STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		12/1/16

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

Electronically Signed | 11/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to completely assess residents on the comprehensive assessment in the area of height (Resident #171) and weight (Resident #202) for 2 of 25 sampled residents. The findings included: 1. Resident #171 was admitted to the facility on 7/6/16 with multiple diagnoses including chronic kidney disease. The admission Minimum Data Set (MDS) assessment indicated she had moderately impaired cognition. Section K, the Swallowing/Nutritional Status section, was not fully completed. Question K0200A required documentation of Resident #171's height in inches. This question was coded with a dash that indicated the question was not answered. An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. The DM revealed that if there was no documented height in the medical record for a resident at the time she completed Section K then she left the question (K0200A) blank or entered a "0". She reported she had not asked anyone to obtain a resident's height for her if it was not readily available. An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 7/6/16 for Resident #171 that indicated her height was not assessed was	F 272	For the residents found to have been affected by the alleged deficient practice (#171 and #202) a minimum data set (MDS) correction was submitted on 11/4/2016 by the Minimum data set coordinator. For those residents having the potential to be affected by the alleged deficient practice the Dietary Manager was educated on 11/7/2016 by Director of Nursing (DON) on facility procedures on coding MDS assessments properly. The MDS nurses were educated on 11/4/2016 by Director of Nursing on coding MDS assessments properly. 100% of current residents were audited on 11/7/2016 for heights and weights entered into the system by the DON. There were 20 residents noted to not have heights and/or weights in system and they were added. All residents now have a current height and weight entered into the system. The most recent yearly, quarterly or admission assessment for 100% of residents were audited by Director of Nursing and Assistant director of nursing on 11/25/16. As a result of the audit 25 MDS assessments were found to not have either a height and /or weight entered. All MDS assessments with missing information will be corrected by the MDS nurses by 12/1/2016. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place: Heights and weights will be entered in computer	

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F 272	Continued From page 2 reviewed with the MDS Coordinator. She indicated the height was required to be entered on the MDS. She reported if a height had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. The MDS Coordinator revealed the facility needed a system to obtain a resident's height at the time of admission. She reported there was no system in place at this time. An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were fully completed. 2. Resident #202 was admitted to the facility on 10/5/16 with multiple diagnoses including heart disease. The admission Minimum Data Set (MDS) assessment dated 10/12/16 indicated he was cognitively intact. Section K, the Swallowing/Nutritional Status section, was not fully completed. Question K0200B required documentation of Resident #202's weight in pounds. This question was coded with a dash that indicated the question was not answered. An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. The DM revealed that if there was no documented weight in the medical record for a resident at the time she completed Section K then she left the question (K0200B) blank or entered a "0". She reported she had not asked anyone to obtain a resident's weight for her if it was not readily available.	F 272	system within 72 hours of admission to facility by the admitting nurse. All new admissions will be reviewed by the administrative nurses which include the Director of nursing, Assistant Director of Nursing, the Clinical Coordinator and the MDS Coordinator in the clinical meeting the next business day after admission for completion of heights and weights. Audits will be performed during weekly Patients at Risk meeting by Patients at risk committee team members, to include the Director of Nursing, Clinical Coordinator or Assistant Director of Nursing, the MDS coordinator and the Dietary Manager. The Dietary Manager is responsible for completing section K and the MDS Coordinator will ensure that section K is completed prior to signing the MDS as complete. Five MDS assessments will be audited weekly for height and weight for four weeks and five MDS assessments will be audited biweekly for one month then monthly for four months alternating different residents in each MDS assessment review period. Results of these audits will be kept to the Director of nursing who will bring to the monthly Quality Assurance meeting (QA) meeting to be reviewed and discussed. The Plan of Correction will be monitored and if needed will be altered to ensure that compliance is met. Continued audits will be performed based on results of the previous audits.	

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F 272	Continued From page 3 An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated that she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 10/12/16 for Resident #202 that indicated his weight was not assessed was reviewed with the MDS Coordinator. She indicated the weight was required to be entered on the MDS. She reported if a weight had not been documented in the resident's medical record at the time of the MDS assessment that the weight needed to be obtained prior to completion of the MDS. The MDS Coordinator revealed the facility needed a system to obtain a resident's weight at the time of admission. She reported there was no system in place at this time. An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were fully completed.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by:	F 273		11/25/16

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F 273	Continued From page 4 Based on record review and staff interview the facility failed to complete a comprehensive assessment within the first 14 days of admission for 1 of 14 sampled residents (Resident #194). The findings included: Resident #194 was admitted to the facility on 10/10/16 with multiple diagnoses including heart failure and chronic kidney disease. A review of Resident #194's medical record revealed an admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/17/16. The MDS assessment was signed as complete by the MDS Coordinator on 11/1/16 (Question Z0500B). This was 22 days after Resident #194's admission to the facility. An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completion. She reported the MDS admission assessments were required to be completed within the first 14 days of a resident's admission. The MDS Coordinator stated she began working at the facility in the end of April 2016. She reported that since she started working at the facility the MDS assessments had been behind. She indicated when she started at the facility the MDS assessments were "about a month and a half behind" and they were currently still "playing catch up". The MDS assessment with an ARD of 10/17/16 and a completion date of 11/1/16 for Resident #194 was reviewed with the MDS Coordinator. The MDS Coordinator revealed this was not a surprise to her that the MDS was not completed within the first 14 days of admission for Resident #194.	F 273	F273 The resident found to have been affected by the alleged deficient practice (#194) had comprehensive assessment not completed within the first 14 days of admission. Being that the resident already had the assessment completed but not within the required time frame, the minimum data set (MDS) nurses were educated on timely completion of MDS assessments by the Director of Nursing (DON) and MDS consultant on 11/4/2016. For those residents having the potential to be affected by the alleged deficient practice the Minimum data Set Coordinators were educated on 11/4/2016 by Director of Nursing on timely completion of Minimum Data Set assessments. An audit was performed by Director of Nursing and assistant director of nursing on all residents admitted within the past 90 days to identify timely completion of admission 14 day assessments within 14 days on 11/25/2016. There were multiple MDS admission assessments identified as not completed within the required time frame. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place. MDS calendar will be reviewed for upcoming admission assessments during morning meeting each business day to evaluate upcoming admission assessment due dates. Director of Nursing and Assistant Director of Nursing will assist to complete MDS assessments timely as indicated by MDS calendar.	

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F 273	Continued From page 5 An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed timely.	F 273	Audits will be performed during weekly Patients at Risk (PAR) meeting by team members to include the Director of Nursing, Assistant Director of Nursing and Clinical Coordinator. Five MDS 14 day admission assessments will be audited weekly for completion and accuracy for four weeks and five MDS 14 day admission assessments will be audited biweekly for one month and monthly for four months alternating different residents in each MDS assessment review period. These audits will be discussed in PAR with immediate action taken if issues are identified. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting (QA)and they will be reviewed and discussed. Continued audits be performed based on results of the previous audits.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 92 days of the Assessment Reference Date (ARD) for 2 of 12 sampled residents (Residents #28 and #171). The findings included:	F 276	For the residents found to have been affected by the alleged deficient practice (#28 and #171) had quarterly Minimum Data Set assessments not completed within 92 days of the assessment period. Resident #171 had quarterly assessment	11/25/16

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F 276	Continued From page 6 1a. Resident #28 was admitted to the facility on 11/25/09 with multiple diagnoses that included cerebrovascular disease. A review of Resident #28's medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/17/16. Resident #28 had a quarterly MDS assessment with an ARD of 6/16/16. The MDS assessment required a signature of a Registered Nurse (RN) Assessment Coordinator to verify its completion. This quarterly MDS assessment for Resident #28 was indicated to be completed on 7/11/16 (Question Z0500B). This quarterly assessment was completed 117 days after the most recent MDS assessment's ARD (3/17/16). An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completion. She reported the MDS quarterly assessments were required to be completed within 92 days of the previous MDS assessment's ARD. She stated she began working at the facility in the end of April 2016. She reported that since she started working at the facility the MDS assessments had been behind. She indicated when she started at the facility they were "about a month and a half behind" and they were currently still "playing catch up". The MDS assessment with an ARD of 6/16/16 and a completion date of 7/11/16 for Resident #28 was reviewed with the MDS Coordinator. The MDS Coordinator revealed this was not a surprise to her that the MDS was not completed within 92 days of the previous MDS ARD for Resident #28.	F 276	completed on 11/3/16 by Minimum Data set Coordinator. Being that the resident #28 already had the assessment completed but not within the required time frame, the minimum data set (MDS) nurses were educated on timely completion of MDS assessments by the Director of Nursing (DON) and MDS consultant on 11/4/2016. For those residents having the potential to be affected by the alleged deficient practice the MDS nurses, Dietary Manager, Social Services Director, Activities Director and Wound Care Nurse were educated by the Director of Nursing on 11/4/16 on timely completion and accuracy of MDS assessments. An audit was performed by DON and assistant director of nursing on all residents who had a quarterly assessment due within the past 90 days to identify timely completion of Quarterly Assessments within 92 days on 11/25/2016. There were multiple MDS assessments identified as not completed within the required time frame. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place: MDS calendar will be reviewed for upcoming quarterly assessments during morning meeting each business day to evaluate upcoming assessment due dates. Director of Nursing and Assistant Director of Nursing will assist to complete quarterly MDS assessments timely as indicated by MDS calendar. Audits will be performed during weekly Patients at Risk meeting by team	

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F 276	Continued From page 7 An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed timely. 1b. Resident #28 was admitted to the facility on 11/25/09 with multiple diagnoses that included cerebrovascular disease. A review of Resident #28's medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/16/16. Resident #28 had a quarterly MDS assessment with an ARD of 9/16/16. The MDS assessment required a signature of an RN Assessment Coordinator to verify its completion. This quarterly MDS assessment for Resident #28 was indicated to be completed on 9/30/16 (Question Z0500B). This quarterly assessment was completed 107 days after the most recent MDS assessment's ARD (6/16/16). An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completion. She reported the MDS quarterly assessments were required to be completed within 92 days of the previous MDS assessment's ARD. She stated she began working at the facility in the end of April 2016. She reported that since she started working at the facility the MDS assessments had been behind. She indicated when she started at the facility they were "about a month and a half behind" and they were currently still "playing catch up". The MDS assessment with an ARD of 9/16/16 and a	F 276	members to include the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator. Five quarterly MDS assessments will be audited weekly for completion and accuracy for four weeks and five quarterly MDS assessments will be audited biweekly for one month then five quarterly assessments per month for four months alternating different residents in each MDS assessment review period. These audits will be reviewed in the PAR meeting with immediate action taken if issues are identified. Results of these audits will be kept by the Director of Nursing who will bring them to the monthly Quality Assurance (QA) meeting where they will be reviewed and discussed. Continued audits be performed based on results of the previous audits.	

