STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to prevent a dependent resident from falling out of the bed during incontinence care for 1 (Resident #1) of 4 residents reviewed for falls. Resident #1 fell from the right side of the bed while the bed was in the high position sustaining bilateral femoral fractures requiring surgical intervention. The finding included: Resident #1 was admitted 11/18/17 with a diagnosis of Multiple Sclerosis (MS). Review of Resident #1's quarterly fall assessment dated 8/15/18 read she had no history of falls in the last six months, she was cognitively intact. She was coded as non-ambulatory. Resident #1's quarterly Minimum Data Set (MDS) dated 8/17/18 indicated she was cognitively intact and exhibited no behaviors. She was coded as requiring extensive assistance of two staff for bed mobility, extensive assistance of one staff for toileting and personal hygiene. Resident #1 was coded for one side impairment to the upper extremity and bilateral impairment to lower extremities. She was coded as having had no	F 689	CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Resident #1 was assessed by the licensed nurse following the incident on 10/08/18. The licensed nurse notified the physician on 10/08/18 at approximately 6:45am, and received an order to send Resident #1 to the hospital for evaluation and treatment. Resident #1 was admitted to the hospital on 10/08/2018 and readmitted to the facility on 10/12/2018.The licensed nurse assessed the resident for bed mobility upon return to the facility on 10/12/2018 and updated plan of care to include two person assistance for bed mobility. A therapy order was obtained on 10/15/18, to evaluate and treat as indicated for bilateral lower extremity knee fractures. IDENTIFICATION OF OTHER RESIDENTS: Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and the Assistant Director of Nursing assessed and/or observed all current	11/9/18

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

Electronically Signed | 11/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 1 falls since the previous MDS assessment. Review of Resident #1's plan of care initiated on 11/09/17 and in place on 10/08/18 identified the resident as being a "fall risk". The interventions for Resident #1 included to reinforce her to call for assistance. A review of a nursing note dated 10/8/18 at 6:45 AM read Resident #1 was heard screaming. On entry to the room, Resident #1 was observed lying on the floor. She complained of pain to both knees. Nursing Assistant (NA) #1 stated she rolled Resident #1 to change her brief and Resident #1 was trying to get something off the nightstand when she rolled onto the floor. Resident #1 requested to be transferred to the hospital for an evaluation. The Physician was notified, and Resident #1 was transported to the hospital by Emergency Medical Services (EMS). Review of the facility incident report and investigation dated 10/8/18 read Resident #1 fell to the floor while NA #1 was providing care. The report indicated Resident #1 was alert and oriented, but no statement was obtained at the time of the fall at 6:45 AM. The Post Fall Investigation Summary dated 10/8/18 at 7:15 AM read Resident #1 rolled out of the bed to the floor while NA #1 was rendering care. Resident #1 was receiving perineal care at the time of the fall. The new intervention care plan decision read the facility would assess for safe bed mobility on Resident #1's return from the hospital. Review of the hospital records 10/8/18 revealed Resident #1 fell from the bed while being changed. Resident #1 was diagnosed with bilateral acute commuted displaced fractures of	F 689	facility residents during bed mobility for safety and needs with completion on 10/09/18.Nineteen residents were identified to be screened by therapy for needs regarding bed mobility. Nine residents were already receiving therapy services, four residents received orders for evaluation and treat as indicated and six residents were screened by therapy with no new recommendations. The licensed nurses made referrals to the therapy department on 10/09/18, for residents identified with potential bed mobility needs. The Physical therapists and/or the Occupational therapists made recommendations and/or implemented interventions as necessary for safe bed mobility for identified residents on 10/09/18. MEASURES FOR SYSTEMIC CHANGE: The Director of Nursing and/or the Assistant Director of Nursing completed education for the licensed nurses and certified nursing assistants on 10/09/18, regarding Safety during bed mobility and communicating changes with resident needs during bed mobility. No nursing staff who was absent or PRN staff will be allowed to return to the floor and provide resident care until the training has been completed. Newly hired licensed nurses and certified nursing assistants will be educated during new hire orientation. HOW CORRECTIVE ACTION WILL BE MONITORED:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 2 the left and right femur requiring bilateral open reduction internal fixation of both fractures. She was discharged back to the facility on 10/12/18. Review of Resident #1's readmission fall assessment dated 10/12/18 read she had a history of one fall in the last six months and she was cognitively intact. She was coded as non-ambulatory. Review of Resident #1's revised care plan dated 10/12/18 included the following new interventions: Discourage Resident #1 from rearranging her nightstand and over the bed table during turning and repositioning, have commonly used articles within easy reach, total care of two staff for bed mobility and transfers. In an interview on 11/6/18 at 10:05 AM, the Director of Nursing (DON) stated Resident #1 could not move independently in the bed and required two staff assistance with bed mobility and incontinence care. An observation and interview with Resident #1 was conducted on 11/6/18 at 10:10 AM. Resident #1 was lying in the bed with her nightstand and her bedside table on the right side of the bed. She was deemed cognitively intact and recalled the fall that occurred on 10/8/18. Resident #1 stated NA #1 was changing her early that morning. She stated NA #1 raised her bed to the highest position and was rolling her back and forth to change her brief when NA #1 rolled her onto her right side and she was too close to the edge of the bed. She recalled suddenly rolling onto the floor and landing on her knees. Resident #1 stated she thought NA #1 took her hands off her to reach for something when she rolled onto	F 689	The Director of Nursing and/or the ADON/Unit managers will observe 5 residents weekly for 4 weeks and 10 residents monthly for 3 months, during bed mobility to validate current bed mobility interventions are followed and remain appropriate for the resident□s safety and staff verbalize process for communicating resident changes. The Director of Nursing will review monthly the audits/observations to identify patterns or trends and will adjust plan as necessary. The Director of Nursing will review the plan during monthly QAPI meeting and the plan will continue at the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 3	F 689		

