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 11/16/2017

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 159 SS=C	FACILITY MANAGEMENT OF PERSONAL FUNDS CFR(s): 483.10(f)(10)(i)-(iv) (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a	F 159		12/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2017

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F 159	Continued From page 1 system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure residents had access to their personal funds beyond regular business hours for 42 of 42 residents who participated in the Resident Trust Account. The findings included: During an interview with Resident #53 on 11/13/17 at 9:39 AM she stated residents could not access their personal funds on the weekends.	F 159	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F159 Residents were unable to access their Personal fund account on the week-ends.	

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F 159	Continued From page 2 A review of the facility list of residents with trust fund accounts revealed a total of 42 residents had accounts. An interview was conducted with the Personnel Manager on 11/16/17 at 8:50 AM. She stated she had been handling the resident personal fund accounts for 15 years. She indicated residents were only able to access their funds through her. She reported her normal working hours were Monday through Friday from 9:00 AM to 5:30 PM or 6:00 PM. The Personnel Manager revealed there was no way for residents to access their personal funds after normal business hours or on the weekend. An interview was conducted with the Director of Nursing on 11/16/17 at 11:40 AM. She stated she expected residents to be able to access their personal funds beyond regular business hours.	F 159	Resident number 53 was told that she could access her account and available funds and how to do that on the week-ends on11/29/2017 by the Administrator. A 100% of residents and /or their Responsible party with accounts were told the process of accessing their account on the week-end by the Administrator and the Office Manager on 11/29/2017. A Resident Council Meeting was held on 11/17/17 by the Activity Director to review with the council members how to access their personal accounts on the week-end if they had an active account. All new Admission will be educated during the admission process regarding the availability of funds in active resident accounts and how to access them by the Admissions Coordinator. The Office Manager utilized a QI tool and provided it to the week-end Supervisor located in a locked money box in the Director Of Nursing's Office so that residents who wanted money from their account would have access to it. On Mondays the Office Manager will balance all personal accounts to keep them readily available for the residents to access their accounts. This process will become a permenant process for all accounts. The QI tool will be turned into the	

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F 159	Continued From page 3	F 159	Administrator weekly. An in-service was conducted with the Office Manager and The Business Office Manager on the new process for residents to access their funds on 11/17/17 by the Administrator. A 100% in-service was conducted with all staff on the availability of personal funds for the residents on the week-ends by the Assistant Director of Nursing on 12/01/2017. The QI tool will be reviewed at the weekly QI Committee meeting for any Areas of concern for 4 weeks, bi-weekly for 4 weeks and monthly for 2 months. The monthly QI Committee meeting will review the minutes of the weekly QI Committee to determine the continued need and frequency of monitoring for	
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 221		12/10/17

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F 221	Continued From page 4 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility utilized bilateral quarter length side rails combined with bilateral wedge cushions without considering them as a restraint and without a medical diagnosis for 1 of 1 residents reviewed for physical restrains (Resident #41). The findings included: Resident #41 was admitted to the facility on 1/27/16 and most recent readmitted on 6/13/17 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting the right	F 221	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F221 Resident number 41 had a wedge in the bed that was not assessed as a possible restraint. Resident number 41 was assessed by the Director of Nursing on 11/17/17 for the wedges as a	

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F 221	Continued From page 5 dominant side, muscle weakness, epilepsy, and cognitive communication deficit. The plan of care for Resident #41 included the problem area of requiring staff assistance for transfers and ambulation initiated on 5/24/16 and last reviewed on 10/2/17. The plan of care for Resident #41 also included the problem area of quarter length side rails per resident ' s choice for independence with bed mobility initiated on 3/1/17 and last reviewed on 10/2/17. Additionally, the plan of care addressed a history of falling, initiated on 2/20/16, and last reviewed on 10/2/17. The quarterly Minimum Data Set (MDS) assessment dated 10/5/17 indicated Resident #41 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #41 was assessed as requiring the extensive assistance of 2 or more staff with bed mobility, transfers, dressing, and personal hygiene. She was dependent on 2 or more staff with toileting and on 1 staff with locomotion on the unit and bathing. Resident #41 was not steady on her feet and she was only able to stabilize with staff assistance. She had one fall with no injury since her previous MDS assessment (7/10/17). She was always incontinent of bladder and bowel. The assessment indicated Resident #41 had no physical restraints. An incident report dated 10/31/17 indicated Resident #41 had a fall with no injuries. She was observed laying on the floor beside her bed and was unable to state how she got there. The plan of care for Resident #41 related to the problem area of a history of falls was updated on 10/31/17. A new intervention was added for	F 221	restraint. The Director of Nursing utilized a restraint tool to determine that it reviews physical , vision, emotional, and the environment to base a decision on. The Director of Nursing reports that the Resident was able to move the wedge when asked to so the wedge was not considered to be a restraint. A 100 % audit using a restraint tool That reviews the physical, vision, Emotional, and the environment for all residents with a devices that could be considered a restraint was completed on 11/27/17 and 11/29/17 by the Clinical RN Supervisor and the MDS Nurse.The results showed that there were no devices used on residents that were assessed as a restraint. The devices that are implemented will be reviewed using a restraint tool during the interdisciplinary meeting each morning by the clinical nurses. A QI tool will be completed to audit the need for the continued use of the intervention 2 times a week by the RN Clinical Supervisor and turned into the Director of Nursing and / or the Administrator for review. A 100 % in-service was completed with Nurses and the interdisplinary team regarding devices being possible restraints by the Staff Development Coordinator and the week-end Supervisor on 12/1//17.	