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F 276	Continued From page 8	F 276		

completion date of 9/30/16 for Resident #28 was reviewed with the MDS Coordinator. The MDS Coordinator revealed this was not a surprise to her that the MDS was not completed within 92 days of the previous MDS ARD for Resident #28.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed timely.

2. Resident #171 was admitted to the facility on 7/6/16 with multiple diagnoses including chronic kidney disease.

A review of Resident #171's medical record revealed an admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 7/13/16.

Resident #171 had a quarterly MDS assessment with an ARD of 10/13/16. This quarterly MDS assessment required a signature of an RN Assessment Coordinator to verify its completion (Question Z0500A). As of 11/2/16 this quarterly MDS assessment for Resident #171 was indicated to be incomplete as evidenced by no RN Assessment Coordinator signature (Question Z0500A) and no date of completion (Question Z0500B). This quarterly MDS was already 113 days after the most recent MDS assessment's ARD (7/13/16) and it had not yet been completed as of 11/2/16.

An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completion. She reported the MDS quarterly assessments were required to be

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F 276	Continued From page 9 completed within 92 days of the previous MDS assessment's ARD. She stated she began working at the facility in the end of April 2016. She reported that since she started working at the facility the MDS assessments had been behind. She indicated when she started at the facility they were "about a month and a half behind" and they were currently still "playing catch up". The MDS assessment with an ARD of 10/13/16 and no completion date for Resident #171 was reviewed with the MDS Coordinator. The MDS Coordinator revealed this was not a surprise to her that the MDS was not completed within 92 days of the previous MDS ARD for Resident #171. An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed timely.	F 276		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		12/1/16

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F 278	Continued From page 10 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of urinary catheters (Residents # 106 & # 14), weight (Resident # 125), height (Residents #74, #158, #12, #125, #105, #202 & #72), limitation in range of motion and ambulation (Resident #107) and medications (Resident #12) for 10 of 25 sampled residents reviewed. Findings included: 1. Resident #106 was admitted to the facility on 9/8/16 with multiple diagnoses including sacral pressure ulcer. The admission MDS assessment dated 9/15/16 indicated that Resident # 106's cognition was intact and she had no indwelling urinary catheter. Review of the physician's orders for Resident #106 revealed that she was admitted with an order for the indwelling urinary catheter and on 10/20/16 the catheter was discontinued. On 11/2/16 at 5:40 PM, MDS Nurse #1 was interviewed. The MDS Nurse stated that Resident #106 had an indwelling urinary catheter during the assessment period and it should have been	F 278	For the residents found to have been affected by the alleged deficient practice residents (urinary catheters #106, #14) (weight #125) (height #74,#158,#12, #125, #105 , #202, #72) (limitation in range of motion and ambulation #107) (medications #12). Resident #106 Minimum Data Set (MDS) admission assessment was corrected on 11/4/16 to reflect that the resident had a catheter at that time. Resident #14 MDS admission assessment was corrected by MDS coordinator on 11/4/16 to reflect that the resident had a catheter at that time. Resident #74 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect the residents accurate height. Resident #158 MDS quarterly assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 11 coded on the admission MDS assessment but it was not. On 11/3/16 at 8:20 AM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 2. Resident # 14 was originally admitted to the facility on 6/25/16 with multiple diagnoses including stage IV pressure ulcers. The quarterly MDS assessment dated 9/30/16 indicated that Resident #14's cognition was intact and he had no indwelling urinary catheter. Review of the physician's orders for Resident #14 revealed that he was admitted with an indwelling urinary catheter due to stage IV pressure ulcers on his sacrum and buttocks. On 11/2/16 at 8:35 AM, Resident #14 was observed in bed. He was observed to have an indwelling urinary catheter. On 11/2/16 at 5:40 PM, MDS Nurse #1 was interviewed. MDS Nurse #1 stated that she had known Resident #14 to have an indwelling catheter since admission. She indicated that the MDS assessment was inaccurate. On 11/3/16 at 8:20 AM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 3. Resident #74 was admitted to the facility on 9/28/16 with multiple diagnoses including end stage renal disease and on hemodialysis. The admission MDS assessment dated 10/5/16 indicated that Resident #74's cognition was intact and her height was 0 inches.	F 278	Resident #125 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and weight Resident #202 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #105 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #12 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and accurately coded 3 for anti-anxiety medication. Resident #107 MDS quarterly assessment was corrected by MDS coordinator to ensure accurate coding of range of motion for assessment period of 8/20/16 on 11/4/16. Resident #107 MDS assessment was coded inaccurately for documentation by Certified Nursing Assistant (CNA) for Activities of daily living (ADL□s). MDS quarterly assessment was corrected by MDS coordinator to ensure accurate coding of activities of daily living for the assessment period of 8/20/16 on 11/4/16. Coding was reviewed with CNA involved, the CNA was educated on proper documentation of accurate information by the assistant Director of Nursing on 11/4/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 278	Continued From page 12 On 11/1/16 at 5:03 PM, an interview was conducted with the dietary manager. She stated she completed section K of the MDS assessments. She stated if she did not have the height when she completed the assessments, she left that area blank. She said she would not ask anyone for the height if she could not find it in the resident's chart and would enter "0" or leave the height blank on section K0200 (height). On 11/2/16 at 5:40 PM, MDS Nurse #1 was interviewed. She stated that the Dietary Manager (DM) was responsible in coding section K on the MDS assessment including the height. The MDS Nurse further indicated that the height should not be coded as 0, if there was no height recorded, the DM should have asked nursing to measure the height of the resident. On 11/3/16 at 8:20 AM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 4. Resident # 158 was admitted to the facility on 5/27/16 with multiple diagnoses including Hypertension. The quarterly MDS assessment dated 9/3/16 indicated that Resident #158 had memory and decision making problems and his height was 0 inches. On 11/1/16 at 5:03 PM, an interview was conducted with the dietary manager. She stated she completed section K of the MDS assessments. She stated if she did not have the height when she completed the assessments, she left that area blank. She said she would not ask anyone for the height if she could not find it in	F 278	For those residents with potential to be affected by alleged deficient practice 100% of current residents were audited on 11/7/2016 by the Director of Nursing and Assistant director of nursing, for heights and weights entered into the system. 20 residents were found to not have heights and weights in the electronic health system and those were added. All residents currently have a height and weight entered into the system. All residents who currently have a catheter had their MDS assessment audited and reviewed by Director of nursing and assistant director of nursing to ensure accurate coding of a catheter in place on 11/18/2016. All residents with catheters were found to be correctly coded. All residents who are currently receiving a psychotropic medication will have their MDS assessment audited by the DON and ADON and reviewed for accurate coding of psychotropic medications by 12/1/16.All current residents will have the most current MDS assessment audited for accurate range of motion and ambulation by the DON and ADON by 12/1/16. All inaccurate coding will be corrected by the MDS nurses by 12/1/2016. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place. The Dietary Manager was educated on 11/7/2016 by Director of Nursing on facility procedures on coding MDS assessments properly specifically regarding height and weight. MDS nurses, Dietary Manager, Social Services Director, Activities Director and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 13 the resident's chart and would enter "0" or leave the height blank on section K0200 (height). On 11/2/16 at 5:40 PM, MDS Nurse #1 was interviewed. She stated that the Dietary Manager (DM) was responsible in coding section K on the MDS assessment including the height. The MDS Nurse further indicated that the height should not be coded as 0, if there was no height recorded, the DM should have asked nursing to measure the height of the resident. On 11/3/16 at 8:20 AM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 5a. Resident #125 was admitted to the facility on 6/22/16 and readmitted on 7/2/16 with multiple diagnoses including respiratory failure. The admission Minimum Data Set (MDS) assessment dated 7/9/16 indicated her cognition was intact. Section K, the Swallowing/Nutritional Status section, indicated Resident #125's height was 0 inches (Question K0200A). An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. She revealed that if there was no documented height in the medical record for a resident at the time she completed Section K then she left the question (K0200A) blank or entered a "0". She reported she had not asked anyone to obtain a resident's height for her if it was not readily available. An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated	F 278	Wound Care Nurse were educated by the Director of Nursing on 11/4/16 on timely completion and accuracy of MDS assessments. Heights and weights will be entered in computer system within 72 hours of admission to facility by admitting nurse. All new admissions will be reviewed by administrative nurses , which include DON, ADON, and clinical coordinator in the clinical meeting the next business day after admission for completion of heights and weights. In services will be provided to all CNA□s and Nurses to include weekend and PRN staff on accurate coding of ADL documentation by December 1, 2016 by either ADON, MDS nurses or Director of Nursing. Audits will be performed during weekly Patients at Risk meeting by team members to include the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator. Five MDS assessments will be audited for height and weight, psychotropic medications, urinary catheters and accurate ADL documentation weekly for four weeks, five MDS assessments will be audited biweekly for one month then monthly for four months alternating different residents in each MDS assessment review period. After review of the audits corrections will be done immediately if noted. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting and they will be discussed. Continued audits will be performed based on results of the previous audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 14	F 278		

she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 7/9/16 for Resident #125 that indicated the height was 0 inches was reviewed with the MDS Coordinator. She indicated the height was required to be entered on the MDS. She reported if a height had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. She revealed the facility needed a system to obtain a resident's height at the time of admission. She reported there was no system in place at this time.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed accurately.