the floor. Resident #1 stated as soon as she fell, the aide stated, "I'm so sorry" and yelled for help. She stated she was experiencing extreme pain to both knees and was sent to the hospital. Resident #1 said while at the hospital, she required surgery to both legs and was now having to wear bilateral knee immobilizers when she was up to the chair. She stated she spoke with the DON and requested NA #1 not work with her anymore. Resident #1 stated she could not independently reposition or roll herself in the bed prior to the fall due to her MS and limited range of motion in her left arm. She stated she had not experience any other falls.

In an interview on 11/6/18 at 11:50 AM, NA #2 stated Resident #1 was only one-person assistance for bed mobility and incontinence care prior to the fall but now she needed the assistance of two staff. NA #2 stated Resident #1 had limited movement in her left arm prior to the fall on 10/8/18. NA #2 stated after the fall, the staff were in-serviced on proper bed positioning when providing incontinence care to dependent residents and that the resident was positioned in the middle of the bed.

In an interview on 11/6/18 at 2:20 PM, NA #4 and NA #3 stated Resident #1 could not roll herself independently and could not reposition herself independently due to limited range of motion in the left upper extremity and bilateral lower extremities prior to the fall and after the fall. NA #4 stated she had not observed Resident #1 reaching for items off the nightstand during care. NA #3 stated she had observed Resident #1 reaching for things off her bedside table but not during incontinence care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 4	F 689		

In a telephone interview on 11/6/18 at 2:23 PM, Nurse #1 stated she was working that night and was standing at the nursing station when she heard a "thump" and a scream. She stated she and another nurse entered Resident #1's room and noted there was no lights on in the room. Resident #1 was on the right of her bed on the floor. Nurse #1 stated NA #1 was standing near Resident #1 and stated she rolled Resident #1 over to clean her and she "just keep rolling." Nurse #1 stated NA #1 stated she did not leave Resident #1 unattended but could not stop her fall because it happened so fast. She recalled NA #1 stating Resident #1 was reaching for her nightstand when she fell. Nurse #1 stated she was not sure if Resident #1 was near the edge of the bed when the fall occurred but stated the bed was observed in the high position.

Attempts to speak with Nurse #2 who was assigned Resident #1 on third shift at the time of her fall on 10/8/18 were unsuccessful.

In a telephone interview on 11/6/18 at 2:34 PM, NA #1 stated she was changing Resident #1 toward the end of her shift on 10/08/18. She stated Resident #1 preferred to keep her bed control and light cord near her right side since her left arm was "weak." NA #1 stated she turned on the overbed light and raised Resident #1's bed. NA #1 stated she removed her brief and rolled Resident #1 over to clean her. NA #1 stated she rolled Resident #1 onto her right side and she "just keep rolling" and she couldn't catch her. She stated when Resident #1 rolled off the bed, her overbed light cord was near Resident #1's right hand and it must have got caught when she fell and the overbed light was turned off. NA #1 stated Resident #1 was reaching for something

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 5	F 689		

on the nightstand causing her to roll off the bed. NA #1 confirmed Resident #1 was lying on her right side. NA #1 could not offer an explanation how Resident #1 was able to reach over to her nightstand using her left arm. NA #1 stated she could not recall removing her hand off Resident #1, but it happened so fast. NA #1 stated she thought Resident #1 was repositioned into the middle of the bed when she rolled her over. NA #1 stated the DON asked for her statement and she was reminded to keep Resident #1 in middle of bed prior to turning her.

In an interview on 11/6/18 at 3:45 PM, NA #5 stated she had not observed Resident #1 reaching for her bedside table or nightstand during care. NA #5 stated Resident #1 was total staff assistance for bed mobility and had limited range of motion in her legs and left arm prior to her fall and after the fall. NA #5 stated the DON educated the aides after Resident #1's fall to ensure any resident dependent on staff assistance for bed mobility or incontinence care was re-positioned in the middle of the bed prior to being turned.

In another interview on 11/6/18 at 4:43 PM, the DON produced an undated in-service which reminded the staff to ensure the resident was re-positioned in the center of bed during care prior to turning. The DON produced an employee signature log regarding proper bed positioning dated 10/9/18. The DON did not provide any evidence of re-education for NA #1. The DON stated it was her expectation that all residents who were dependent on staff for bed mobility and incontinence care include the correct number of staff assistance, proper bed positioning prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 689	Continued From page 6 turning the resident and staff not the leave a resident unattended during care.	F 689		