility usually called him for a hard script (hand written prescription) for these medications as they were controlled substances and required a written prescription. He added that he was at the facility every Tuesday and wrote the hard scripts for Lyrica and Klonapin on the Tuesday when he signed the Resident ' s admission orders (Resident #4 was admitted on a Friday). He said that the facility was pretty good about calling him and he thought it was an unusual occurrence. On 6/10/16 at 3:10 PM interview with Nurse #3 revealed that since both Klonapin and Lyrica were controlled substances and required a hard script (hand written prescription) from the doctor, the hall nurse needed to contact the doctor when these type of medications were ordered to get the had script and fax it to the pharmacy. She stated that when she was responsible for processing orders for controlled medications she would send the hard script to the pharmacy with the pharmacy courier. She added that the pharmacy closed at 4:00 - 5:00 PM but if the hard script got there before they closed the medication should arrive with the next delivery around midnight. Nurse #3 said there was a back-up pharmacy phone number but sometimes an answering machine for service the next day would pick up. She stated that the facility also had and stat/emergency box of selected back-up medications. She said she thought it contained Klonapin but not Lyrica. She did not know why it had taken four days for Resident #4 ' s	F 329	Committee monthly x 6 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 329	Continued From page 14 medication to arrive and be given to Resident #4. On 6/10/16 at 4:20 PM the Director of Nursing was interviewed. She indicated that she expected a hard script be obtained at the time of a resident ' s admission and that medications should be available and given to the resident as ordered. She added that she recently discovered that the fax machine used for faxing hard scripts was broken and unable to send faxes, it could only receive incoming faxes.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, resident, physician, pharmacy consultant and staff interview, the facility failed to ensure that the medication error rate was 5% or below by not administering a renal medication at meals as ordered by the physician (Resident # 6 and #7). There were 2 errors of 25 opportunities for error resulting in an 8% error rate. The findings included: Renvela (sevelamer) is a phosphate binder. Sevelamer helps prevent hypocalcemia (low levels of calcium in the body) caused by elevated phosphorus. 1. On 6/9/16 at 1:20PM, an interview was conducted with Resident #6. He stated there were times when he did not get his medication when he should and stated he should have received his Renvela when he ate his lunch at 12:00noon and he had not received his	F 332	F- 332 On 06/10/2016, resident # 6&7 was immediately assessed by the director of nursing (DON) with no negative findings. The notation to administer the Renvela medication with meals was noted on the MAR by the DON. All residents on Renvela were checked by the DON and any negative findings corrected immediately by the DON. On 6/10/2016, the DON and quality improvement (QI) Nurse initiated in-servicing RNs, LPNs, and medication aides on administration of Renvela with meals. The in-servicing and will be completed by 7/9/16. All newly hired	7/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 332	Continued From page 15 medication as of 1:20PM. A Quarterly Minimum Data Set (MDS) dated 3/4/16 indicated Resident #6 was cognitively intact. On 6/9/16 at 1:37PM, medication aide #1 was observed as she prepared medications for administration to Resident #6. The medication was Renvela 800 milligrams (mg) 5 tablets=4000mg. The medication aide was observed as she administered the Renvela tablets to Resident #6. A review of Resident #6 ' s medication orders included a current order for Renvela 800 milligrams (mg). Take 5 tablets=4000mg by mouth three times a day with meals. An interview was conducted with medication aide #1 on 6/9/16 at 2:00PM. She stated sometimes they " catch " Resident #6 in the dining room and administer the medication at that time. Medication aide #1 stated she knew the medication was late and should have administered the medication when Resident #6 was having lunch. On 6/10/16 at 11:40AM, an interview was conducted with Resident #6 ' s attending physician. He stated the medication was ordered by the nephrologist (kidney specialist) and he felt the medication should be administered with meals if that was the order given by the nephrologist. On 6/10/16 at 11:48AM , an interview was conducted with the pharmacy consultant. She stated Renvela had to be given at the time food was given because the medication immediately acted like a sponge to " soak " up the phosphorus. The pharmacist consultant stated she had spoken to nursing about the need to administer the medication at the time the resident was eating and that the times on the Medication Administration Record did not matter because the	F 332	nurses and medication aides will be trained. On 06/10/2016, the DON and QI nurse performed a 100% audit of all residents on Renvela medication to ensure medication is given with food at meals. The DON, assistant director of nursing (ADON), QI nurse, and/or staff facilitator will audit Dialysis patients medication administration records (MARs) utilizing the Audit tool. The DON, assistant director of nursing (ADON), QI nurse, staff facilitator, and/or Administrator The will complete the audits 5x weekly for 2 weeks, then weekly x 10 weeks then monthly x3. Beginning 07/09/16, the DON, ADON, QI nurse, staff facilitator, consultants and/or resident care coordinators will perform medication pass audits utilizing the Medication Pass Audit Form. The medication pass audits will monitor to ensure medications are administered at the time the medication is ordered to be given, including the administration of Renvela with meals. The audits will be completed 5x weekly for 2 weeks, then weekly x 10 weeks then monthly x3, to include weekend shifts. The results of the completed audit tools will be reviewed weekly by the Administrator. The DON or QI nurse will present the results of the audits to the QI Committee (administrator, DON, ADON, QI nurse,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 332	Continued From page 16 administration of Renvela was " meal dependent " . On 6/10/16 at 4:27PM, an interview was conducted with the Director of Nursing. She stated she expected the medication to be given as ordered with meals. 2. . On 6/9/16 at 1:20PM, an interview was conducted with Resident #7. He stated he did not receive his Renvela when he ate his meals and that happened most of the time. He said he had eaten lunch at 12:00 noon and had not received his medication as of 1:20PM. A Quarterly Minimum Data Set (MDS) dated 5/20/16 indicated Resident #7 was cognitively intact. On 6/9/16 at 1:34PM, medication aide #1 was observed as she prepared medications for administration to Resident #7. The medication was Renvela 800 milligrams (mg) 3 tablets=2400mg. The medication aide was observed as she administered the Renvela tablets to Resident #7. A review of Resident #7 ' s medication orders included a current order for Renvela 800 mg 3 tablets=2400mg by mouth three times a day with meals. An interview was conducted with medication aide #1 on 6/9/16 at 2:00PM. She stated sometimes they " catch " Resident #7 in the dining room and administer the medication at that time. Medication aide #1 stated she knew the medication was late and should have administered the medication when Resident #7 was having lunch. On 6/9/16 at 4:34PM, an interview was conducted with Resident #7 ' s attending physician. He stated he followed the recommendations of the nephrologist and the recommendation was to give the medication with meals. On 6/10/16 at 11:48AM , an interview was	F 332	staff facilitator, MDS nurse, rehab manager, social worker, maintenance supervisor, admissions coordinator, dietary manager). The QI Committee will review the audits monthly x 6 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 06/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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
F 332	Continued From page 17 conducted with the pharmacy consultant. She stated Renvela had to be given at the time food was given because the medication immediately acted like a sponge to " soak " up the phosphorus. The pharmacist consultant stated she had spoken to nursing about the need to administer the medication at the time the resident was eating and that the times on the Medication Administration Record did not matter because the administration of Renvela was " meal dependent " . On 6/10/16 at 4:27PM, an interview was conducted with the Director of Nursing. She stated she expected the medication to be given as ordered with meals.	F 332		