5b. Resident #125 was admitted to the facility on 6/22/16 and readmitted on 7/2/16 with multiple diagnoses including respiratory failure. The admission Minimum Data Set (MDS) assessment dated 7/9/16 indicated her cognition was intact. Section K, the Swallowing/Nutritional Status section, indicated Resident #125's weight was 0 pounds (Question K0200B).

An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. She revealed that if there was no documented weight in the medical record for a resident at the time she completed Section K then she left the question (K0200B) blank or entered a "0". She reported she had not asked anyone to obtain a resident's weight for her if it was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 15	F 278		

readily available.

An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 7/9/16 for Resident #125 that indicated her weight was 0 pounds was reviewed with the MDS Coordinator. She indicated the weight was required to be entered on the MDS. She reported if a weight had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. She revealed the facility needed a system to obtain a resident's weight at the time of admission. She reported there was no system in place at this time.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed accurately.

6. Resident #202 was admitted to the facility on 10/5/16 with multiple diagnoses including heart disease. The admission Minimum Data Set (MDS) assessment dated 10/12/16 indicated he was cognitively intact. Section K, the Swallowing/Nutritional Status section, indicated Resident #202's height was 0 inches (Question K0200A).

An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. She revealed that if there was no documented height in the medical record for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 16	F 278		

resident at the time she completed Section K then she left the question (K0200A) blank or entered a "0". She reported she had not asked anyone to obtain a resident's height for her if it was not readily available.

An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 10/12/16 for Resident #202 that indicated the height was 0 inches was reviewed with the MDS Coordinator. She indicated the height was required to be entered on the MDS. She reported if a height had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. She revealed the facility needed a system to obtain a resident's height at the time of admission. She reported there was no system in place at this time.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed accurately.

7. Resident #105 was admitted to the facility on 7/29/16 with multiple diagnoses including a femur (thighbone) fracture. The admission MDS dated 8/5/16 indicated she was cognitively intact. Section K, the Swallowing/Nutritional Status section, indicated Resident #105's height was 0 inches (Question K0200A).

An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 17	F 278		

and the MDS Coordinator reviewed the assessments. She revealed that if there was no documented height in the medical record for a resident at the time she completed Section K then she left the question (K0200A) blank or entered a "0". She reported she had not asked anyone to obtain a resident's height for her if it was not readily available.

An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 8/5/16 for Resident #105 that indicated the height was 0 inches was reviewed with the MDS Coordinator. She indicated the height was required to be entered on the MDS. She reported if a height had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. She revealed the facility needed a system to obtain a resident's height at the time of admission. She reported there was no system in place at this time.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed accurately.

8. Resident #72 was admitted to the facility on 6/6/16 with multiple diagnoses including a pelvic fracture. The admission MDS dated 6/13/16 indicated she was cognitively intact. Section K, the Swallowing/Nutritional Status section, indicated Resident #72's height was 0 inches (Question K0200A).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 18	F 278		

An interview was conducted with the Dietary Manager (DM) on 11/1/16 at 5:03 PM. She indicated she completed Section K of the MDS and the MDS Coordinator reviewed the assessments. She revealed that if there was no documented height in the medical record for a resident at the time she completed Section K then she left the question (K0200A) blank or entered a "0". She reported she had not asked anyone to obtain a resident's height for her if it was not readily available.

An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completeness and accuracy. The admission MDS dated 8/5/16 for Resident #72 that indicated the height was 0 inches was reviewed with the MDS Coordinator. She indicated the height was required to be entered on the MDS. She reported if a height had not been documented in the resident's medical record at the time of the MDS assessment that the height needed to be obtained prior to the completion of the MDS. She revealed the facility needed a system to obtain a resident's height at the time of admission. She reported there was no system in place at this time.

An interview was conducted on 11/3/16 at 8:21 AM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were completed accurately.
9 a. Resident #12 was admitted to the facility 6/28/16. Cumulative diagnoses included anxiety and major depressive disorder.

An Admission Minimum Data Set (MDS) assessment dated 7/6/16 indicated Resident #12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 19	F 278		

was cognitively intact. Under section K (Swallowing/ Nutritional status), K0200 A. height was documented as "0".

On 11/1/16 at 5:03PM, an interview was conducted with the dietary manager. She stated she completed the admission assessments on all residents and completed section K of the MDS assessments. She stated if she did not have the height and/or weight when she completed the assessments, she left that area blank. The dietary manager stated she did not go back and update her information after the assessments were completed. She said she would not ask anyone for the height if she could not find it in the resident ' s chart and would enter "0" or leave the height blank on section K0200 (height).

On 11/2/16 at 5:25PM, an interview was conducted with the MDS coordinator who stated the height should have been documented accurately on the MDS. If the height was not available, the dietary manager should have asked for the height of the resident so it could be coded accurately on the MDS.

On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately.

9 b. Resident #12 was admitted to the facility 6/28/16. Cumulative diagnoses included anxiety and major depressive disorder.

A Quarterly MDS dated 10/6/16 indicated resident #12 was cognitively intact. A review of the medications received during the seven day look back period (9/30/16-10/6/16) indicated Resident #12 received anti-anxiety medication two days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 20	F 278		

during the assessment period.

A review of physician orders for September 1016 and 0ctober 2016 revealed an order for clonazepam (anti-anxiety medication) 0.5 milligrams by mouth twice a day as needed.

A review of the September and October Medication Administration Sheets (MAR) for the look-back period of 6/30/16-10/6/16 revealed Resident #12 received clonazepam 0.5 milligrams on 9/30/16, 10/2/16 and 10/6/16 (three days).

On 11/2/16 at 5:20PM, an interview was conducted with the MDS Coordinator. She reviewed the MARs' for September and October for the look back period of 9/30/16-10/6/16 and stated the MDS should have been coded as "3" for anti-anxiety medication. It must have been miscounted.

On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately.

10 a. Resident #107 was admitted to the facility on 4/3/13 and readmitted on 11/19/15. Cumulative diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) in the right dominant side and contracture of the right hand.

An Admission MDS dated 11/26/15 indicated Resident #107 had short term and long term memory impairment and was severely impaired in decision-making skills. Section G0400 (Functional limitation in range of motion) indicated Resident #107 had no range of motion limitations for the upper extremities and impairment on one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 21	F 278		

side for range of motion for the lower extremities.

Observations conducted from 10/31/16 through 11/3/16 revealed Resident #107 moving about the facility in her wheelchair independently. She used her left leg and arm to manipulate the wheelchair. Her right arm and leg were impaired in range of motion.

On 11/2/16 at 5:36PM, an interview was conducted with the MDS Coordinator. She stated section G0400 for range of motion was coded inaccurately and should have indicated impairment of range of motion on one side for upper and lower extremities. She said she was not sure why it was inaccurate as she was not the MDS Coordinator on 11/26/15.

On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately.

10 b. Resident #107 was admitted to the facility on 4/3/13 and readmitted on 11/19/15. Cumulative diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) in the right dominant side and contracture of the right hand.

A Quarterly MDS dated 8/20/16 indicated Resident #107 had short term and long term memory impairment and severely impaired in decision-making skills. Section G0400 (Functional limitation in range of motion) indicated Resident #107 had impairment on one side for range of motion for the upper extremities and no range of motion limitations in the lower extremities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD 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 278	Continued From page 22	F 278		

Observations conducted from 10/31/16 through 11/3/16 revealed Resident #107 moving about the facility in her wheelchair independently. She used her left leg and arm to manipulate the wheelchair. Her right arm and leg were impaired in range of motion.

On 11/2/16 at 5:36PM, an interview was conducted with the MDS Coordinator. She stated that section G0400 for range on motion was coded incorrectly and should have indicated impairment on one side for the upper and lower extremities.

On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately.

10 c. Resident #107 was admitted to the facility on 4/3/13 and readmitted on 11/19/15. Cumulative diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) in the right dominant side and contracture of the right hand.

A Quarterly MDS dated 9/30/16 indicated Resident #107 had short term and long term memory impairment and severely impaired in decision-making skills. It was documented that Resident #107 required extensive assistance with ambulation in the room and in the corridor.

Observations conducted from 10/31/16 through 11/3/16 revealed Resident #107 moving about the facility in her wheelchair independently. She used her left leg and arm to manipulate the wheelchair. Her right arm and leg were impaired in range of motion. Resident #107 was non-ambulatory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 278	Continued From page 23 On 11/2/16 at 9:00AM, an interview was conducted with NA #2. She stated Resident #107 was unable to use her left hand and arm and was non-ambulatory. On 11/2/16 at 3:44PM, an interview was conducted with Nursing Assistant (NA) #1. She stated she had been employed at the facility approximately eleven months on evening shift. She stated she had never seen Resident #107 walk and Resident #107 was non-ambulatory. On 11/02/2016 at 5:36PM, an interview was conducted with the MDS Coordinator. She stated they had provided education for nursing staff regarding the need for accurate documentation for activities of daily living (ADL) so the MDS would be accurate. She stated that Resident #107 did not ambulate and the MDS dated 9/30/16 should have been coded as ambulation not occurring during the assessment period. On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		11/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 24 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview, and family interview, the facility failed to develop a plan of care based on a resident's comprehensive assessment for 1 of 3 residents reviewed for nutrition (Resident #194). The findings included: Resident #194 was admitted to the facility on 10/10/16 with multiple diagnoses that included heart failure and chronic kidney disease. A physician's order dated 10/10/16 indicated Resident #194 was on a mechanical soft diet. The admission Minimum Data Set (MDS) assessment for Resident #194 indicates her cognition was intact. Her weight was 92 pounds and she was 65 inches tall. She was assessed with no feeding tube being utilized during the MDS review period (Question K0510B). Resident #194 was additionally assessed as having received no nutritional intake by a feeding tube during the MDS review period (Question K0710). The Care Area Assessment (CAA) for Nutritional Status indicated Resident #194 had a feeding	F 279	For the residents found to have been affected by the alleged deficient practice resident (#194) incomplete care plan for percutaneous endoscopic gastrostomy tube (PEG) for nutritional intake was removed from resident□s care plan on 11/3/16 by Minimum data set (MDS)coordinator. For the residents with the potential to be affected by alleged deficient practice all residents who have a PEG tube were audited by the Director of Nursing and Assistant Director of Nursing to ensure accurate care plans to reflect use of PEG tube on 11/7/16, all residents with PEG tubes had a current care plan for the tube. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place; all new residents who are admitted with a PEG tube will be reviewed at the next Patients at Risk meeting by team members to include the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator to ensure accurate care plans in place for	