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F 221	Continued From page 6 wedges to the bed define parameters of bed. A Patient at Risk (PAR) note dated 11/3/17 indicated Resident #41 had a fall on 10/31/17 and wedges were added to the bed. A PAR note dated 11/9/17 indicated wedges were in place on the bed as an intervention to Resident #41 ' s last fall on 10/31/17. An observation was conducted of Resident #41 on 11/13/17 at 9:00 AM. Resident #41 was alert, but was not interviewable. She had quarter length side rails and positioning wedges located on both sides of her bed. An interview was conducted with Nurse #4 on 11/13/17 at 9:14 AM. She stated Resident #41 had bilateral quarter length side rails. She indicated Resident #41 was not capable of getting out of bed on her own. She reported that Resident #41 recently had a decline in condition and her speech was very mumbled and she was unable to be understood. An interview was conducted with Nursing Assistant (NA) #3 on 11/15/17 at 2:07 PM. NA #3 stated she was familiar with Resident #41. She indicated Resident #41 was not able to get out of bed without assistance. She stated Resident #41 recently had a decline in condition and she was now dependent on staff for most of her Activities of Daily Living (ADLs). She reported Resident #41 required a mechanical lift for transfers. She stated Resident #41 was at risk for falls and she was not steady on her feet. She indicated the fall interventions included bilateral quarter length side rails and bilateral wedge cushions. She reported the interventions were in place to keep Resident	F 221	A restraint assessment tool will be used by the interdisplinary team and the nurses for the assessment of possible restraints daily for interventions that could be a restraint (i.e.: wedges, and pillows etc.). The tool will be turned into the Administrator and / or the Director of Nursing for review of areas of concerns. The RN Clinical Supervisor will use a QI tool to monitor the continued need of the device 2 times a week for 4 weeks, bi-weekly, and monthly for 4 months. The Administrator will bring the tools to the weekly QI Meeting for review of the interventions and assessment review for 4weeks, biweekly for 4 weeks, and monthly for 2 months. Any identified area will be addressed as it is identified. The monthly QA Meeting will review the minutes of the Weekly QI Meetings for the continued need and frequency of monitoring for 4 months.	

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F 221	Continued From page 7	F 221		

#41 from falling off the bed. NA #3 stated Resident #41 had some bed mobility and she occasionally tried to swing her legs over to the side of the bed. She explained that if Resident #41 swung her legs off the bed too much she would have fallen to the ground if the side rails and wedge cushions were not on the bed.

Resident #41 ' s "Nurse Tech Information Kardex", a care guide for Nursing Assistants (NAs), was reviewed on 11/15/17 at 2:15 PM. The care guide indicated Resident #41 required the assistance of one staff for bed mobility and the assistance of two staff and a full body lift for transfers.

An interview was conducted with the Director of Nursing (DON) on 11/15/17 at 2:45 PM. The plan of care that indicated quarter length side rails and wedge cushions were utilized for Resident #41 was reviewed with the DON. She stated the wedge cushions were implemented to keep Resident #41 from falling out of the bed. She indicated she had not considered or assessed the bilateral wedge cushions combined with the bilateral quarter length side rails as a restraint.

An interview was conducted with Nurse #3 on 11/15/17 at 4:40 PM. The plan of care that indicated quarter length side rails and wedge cushions were utilized for Resident #41 was reviewed with Nurse #3. She indicated Resident #41 had gotten to the edge of her bed and slid off onto the ground. She stated the wedge cushions were implemented to keep Resident #41 in the bed. Nurse #3 indicated she had not considered or assessed the bilateral wedge cushions combined with the bilateral quarter length side rails as a restraint.