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F 279	Continued From page 25 tube that was not being utilized and she was on a mechanical soft diet. The plan of care for Resident #194, with the most recent documented date of 11/1/6, was reviewed. A problem/need was noted that indicated "[Resident #194] requires a [Percutaneous endoscopic gastrostomy (PEG)] tube for adequate nutritional intake." The interventions included maintaining Resident #194 in an upright position after each feeding, checking Resident #194's placement before initiating feeding, and checking for residual before initiating Resident #194's feeding. A Registered Dietician (RD) note dated 10/20/16 indicated Resident #194 was on a mechanical soft diet. An interview was conducted with Resident #194 on 11/1/6 at 4:35 PM. She indicated she had not received any nutritional intake through her feeding tube since her admission to the facility (10/10/16). An interview was conducted with Resident #194's family member on 11/1/16 at 4:37 PM. He confirmed Resident #194's statement that she had not received any nutritional intake through her feeding tube since her admission to the facility (10/10/16). An interview was conducted with the Dietary Manager on 11/1/16 at 5:03 PM. She indicated Resident #194 received no nutritional intake through her PEG tube. An interview was conducted with the MDS Coordinator on 11/2/16 at 5:13 PM. She reported	F 279	PEG tubes. Any resident found to not have a care plan for PEG tube will have one placed immediately by MDS nurses. Due to the limited number of residents with a PEG tube, audits will be performed for all residents with a PEG tube for accurate care plans monthly for six months. These audits will be performed by the Assistant Director of Nursing and/or the Clinical Coordinator. Results of these audits will be kept by the Director of Nursing who will be responsible for bringing them to the monthly Quality Assurance meeting where they will be reviewed and discussed. Continued audits will be performed based on results of the previous audits.	

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F 279	Continued From page 26 she was responsible for the completion of initial plans of care for all residents. The plan of care related to Resident #194's PEG tube for nutritional intake was reviewed with the MDS Coordinator. She revealed this plan of care for Resident #194 was inaccurate. She indicated Resident #194 had not received any nutritional intake through the PEG tube. The MDS Coordinator explained that another staff member had added this problem/need to Resident #194's plan of care. She indicated the staff member was probably trying to help her out. The MDS Coordinator reported she was unable to tell who had added this problem/need to Resident #194's plan of care. She stated she was going to remove the problem/need for the PEG tube for nutritional intake on Resident #194's plan of care. An interview was conducted with the Director of Nursing (DON) on 11/3/16 at 8:21 AM. She indicated her expectation was for plans of care to be comprehensive based on each resident's MDS assessment.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		11/28/16

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F 280	Continued From page 27 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on review review and staff interview, the facility failed to revise the care plan for 1 (Resident #14) of 3 sampled residents reviewed for pressure ulcers and for 1 (Resident #12) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident 14 was originally admitted to the facility on 6/25/16 with multiple diagnoses including stage IV pressure ulcers. The quarterly Minimum Data Set (MDS) assessments dated 9/30/16 indicated that Resident #14's cognition was intact and he had 4 stage IV pressure ulcers. The physician's orders for Resident#14 were reviewed. Resident #14 had an order for a nutritional supplement to be given 3 times a day on 8/31/16 to promote wound healing. On 9/15/16, there was a physician's order to discontinue the nutritional supplement for Resident #14. The care plan for pressure ulcer dated 9/30/16 was reviewed. The care plan approaches included to provide the nutritional supplement 3 times a day with meals.	F 280	For the residents found to have been affected by the alleged deficient practice resident (#14) care plan was updated accurately to reflect Physician□s order to discontinue nutritional supplement by Minimum Data Set coordinator (MDS)on 11/4/2016. Resident (#12) care plan for anti-psychotic medication was discontinued by MDS coordinator on 11/4/16. For the residents with the potential to be affected by alleged deficient practice 100% of all residents will have their care plans compared with current orders to ensure accuracy of care plans by November 28,2016. The audits will be completed by the Director of Nursing, Assistant Director of Nursing and the Clinical Coordinator and wound care nurse. All care plans will updated by the MDS nurses based on results of audits performed at the time of the audit. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place; all new orders will be brought the next business day to daily clinical meeting to have the care plan	

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F 280	Continued From page 28 On 11/2/16 at 5:40 PM, MDS Nurse #1 was interviewed. MDS Nurse #1 stated that care plans were reviewed after the completion of the MDS assessment and new physician's orders. She added that the nutritional supplement was discontinued before the quarterly MDS assessment was completed and should have been removed when the care plan was reviewed. On 11/3/16 at 8:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the care plan to be reviewed and revised based on the MDS assessments and physician's orders. 2. Resident #12 was admitted to the facility on 6/28/16. Cumulative diagnoses included major depressive disorder and anxiety. A review of physician's orders revealed an order dated 6/30/16 for Seroquel (antipsychotic medication) 50 milligrams by mouth twice daily. An Admission Minimum Data Set (MDS) assessment dated 7/6/16 indicated Resident #12 was cognitively intact. No mood or behaviors were noted. Medications administered during the 7 day look back period indicated Resident #12 received antipsychotic medication 7 days during the assessment period. A review of the care plan for Resident #12 dated 7/15/16 and last reviewed on 10/13/16 stated Resident #12 was at risk for side effects from antipsychotic drug use (Seroquel). Approaches included: administer medications as ordered by the physician, monitor resident's behavior and observe for adverse side effects of the medication.	F 280	updated by the MDS nurse at that time. Audits will be performed by the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator on 5 residents to compare new and discontinued orders to the care plan weekly for four weeks and five residents will be audited biweekly for one month then five residents monthly for four months. Any orders either new or discontinued found not to be reflected in care plan during audits will be adjusted immediately by MDS nurses. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting where they will be reviewed and discussed. Continued audits will be performed based on results of the previous audits.	

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	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 280	Continued From page 29 A physician's order dated 8/5/16 indicated Seroquel 25 milligrams nightly by mouth x fourteen (14) days, then discontinue. Seroquel was discontinued on 8/19/16. On 11/2/16 at 5:22PM, an interview was conducted with the MDS Coordinator. She stated the care plan was reviewed and updated on 10/13/16 and the care plan for antipsychotic medication should have been discontinued. On 11/3/16 at 8:20AM, an interview was conducted with the Director of Nursing. She stated she expected the care plan to be reviewed and revised based on the MDS assessment and physician's orders.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview, and family interview, the facility failed to follow the plan of care to offer a nutritional supplement for 1 of 3 residents reviewed for nutrition (Resident #194). The findings included: Resident #194 was admitted to the facility on 10/10/16 with multiple diagnoses that included heart failure and chronic kidney disease.	F 282	For the resident found to have been affected by the alleged deficient practice resident (#194) had the care plan updated and removed the intervention to provide nutritional supplement on 11/2/16 by the Minimum Data Set coordinator (MDS). For the residents with the potential to be affected by alleged deficient practice 100% of all residents will have their care plans compared with current orders to	11/28/16

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F 282	Continued From page 30 The admission Minimum Data Set (MDS) assessment for Resident #194 indicated her cognition was intact. Her weight was 92 pounds and she was 65 inches tall. The plan of care for Resident #194, with the most recent documented date of 11/1/16, was reviewed. A problem/need was noted that indicated "[Resident #194] has a skin tear/laceration." The intervention included offering Resident #194 supplemental nutritional support. The physician's orders for Resident #194 were reviewed. There was no physician's order for a nutritional supplement for Resident #194. An interview was conducted with the Dietary Manager on 11/1/16 at 5:03 PM. She indicated Resident #194 received no nutritional supplement. An interview was conducted with Resident #194 on 11/2/6 at 3:35 PM. She revealed she had not received or been offered a nutritional supplement since her admission to the facility (10/10/16). Resident #194 reported she had taken a nutritional shake once daily when she resided at her home. She indicated her current weight of 92 pounds was under her normal body weight. Resident #194 stated she would have been accepting of a nutritional supplement if one had been offered. An interview was conducted with Resident #194's family member on 11/2/16 at 3:37 PM. He confirmed Resident #194's report that she had not received or been offered a nutritional supplement since her admission to the facility	F 282	ensure accuracy of care plans by November 28,2016 by Director of nursing, assistant director of nursing, clinical coordinator and wound care nurse. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place; all new orders will be brought the next business day to daily clinical meeting to have the care plan updated by the MDS nurse at that time. Audits will be performed by The Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator on 5 residents to compare new and discontinued orders to the care plan weekly for four weeks and five residents will be audited biweekly for one month then five residents monthly for four months. Any orders either new or discontinued found not to be reflected in care plan during audits will be adjusted immediately by MDS nurses. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting where they will be reviewed and discussed. Continued audits be performed based on results of the previous audits.	

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F 282	Continued From page 31 (10/10/16). He additionally confirmed that he had given her one nutritional shake daily when she resided at home and that she was currently under her normal body weight. An interview was conducted with the MDS Coordinator on 11/2/16 at 5:13 PM. She reported she was responsible for the completion of initial plans of care for all residents. The plan of care related to a skin tear/laceration that indicated supplemental nutritional support was to be offered to Resident #194 was reviewed with the MDS Coordinator. She revealed that Resident #194 had not been offered a nutritional supplement and this plan of care was not followed. The MDS Coordinator explained that another staff member had added this problem/need and intervention to Resident #194's plan of care. She indicated the staff member was probably trying to help her out. The MDS Coordinator reported she was unable to tell who had added this problem/need and intervention to Resident #194's plan of care. She stated she was going to update the plan of care and remove the intervention "offer resident supplemental nutritional support" because Resident #194 had not been offered a nutritional supplement. An interview was conducted with the Director of Nursing (DON) on 11/3/16 at 8:21 AM. She indicated her expectation was for plans of care to be followed.	F 282		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		11/25/16

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F 325	Continued From page 32 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to notify the registered dietician of significant weight loss and provide supplements as ordered for one of three residents reviewed for nutrition (Resident #107). The findings included: 1a. Resident #107 was admitted to the facility 4/3/13 and last readmitted on 11/19/15. Cumulative diagnoses included dysphagia (difficulty swallowing), hemiplegia (paralysis) on right dominant side and Alzheimer ' s disease. A care plan dated 2/25/16 with last approaches updated on 8/31/16 indicated Resident #107 was at risk for weight loss related to right sided paresis and cognitive deficits. Approaches included Med Pass (nutritional supplement) as ordered 120 milliliters (4 ounces) four times daily (5/18/16). Dietician to evaluate nutritional status prn (as needed). A Quarterly Minimum Data Set (MDS) dated 9/30/16 indicated Resident #107 had short and long term memory impairment and was severely impaired in decision making skills. Limited assistance was required with eating. Weight was	F 325	For the resident found to have alleged deficient practice (resident #107) The resident was referred and evaluated by the Registered Dietitian (RD) on 11/3/16. The RD ordered weekly weights for four weeks. Weights were noted to be stable past 3 months. Resident's weights will be reviewed weekly in Patients at risk Meeting for four weeks as recommended by RD. For residents with potential to be affected all weights were reviewed by RD on 11/3/2016 to identify any weight loss trends. During RD review, six residents were noted with weight loss trends with appropriate interventions added to include obtaining labs, weekly weights, supplements, and resident dietary preferences. All interventions had orders placed by physician and were added to the residents care plans by Minimum Data Set (MDS) coordinator on 11/4/2016. To ensure the alleged deficient practice does not reoccur all weights will be reviewed in Patient's At Risk meeting held on Wednesdays. Any resident who has had a 5 pound or greater weight loss will	

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F 325	Continued From page 33 documented as 108 pounds with weight loss noted. A review of the medical record revealed the following weights: 2/1/16-121.8 pounds; 3/3/16-104 pounds; 3/23/16-108.2 pounds; 6/15/16-107.4 pounds; 6/29/16-94.4 pounds; 7/6/16-94.4 pounds; 7/13/16-108.2 pounds; 10/3/16-109.8 pounds and 11/3/16-107.8 pounds. A review of the Patients at Risk (PAR) notes revealed Resident #107 was reviewed by the PAR committee on 3/9/16. On 11/2/16 at 9:00AM, an interview was conducted with NA#2. She stated Resident #107 had good food and fluid intake. She stated Resident #107 had consumed 75% of breakfast this morning and that was her usual amount consumed for breakfast. On 11/2/16 at 12:30PM, Resident #107 was observed eating lunch. She was fed by nursing staff and consumed 100% of food and fluids. On 11/02/2016 at 4:55PM, an interview was conducted with Nurse #3. She stated the PAR committee consisted of the dietary manager, the Director of Nursing, the clinical supervisor (Nurse #3) and the MDS Coordinator. The committee met weekly and reviewed resident weights. If weight loss was noted, a list of those residents was made and given to the registered dietician (RD) for review and recommendations. Nurse #3 stated she was not sure who gave the RD the list of residents for review. Nurse #3 said if weight loss was noted for Resident #107 on 3/9/16, a referral would have been made to the RD for evaluation. Nurse #3 said she expected that the	F 325	be referred to the Registered Dietitian no later than the next business day by the Director of Nursing. All new admissions will have a face sheet placed in the Registered Dietitian's folder by the Director of Nursing for notification of all new admissions for his review of charts when he visits facility. Any new admission that needs to be seen for issues such as wounds, tube feedings, diagnosis such as failure to thrive, etc. will be referred via telephone to the RD by the DON no later than the next business day. An RD referral log will be kept by the Director of Nursing with referral to RD date, date seen by RD and any interventions noted. DON will monitor log weekly to ensure timely assessment by RD. An audit of all residents with a 5 pound or greater weight loss will be conducted weekly for four weeks to ensure an RD referral was placed, RD was notified, any new interventions and care plan was updated. These audits will be performed by the administrative nurses to include the Director of Nursing the Assistant Director of Nursing and the Clinical Coordinator. These audits will continue weekly times four weeks, biweekly times one month and monthly for four months. Audits will be performed by Patients at Risk team members weekly during meeting. Continued audits will be based on results of previous audits. Results of all audits will be maintained by the Director of Nursing who will bring them to monthly quality assurance meetings where they will be reviewed and discussed.	

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	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 325	Continued From page 34	F 325		

Director of Nursing (who no longer worked at the facility) would have informed the RD of the need to see the resident.

A nutrition note dated 1/14/16 by the registered dietician stated Resident #107 ' s weight was documented at 123.6 pounds. Resident was eating well and fed herself after tray set-up. Continue to monitor. There was no further documentation from the registered dietician that he had evaluated/ seen Resident #107 since January.

On11/03/2016 at 9:13AM, an interview was conducted with the RD. He stated he comes to the facility once a month and also gets phone calls from the facility regarding residents that have been reviewed during the PAR meetings for recommendations. The RD stated he asks the facility about residents who have weight concerns, wound concerns, tube feeders and also sees new admissions as needed. He stated he does not review all new admissions and sees residents on an " as needed " basis. The RD stated there might not be RD notes on a resident if he had made recommendations over the phone. The RD stated he could not remember if he had received a phone call regarding Resident #107 in March for weight loss. He stated he would review his March report to see if Resident #107 had been referred to him. A review of the March referrals to the RD revealed no referral was made to the RD to see resident #107. He said he should have had a referral in March for the weight loss and added that he thought the weights documented at the end of June and first part of July were incorrect.

On 11/3/16 at 11:45AM, the RD stated he had the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 35	F 325		

facility obtain a current weight for Resident #107 and her current weight was 107.8 pounds which was a loss of two pounds since October.

2b. Resident #107 was admitted to the facility 4/3/13 and last readmitted on 11/19/15. Cumulative diagnoses included dysphagia (difficulty swallowing), hemiplegia (paralysis) on right dominant side and Alzheimer ' s disease.

A care plan dated 2/25/16 with last approaches updated on 8/31/16 indicated Resident #107 was at risk for weight loss related to right sided paresis and cognitive deficits. Approaches included Med Pass (nutritional supplement) as ordered 120 milliliters (4 ounces) four times daily (5/18/16). Dietician to evaluate nutritional status prn (as needed).

A Quarterly Minimum Data Set (MDS) dated 9/30/16 indicated Resident #107 had short and long term memory impairment and was severely impaired in decision making skills. Limited assistance was required with eating. Weight was documented as 108 pounds with weight loss noted.

A review of the medical record revealed the following weights: 2/1/16-121.8 pounds; 3/3/16-104 pounds; 3/23/16-108.2 pounds; 6/15/16-107.4 pounds; 6/29/16-94.4 pounds; 7/6/16-94.4 pounds; 7/13/16-108.2 pounds; 10/3/16-109.8 pounds and 11/3/16-107.8 pounds.

A review of physician orders for September 2016 revealed an order for Med Pass (nutritional supplement) 120 milliliters (4 ounces) by mouth four times daily.

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F 325	Continued From page 36 A review of the September Medication Administration Record (MAR) revealed that Med Pass 120 milliliters (ml) four times daily was documented as having been administered and received by Resident #107 through 9/5/16. The remainder of the September MAR from 9/6/16 through 9/30/16 revealed no documentation that Med Pass 120 ml was administered. A review of the physician orders for October 2016 and November 2016 was completed and there was not a physician ' s order for Med Pass 120 ml four times daily. Medical record review revealed there was not a physician ' s order to discontinue the Med Pass. Medical review of the October MAR and November MAR revealed there was no documentation that Med Pass 120 ml four times daily had been administered in October or November. On 11/2/16 at 5:30PM, an interview was conducted with the Director of Nursing. She stated the facility changed systems that printed the MAR ' s and physician orders in September. Apparently the order for the Med Pass 120 ml. four times daily did not carry over to the October orders nor was in on the MAR. The Director of Nursing said the nurses should have caught the error because they were supposed to review the MAR and physician orders in the old system and compare it to the ones in the new system to make sure nothing was missed.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		11/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 329	Continued From page 37 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 record review and staff interview, the facility failed to complete an AIMS (abnormal involuntary movements) test (Resident #153) and to obtain the weight as ordered (Resident #12) for 2 of 5 sampled residents reviewed for unnecessary medications. Findings included: The facility's policy on antipsychotic medications (undated) was reviewed. The policy indicated that AIMS test will be used to monitor for tardive dyskinesia which may develop from antipsychotic medication. The policy further indicated that AIMS	F 329	For the resident affected by the alleged deficient practice resident (#153) there was a DISCUSS completed on 11/4/2016 by the Assistant Director of Nursing. This form monitors for negative effects of psychotropic drugs to include tardive dyskensia which monitors for the same movements as the AIMS (abnormal involuntary movements scale). For the resident (#12) a weight was obtained on 11/4/16 and entered into computer system by Director of Nursing. The order for	

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F 329	Continued From page 38	F 329		

test will be completed 72 hours after new admission on antipsychotic medication and current resident with initiation of new order of antipsychotic medication and then every 6 months.

1. Resident # 153 was admitted to the facility on 7/29/16 with multiple diagnoses including hallucinations and delusions secondary to Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment dated 9/23/16 indicated that Resident #153 had memory and decision making problems and had received an antipsychotic drug in the last 7 days.

The physician's orders for Resident #153 were reviewed. On 8/22/16, there was an order for Seroquel (antipsychotic drug) 25 milligrams (mgs) and to give 1 and ½ tablet by mouth 3 times a day for hallucinations and delusions.

On 9/6/16, there was an order to discontinue the Seroquel.

On 9/7/16, there was an order to give Nuplacid (antipsychotic drug) 17 mgs. 1 tablet by mouth 2 times a day for hallucinations and delusions.

The monthly drug regimen reviews for Resident #153 were reviewed. On 8/25/16, the pharmacist had requested for an AIMS test.

The medical records of Resident #153 including electronic records were reviewed and there was no AIMS test completed.

On 11/2/16 at 4:10 PM, Nurse #1 was interviewed. Nurse #1 stated that the admission nurse was responsible in completing the AIMS

weights to be obtained weekly was scheduled to be discontinued on 11/1/16 and was discontinued as ordered.
For those resident with the potential to be affected by the alleged deficient practice on 11/7/16 an audit for a completed DISCUSS of all residents was performed by the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator. There were three residents found to not have a DISCUSS completed, these residents had a DISCUSS performed and entered into the electronic health record on 11/7/16. All residents were audited by the DON to ensure a current weight was entered into the electronic system and were entered if not already done so by DON completed on 11/7/2016. 100% of resident□s orders were audited for physician□s orders for weights by 11/26/16 by staff nurses assigned to residents on this date to ensure there is an area to document weight on the medication administration record. There were no orders found for weights as it relates to adjusting a medication dosage.For all residents found to have an order for weights it was verified with the restorative aide on 11/28/16 that the weight was being obtained as ordered.
To ensure this practice does not reoccur, audits of residents will be performed using the MDS calendar to ensure the DISCUSS is being performed on all residents quarterly. All new orders will be reviewed in daily Clinical Meetings that are attended by the DON, ADON, MDS Coordinator and the Clinical Coordinator any orders that are given over

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F 329	Continued From page 39 test on admission if a resident was admitted on antipsychotic medication. Nurse #1 further indicated that she didn't know why the AIMS test was not completed for Resident #153. On 11/3/16 at 8:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected AIMS test to be completed per the facility policy. 2. Resident #12 was admitted to the facility on 6/28/16. Cumulative diagnoses included congestive heart failure and diabetes. A Quarterly Minimum Data Set (MDS) dated 10/6/16 indicated Resident #12 was cognitively intact. Medications administered during the assessment period indicated Resident #12 received diuretic medication 7 days. A care plan dated 7/15/16 and last reviewed and updated 10/13/16 sated Resident #12 had potential for fluid volume deficit due to diuretic use. Approaches included, in part, weigh resident as ordered and prn (as needed. Record and report weight variance to physician and dietician. Physician's orders for September were reviewed and revealed an order dated 9/20/16 for Lasix (a diuretic medication) 20 milligrams by mouth daily 8 AM. If 5 pounds weight gain, increase back to 40 milligrams daily. There was also an order to check weight every Friday 2 PM; if weight increase 5 pounds, go back to 40 milligrams daily. A review of the September Medication Administration record (MAR) revealed there were no weights were documented on the MAR from	F 329	the weekend are reviewed in the next business day meeting. Any new physician orders for weights to be obtained will be reviewed by the DON, ADON, clinical coordinator and MDS coordinator in the electronic health record to ensure that an area to record weight is available. A copy of the weight log for daily, weekly and monthly weights will be kept by the Director of Nursing and a copy for the restorative aides who are responsible for obtaining weights. The DON will review all weights weekly prior to Patients at Risk meeting to ensure all weights have been obtained as ordered. Review of log will be ongoing as to ensure weights are obtained as ordered. Audits will be performed by the MDS nurses weekly for 4 weeks, biweekly for one month and monthly for four months. Results of the audits will be kept by the Director of Nursing and will be brought to monthly Quality assurance meeting to review and discuss. Continued audits will be performed based on the outcome of the audits previously performed.	

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F 329	Continued From page 40	F 329		

9/20-9/30/16.

A physician's order dated 10/31/16 indicated Lasix 20 milligrams by mouth daily. Check weight every Friday--if weight increase 5 pounds, go back to Lasix 40 milligrams daily.

A review of the October MAR revealed there were no weights documented for the month of October.

A review of resident #12's record revealed no weekly weights had been documented in the record.

On 11/1/16 at 4:30PM, an interview was conducted with Nurse #1. She stated it was in the computer to obtain Resident #12's weight every Friday. She stated she would ask the nursing assistant to obtain the weight and she recorded the weight on the 24 hour report sheet. Nurse #1 stated she would review the 24 hour report from the previous Friday to determine if Resident#12 had a weight gain. She said she always wrote it down on the 24 hour report sheet and the weight should also have been recorded on the MAR. She indicated she did not know why it was not recorded on the MAR.

On 11/2/16 at 3:53PM, an interview was conducted with the Director of Nursing. She stated she had reviewed the 24 hour report sheets and could only find the report sheets for 10/14, 10/21 and 10/28/16. A review of the 24 hour report sheets revealed the following weights: 10/14-228 pounds: 10/21--227.2 pounds and 10/28-230 pounds. The Director of Nursing said her expectation was for the weights to be documented in the computer under weights so nursing staff could review the weight and

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F 329	Continued From page 41 determine if the Lasix needed to be increased.	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 record review, observation and staff interview, the facility failed to maintain the medication error rate at 5%% or below by not following the physician's orders. There were 2 errors of 29 opportunities for error resulting in a 6.9% error rate. Findings included: 1. Resident #60 had a physician's order dated 10/19/16 for Morphine Sulfate (a narcotic pain reliever) 15 milligrams (mgs) via tube twice a day for pain. On 11/2/16 at 7:40 AM, Nurse #2 was observed during the medication pass. She was observed to prepare and to administer 10 Millie liter (ml) of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate read "10 mgs. per 5 ml." On 11/2/16 at 9:30 AM, Nurse #2 was interviewed. Nurse #2 acknowledged that she had administered 10 ml of Morphine Sulfate to Resident #60. After reading the direction on the bottle of Morphine Sulfate, she stated that she should have given 7.5 ml instead of 10 ml. On 11/2/16 at 11:28 AM, the Director of Nursing	F 332	For the resident affected by the alleged deficient practice resident (#60) order for morphine was clarified with the physician (MD) and the order was corrected with a clarification from MD. The resident was assessed by the Director of Nursing (DON) immediately and no negative outcomes were noted. The nurse administering medications to the resident was educated by DON immediately on proper administration of medications per policy with return demonstration. For those resident with the potential to be affected by the alleged deficient practice all licensed nurses and medication aides will be in serviced of the five rights of medication administration and proper administration of medications per policy by 12/1/2016 by Clinical Coordinator and Assistant Director of Nursing. Audits of medication administration on 100% of licensed nurses and medication aides will be performed on 2 different nurses for 4 weeks, biweekly for one month and monthly for 4 months. These audits will include all weekend and PRN staff. Audits will be performed by Clinical Coordinator	12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 332	Continued From page 42 (DON) was interviewed. The DON stated that she was informed of the medication error regarding the Morphine Sulfate. She indicated that the physician of Resident #60 was informed of the medication error and a new order for Morphine Sulfate was received. The DON further stated that she expected the nurses to administer medications as ordered. 2. Resident #60 had a physician's order dated 10/20/16 for Potassium Chloride (KCL) 40 Millie equivalent (meq.) 30 ml via tube and to dilute with 4-8 ounces (oz.) of water before giving for hypokalemia. On 11/2/16 at 7:40 AM, Nurse #2 was observed during the medication pass. She was observed to prepare and to administer 30 ml of KCL by tube without diluting it with water. On 11/2/16 at 9:30 AM, Nurse #2 was interviewed. She acknowledged that she did not dilute the KCL with water before giving. On 11/2/16 at 11:28 AM, The DON was interviewed. She stated that she expected the nurses to administer the medications as ordered.	F 332	and Assistant Director of Nursing and weekend registered nurse supervisor. Results of the audits will be kept by the DON and who will bring them to monthly Quality assurance meeting to review and discuss. Continued audits will be performed based on the outcome of the audits previously performed.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to administer the	F 333	For the resident affected by the alleged deficient practice resident (#60) order for	12/1/16

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F 333	Continued From page 43 Morphine Sulfate (a narcotic pain reliever) as ordered by the physician for 1 (Resident #60) of 7 sampled residents observed during the medication pass. Findings included: Resident #60 was originally admitted to the facility on 7/6/16 and was readmitted on 10/18/16 with multiple diagnoses including pain. The admission Minimum Data Set (MDS) assessment dated 7/13/16 indicated that Resident #60's cognition was intact. The physician's orders for Resident #60 were reviewed. On 10/19/16, there was a physician order for Morphine Sulfate 15 milligrams (mgs) via tube twice a day for pain. On 11/2/16 at 7:40 AM, Nurse #2 was observed during the medication pass. She was observed to prepare and to administer 10 Millie liter (ml) of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate read "10 mgs per 5 ml." On 11/2/16 at 9:30 AM, Nurse #2 was interviewed. She acknowledged that she had administered 10 ml of Morphine Sulfate to Resident #60. After reading the instruction on the bottle of Morphine Sulfate, Nurse #2 stated that she should have administered 7.5 ml of Morphine Sulfate instead of 10 ml. On 11/2/16 at 11:28 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to follow the physician's orders.	F 333	morphine was clarified with the MD and the order was corrected with a clarification from Physician. The resident was assessed immediately by the Director of Nursing. The nurse administering medications to the resident was educated by DON immediately on proper administration of medications per policy with return demonstration. For those resident with the potential to be affected by the alleged deficient practice all licensed nurses and medication aides will be in serviced of the five rights of medication administration and proper administration of medications per policy by 12/1/2016 by Clinical Coordinator and Assistant Director of Nursing. Audits of medication administration on 100% of licensed nurses and medication aides to include weekend and PRN staff will be performed to include all shifts weekly of 2 different nurses for 4 weeks, biweekly for one month and monthly for 4 months. Audits will be performed by Clinical Coordinator and Assistant Director of Nursing and weekend registered nurse supervisor. Results of the audits will be kept by the DON who will bring them to the monthly Quality assurance meeting to review and discuss. Continued audits will be performed based on the outcome of the audits previously performed.	
F 371	483.35(i) FOOD PROCURE,	F 371		11/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371 SS=E	Continued From page 44 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy and staff interview, the facility failed to date opened items and discard expired food items in the kitchen refrigerator, maintain proper holding food temperatures for the pureed eggs and bacon during the morning meal and failed to maintain a clean refrigerator in the kitchen. The findings included: An undated facility policy titled "Properly labeling and dating openend food items" stated, in part, "All food items that are opened and/or prepped and cooked to be used at a later time must be properly labeled and dated. The label must state the date the item was ether opened or made and the time frame in which it must be used and discarded." 1. On 10/31/16 at 9:30AM, an initial tour of the kitchen was conducted with the dietary manager. The following was noted in the kitchen refrigerator: an opened undated container of pimento cheese, an opened undated container of cole slaw, an opened undated container of	F 371	For the current residents having been affected, an inspection of the entire dietary department was conducted on 11/3/16 by the Dietary Manager (DM) to ensure that all items were properly labeled and dated and that all items were discarded prior to expiration date. DM ensured that all appliances were cleaned immediately. In addition, DM observed food temps to ensure all were within appropriate ranges. For all residents having the potential to be affected, 100% of all Dietary staff were educated on 11/14/2016 by the Administrator on the following areas: Proper labeling, safe food temps, safe zone standards (proper holding temps), sanitation/cleaning standards and a review of the cleaning checklist, food temperature logs and newly developed audit tools. All newly hired dietary staff will receive this education during orientation. Each cook will be responsible	

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PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 371	Continued From page 45 barbeque sauce, an on opened undated jar of dill pickles, an opened undated container of tuna salad, an open undated jar of Italian dressing and an open undated container of mayonnaise. On 10/31/16 at 9:30AM, an interview was conducted with the dietary manager stated any item should be dated when it was opened. On 11/2/16 at 10:30AM, a second observation of the kitchen was conducted. There was a container of chopped slaw in the refrigerator with a use by date of 10/27/16. On 11/2/16 at 10:30AM, an interview was conducted with the dietary manager who stated she thought the use by 10/27 date was incorrect but she would discard it. 2. On 11/2/16 at 6:50AM, an observation of the breakfast tray line was conducted. The cook calibrated the thermometer each time she checked the holding temperature of the food. The holding temperature of the pureed eggs was observed to be 130 degrees. The holding temperature of the cooked bacon was observed to be 114 degrees. The cook did not reheat the pureed eggs or bacon. On 11/2/16 at 7:00AM, the dietary manager began plating the food on the trays to be served to the residents. She was observed to be serving the bacon on the resident trays. When asked at what temperature she would reheat the bacon, she stated she would reheat the bacon to a holding temperature of 140 degrees. She was informed the bacon had a holding temperature of 114 degrees. She removed the bacon from the tray line and reheated the bacon x 2. The last	F 371	for obtaining food temperatures for each food item immediately prior to start of food service. All food temps will be logged and will include temperature, date, product, cook's initials and time. To ensure ongoing compliance, the DM or dietary assistant manager will conduct audits throughout all shifts and mealtimes a minimum of 5 days a week for 6 months to include weekends to ensure all items are properly dated and labeled and that all products are discarded prior to expiration. In addition, a cleaning Inspection Checklist will be used by staff to ensure ongoing compliance with sanitation standards. An audit tool will be developed and used by DM or assistant dietary manager a minimum of five days a week throughout all shifts and mealtimes for 6 months to include weekends to determine staff compliance with the cleaning inspection checklist. In addition, food temperature logs will be audited by DM or assistant dietary manager a minimum of 5 days a week for 6 months to include weekends to ensure ongoing compliance. DM or assistant dietary manager will also observe cook obtaining food temperatures a minimum of five days a week throughout all shifts including weekends and mealtimes for 6 months. All findings from audits will be kept and brought to monthly Quality Assurance (QA) meeting by the dietary manager to be reviewed and discussed by the QA team monthly for 6 months. Based on the findings, the team will determine if it is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 371	Continued From page 46 holding temperature of the bacon was 142 degrees. On 11/2/16 at 7:00AM, the dietary manager began plating the food on the trays to be served to the residents. When asked at what temperature she would reheat the pureed eggs, she stated the holding temperature should be 145 degrees. The dietary manager reheated the pureed eggs, rechecked the temperature and obtained a temperature of 140 degrees. She placed the pureed eggs on the tray line and served the pureed eggs at a holding temperature of 140 degrees. On 11/2/16 at 10:30AM, an interview was conducted with the dietary manager. She stated she expected the holding temperatures of foods to be as noted on the food safety sheet. She reviewed a copy of the food safety sheet that stated bacon should have a temperature of 145 degrees for a minimum of 15 seconds and eggs cooked to hold should be at 155 degrees for a minimum of 15 seconds. She stated the cook should have reheated the foods to the proper holding temperature. 3. On 11/2/16 at 10:30AM, a tour of the kitchen was conducted. The refrigerator in the kitchen area was observed to have dirt and food particles stuck on the right side of the refrigerator and a large amount to white streaks of unknown material was noted covering the bottom half of the right side of the refrigerator. The inside of the refrigerator contained food crumbs and particles on the bottom and sides of the inside of the refrigerator. On 11/2/16 at 10:30AM, an interview was	F 371	necessary to continue audits and respective review of audits in QA meeting.	

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F 371	Continued From page 47 conducted with the dietary manager. She stated the equipment was cleaned every Wednesday and as needed. Her expectation was for the refrigerator to be clean. The dietary manager stated the person that put up supplies on Wednesday also had the duty of cleaning the meal carts, deep fryer and all equipment. She said she did not keep documentation or a calendar that indicated the equipment had been cleaned.	F 371		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the area surrounding one of two dumpsters free of garbage and failed to keep the grease barrel clean in an attempt to reduce the chance of insect and rodent infestation. The findings included: 1. On 11/2/16 at 10:20AM, a tour of the dumpster area was conducted with the dietary manager. There were cooked noodles scattered over the ground beside one of the two dumpsters. There was also a tomato, a bag of yellow corn and a foam sectional plate were on the ground beside the dumpster. On 11/2/16 at 10:20AM, the dietary manager stated it was everyone ' s responsibility to keep the dumpster area clean and thought the items might have fallen out of a bag because the both	F 372	The entire dumpster area was immediately cleaned by the Maintenance Department to include the grease barrel on 11/2/16. The Dietary Manager (DM) will develop a Dumpster and grease barrel Checklist in which the dumpster and grease barrel must be observed every hour from 6AM until 8PM to ensure that the dumpster and grease barrel is free of all debris and that the dumpster doors and grease barrel lids are closed. The cook will be responsible for completing the inspection each hour. If dumpster area or grease barrel needs to be cleaned, the cook will ensure such cleaning is completed immediately by dietary staff. The Dumpster area and grease barrel will be placed on a deep	11/28/16

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F 372	Continued From page 48 of the dumpsters were full. She stated she expected the dumpster area to be clean. 2. On 11/2/16 at 10:20AM, a tour of the dumpster area was conducted with the dietary manager. A barrel was observed at the back of the dumpster area just behind the dumpsters. It was a black barrel with the lid opened approximately 1-11/2 inches. The top of the barrel had large amounts of black thick material with leaves mixed in the black material. The dietary manager stated it was the grease barrel where they dumped the old grease. She stated she did not realize that the barrel looked like that and her expectation was for the barrel to be clean and without debris. On 11/2/16 at 10:45AM, a tour of the dumpster area was conducted with the Administrator. The food items and foam sectional plate had been removed from the ground beside the dumpster. The Administrator observed the grease barrel and stated he expected dietary staff to keep the barrel closed and clean and for maintenance personnel to assist dietary to clean the barrels if necessary.	F 372	cleaning schedule for every Wednesday by maintenance department. All dietary staff were educated by the Dietary Manager regarding these interventions on 11/14/16. To ensure ongoing compliance, the DM will develop an audit tool to ensure compliance with the Dumpster and grease barrel checklist as well as the deep cleaning schedule. The DM or assistant dietary manager will conduct the audits at least five days per week to include weekends throughout both shifts for 6 months. All findings from audits will be kept and brought to monthly Quality Assurance meeting by DM to be discussed and reviewed by the QA team monthly for 6 months. Based on the findings, the team will determine if it is necessary to continue audits and respective review of audits in QA meeting.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		12/1/16

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	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 431	Continued From page 49 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to date one nasal spray, one insulin pen and four inhalers on 3 or 4 medications carts. The facility also failed to discard two bottles expired glucometer testing solution on 1 of the 4 medication carts and one bottle of fecal occult blood developer solution on 1 of the 4 medication carts. Findings included: A review of the undated Drug Storage and Expiration Date Guidelines provided by the Director of Nursing indicated inhaled medications expire 30 days after opening and Levemir Insulin would expire 42 days after opening. A review of page 17 of the manufacture instructions for the	F 431	No residents were specifically identified as having been affected by this alleged deficient practice. For those residents with the potential to be affected by the same alleged deficient practice, all nursing carts were audited by Director of Nursing (DON) and Clinical Coordinator on 11/4/16 to ensure all medications were labeled and dated correctly and all expired medications were discarded properly. All medications found to be expired or not labeled with date opened were immediately discarded on 11/4/16 by DON and clinical coordinator. To ensure the	

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F 431	Continued From page 50 Assure Prism glucometer check system read the control solution should be discarded no later than three months past the expiration date and manufacturer instructions for the Coloscreen Developer read do not use past the expiration date. On 11/2/16 at 4:00 PM, the 100-200 hall medication cart was reviewed for storage. There was one bottle of Fluticasone nasal spray filled 9/6/16 but not dated when it was opened. There was a Levemir Insulin Flex Pen with no fill date on the label and not dated when it was opened. There was also an Anoro Inhaler filled 10/1/16 not dated when it was opened. On the same cart was observed Assure Prism Control Solution (Level 1 vial and a Level 2 vial) used to determine the accuracy of the glucometers used to assess blood sugar levels. The level 1 vial expired 2/16 and the level 2 vial expired 11/15. During an interview with Nurse #1, she stated the items discovered undated should have been dated when they were opened in order to determine when they would need to be discarded. Also, Nurse #1 stated both vials of the control solution for the glucometer should have discarded and not used to determine accuracy the glucometer machine. On 11/2/16 at 4:30 PM the medication cart for 400 odd rooms and 500 hall was reviewed. A Dulera Inhaler filled on 10/17/16 was not dated when it was opened. The Medication Aide #1 stated it should have been dated when it was opened. On 11/2/16 at 4:45 PM, the medication cart for 400 even rooms and 600 hall was reviewed. An Advair Inhaler filled 10/14/16 was not dated when it was opened and a Breo Inhaler filled 10/10/16 not dated when it was opened. Also, a bottle of	F 431	alleged deficient practice does not reoccur all licensed nurses and medication aides to include weekend and PRN staff will be in serviced on the proper dating/ labeling and disposal of out-of-date medications by 12/1/2016 by the Assistant Director of Nursing (ADON) and/or Clinical Coordinator. The licensed nursing staff on first shift will perform weekly inspections for 4 weeks, biweekly inspections for one month and monthly inspections for four month□s to ensure all medications are labeled with date opened and to ensure that all medications are checked for expiration dates and disposed of properly if applicable. ADON, DON and clinical coordinator will make random medication cart audits weekly to ensure all medications are labeled and dated correctly and all expired medications are discarded properly. Results of the audits will be kept by the DON who will bring them to the monthly Quality Assurance meeting to review and discussed. Continued audits will be performed based on the outcome of the audits previously performed.	

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F 431	Continued From page 51 Coloscreen Developer solution used to assess the presence of blood in a stool sample expired 10/16. Nurse #2 stated opened inhalers should have been dated when they were opened to determine expiration date. On 11/2/16 at 5:37 PM, the Director of Nursing stated her expectation that the facility policy on dating inhaled medications and insulin should be dated when opened to determine expiration. Also biological solutions used to test the accuracy of the glucometers and for occult blood should not be used past their expiration date.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		12/1/16

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F 520	Continued From page 52 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedure and to monitor these interventions that the committee put into place following the 12/3/15 recertification survey. Accuracy of the assessment (F278) and review and revise care plan (F280) were cited during the recertification survey of 12/3/15 and was cited again during the recertification/complaint survey of 11/3/16. The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F278 - Accuracy of the assessment - Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of urinary catheters (Residents # 106 & # 14), weight (Resident # 125), height (Residents #74, #158, #12, #125, #105, #202 & #72), limitation in range of motion and ambulation (Residents #107) for 10 of 25 sampled residents reviewed. During the recertification survey of 12/3/15, the facility was cited F278 for not coding the MDS assessments accurately in the areas of radiation and chemotherapy treatment, range of motion exercises and splinting and the use of psychotropic medication. On the current	F 520	For the residents found to have been affected by the alleged deficient practice residents (urinary catheters #106, #14) (weight #125) (height #74,#158,#12, #125, #105 , #202, #72) (limitation in range of motion and ambulation #107) (medications #12). Resident #106 Minimum Data Set (MDS) admission assessment was corrected on 11/4/16 to reflect that the resident had a catheter at that time. Resident #14 MDS admission assessment was corrected by MDS coordinator on 11/4/16 to reflect that the resident had a catheter at that time. Resident #74 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect the residents accurate height. Resident #158 MDS quarterly assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #125 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and weight Resident #202 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #105 MDS admission assessment was corrected by MDS	

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F 520	Continued From page 53 recertification survey of 11/3/16, the facility was recited F278 for not coding the MDS assessments accurately in the areas of urinary catheters, height, weight, limitation in range of motion and ambulation. F280 - Review/revise care plan - Based on record review and staff interview, the facility failed to revise the care plan for 1 (Resident #14) of 3 sampled residents reviewed for pressure ulcer and for 1 (Resident #12) of 5 sampled residents reviewed for unnecessary medications. During the recertification survey of 12/3/15, the facility was cited F280 for not revising the care plan for ADL and nutrition. On the current recertification survey of 11/3/16, the facility was recited F280 for not revising the care plan for pressure ulcer and the use of the psychotropic medication. On 11/3/16 at 9:15 AM, the Administrator was interviewed for QAA. The Administrator stated that the facility has a QA committee that consisted of all the department heads and the Medical Director. He revealed that the committee had met monthly. He stated that he had started working at the facility as an Administrator 5 months ago. He indicated that the Director of Nursing had been monitoring the MDS assessments and the care plan but the MDS nurses were relatively new--one MDS Nurse started 5 months ago and the other MDS Nurse started 3 months ago.	F 520	coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #12 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and accurately coded 3 for anti-anxiety medication. Resident #107 MDS quarterly assessment was corrected by MDS coordinator to ensure accurate coding of range of motion for assessment period of 8/20/16 on 11/4/16. Resident #107 MDS assessment was coded inaccurately for documentation by Certified Nursing Assistant (CNA) for Activities of daily living (ADL s). MDS quarterly assessment was corrected by MDS coordinator to ensure accurate coding of activities of daily living for the assessment period of 8/20/16 on 11/4/16. Coding was reviewed with CNA involved, the CNA was educated on proper documentation of accurate information by the assistant Director of Nursing on 11/4/2016. For those residents with potential to be affected by alleged deficient practice 100% of current residents were audited on 11/7/2016 by the Director of Nursing and Assistant director of nursing, for heights and weights entered into the system. 20 residents were found to not have heights and weights in the electronic health system and those were added. All	

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F 520	Continued From page 54	F 520	residents currently have a height and weight entered into the system. All residents who currently have a catheter had their MDS assessment audited and reviewed by Director of nursing and assistant director of nursing to ensure accurate coding of a catheter in place on 11/18/2016. All residents with catheters were found to be correctly coded. All residents who are currently receiving a psychotropic medication will have their MDS assessment audited by the DON and ADON and reviewed for accurate coding of psychotropic medications by 12/1/16.All current residents will have the most current MDS assessment audited for accurate range of motion and ambulation by the DON and ADON by 12/1/16. All inaccurate coding will be corrected by the MDS nurses by 12/1/2016. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place. The Dietary Manager was educated on 11/7/2016 by Director of Nursing on facility procedures on coding MDS assessments properly specifically regarding height and weight. MDS nurses, Dietary Manager, Social Services Director, Activities Director and Wound Care Nurse were educated by the Director of Nursing on 11/4/16 on timely completion and accuracy of MDS assessments. Heights and weights will be entered in computer system within 72 hours of admission to facility by admitting nurse. All new admissions will be reviewed by administrative nurses , which include DON, ADON, and clinical coordinator in the clinical meeting the next	

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F 520	Continued From page 55	F 520	business day after admission for completion of heights and weights. In services will be provided to all CNA s and Nurses to include weekend and PRN staff on accurate coding of ADL documentation by December 1, 2016 by either ADON, MDS nurses or Director of Nursing. Audits will be performed during weekly Patients at Risk meeting by team members to include the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator. Five MDS assessments will be audited for height and weight, psychotropic medications, urinary catheters and accurate ADL documentation weekly for four weeks, five MDS assessments will be audited biweekly for one month then monthly for four months alternating different residents in each MDS assessment review period. After review of the audits corrections will be done immediately if noted. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting and they will be discussed. Continued audits will be performed based on results of the previous audits. For the residents found to have been affected by the alleged deficient practice resident (#14) care plan was updated accurately to reflect Physician s order to discontinue nutritional supplement by Minimum Data Set coordinator (MDS)on 11/4/2016. Resident (#12) care plan for anti-psychotic medication was discontinued by MDS coordinator on 11/4/16. For the residents with the	

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F 520	Continued From page 56	F 520	potential to be affected by alleged deficient practice 100% of all residents will have their care plans compared with current orders to ensure accuracy of care plans by November 28,2016. The audits will be completed by the Director of Nursing, Assistant Director of Nursing and the Clinical Coordinator and wound care nurse. All care plans will updated by the MDS nurses based on results of audits performed at the time of the audit. To ensure this alleged deficient practice does not reoccur, the following measures will be put into place; all new orders will be brought the next business day to daily clinical meeting to have the care plan updated by the MDS nurse at that time. Audits will be performed by the Director of Nursing, the Assistant Director of Nursing and the Clinical Coordinator on 5 residents to compare new and discontinued orders to the care plan weekly for four weeks and five residents will be audited biweekly for one month then five residents monthly for four months. Any orders either new or discontinued found not to be reflected in care plan during audits will be adjusted immediately by MDS nurses. Results of these audits will be maintained by the Director of Nursing who will bring them to the monthly Quality Assurance meeting where they will be reviewed and discussed. Continued audits will be performed based on results of the previous audits. All findings from MDS assessment and care Plan audits will be brought to the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 520	Continued From page 57	F 520	committee meeting each month for six months. The results of the audits will determine whether or not the QA committee needs to continue the audit review past the originally decision of six months. The QA committee will at this time determine if changes in the current monitoring system need to occur. If so, the appropriate staff will receive education regarding such changes to monitoring system.	