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F 221	Continued From page 8 A follow up interview was conducted with the DON on 11/16/17 at 9:03 AM. The DON reported she observed Resident #41 last night (11/15/17) in her bed. She indicated Resident #41 was able to move around in bed purposefully. She indicated she had also reviewed Resident #41 ' s care plan for falls last night (11/15/17) and reviewed her 10/31/17 fall again to determine a root cause. She reported that Resident #41 had a history of seizures and she had several seizures noted in the last two months. She stated the root cause analysis determined the possible cause of Resident #41 ' s fall from bed on 10/31/17 was due to a seizure. The DON indicated the care plan for Resident #41 was revised on 11/15/17 to indicated the wedges were added to the bed on 10/31/17 to define the parameters of the bed due to seizures. She again stated she had not considered or assessed the bilateral wedge cushions combined with the bilateral quarter length side rails as a restraint.	F 221		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to cover a urinary collection bag to ensure resident dignity for 2 of 2 residents (Resident #146 and Resident #127) reviewed for urinary catheters. Findings	F 241	This Plan of Correction is prepared as a Necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to	12/10/17

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F 241	Continued From page 9 included: 1. Resident #146 was admitted on 10/17/17 with cumulative diagnoses of paraplegia and neurogenic bladder. His admission Minimum Data Set (MDS) dated 10/24/17 indicated he was cognitively intact, feeling depressed with verbal behaviors and rejection of care. Resident #146 was coded as requiring total assistance with his activities of daily living (ADLs) and coded as having urinary catheter. The Care Area Assessment read he required a urinary catheter due to neurogenic bladder. Resident #146 was care planned on 10/24/17 for his urinary catheter. In an observation on 11/13/17 at 12:20 PM, Resident #146 urinary collection bag was observed attached to the right side of his bed facing the window. The window blinds were open. The urinary collection bag was observed uncover with visible yellow urine inside the bag. In an observation on 11/14/17 at 8:33 AM, Resident #146 urinary collection bag was observed attached to the right side of his bed facing the window. The window blinds were open. The urinary collection bag was observed uncover with visible yellow urine inside the bag. In an observation on 11/15/17 at 8:34 AM, Resident #146 urinary collection bag was observed attached to the right side of his bed facing the window. The window blinds were open. The urinary collection bag was observed uncover with visible yellow urine inside the bag. Resident #146 stated the treatment nurse changed his urinary catheter 11/14/17 but he was unsure if the urinary collection bag was changed 11/14/17.	F 241	the validity of the alleged deficient Practice. F241 Resident number 146 and Resident number 127 did not have their urinary collection bag covered with a dignity bag. Resident number 146 and 127 had their urinary collection bag covered with a dignity bag by the wound nurse and the hall nurse on 11/15/2017. A 100 percent audit was completed of all residents by the RN Clinical Supervisor for catheter bags that do not have a dignity bag on them. There were none noted to be without a dignity bag on them by the RN Clinical Supervisor on 11/20/2017. The Assistant Director of Nursing and the week-end Supervisor competed a 100% In-sevice with the nursing staff on 12/1//2017 that all catheters must have a dignity bag over them. A QI tool will be used daily for 2 weeks to monitor urinary collection bags being covered with a dignity bag by the MDS Nurses, weekly for 2 weeks, and monthly for 2 months. The QI tool will be turned into the Director of Nursing or the Assistant Director of Nursing to review. any identified areas of concern will be	

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F 241	Continued From page 10 In an interview on 11/15/17 at 8:35 AM, Nursing Assistant (NA) #1 stated she thought privacy bags were to be placed on collection bags on the residents who got up and out of their room. She confirmed the treatment nurse changed his urinary catheter 11/14/17. In an interview on 11/15/17 at 8:40 AM, the treatment nurse stated he changed Resident #146 ' s urinary catheter 11/14/17. He stated he also changed the urinary collection bag on 11/14/17. The treatment nurse stated he was unsure if he applied a privacy cover to the urinary collection bag on 11/14/17. He stated all residents with urinary collection bags should have a privacy cover to ensure resident dignity. In an interview on 11/15/17 at 9:03 AM, Nurse #1 stated she was assigned Resident #146 on 11/13/17, 11/14/17 and 11/15/17. She stated Resident #146 ' s urinary collection bag should have a privacy cover at all times to ensure his dignity. She stated she did not notice if he had a privacy cover or not. In an interview on 11/15/17 at 9:08 AM, the Director of Nursing (DON) stated it was her expectation that Resident #146 have a privacy cover on his urinary collection bag to ensure dignity. In an observation on 11/16/17 at 9:14 AM, Resident #146 ' s urinary collection bag was covered. Resident #146 stated the treatment nurse put a cover on his urinary collection bag on 11/14/17. 2. Resident #127 was admitted on 9/01/17 with cumulative diagnoses of pressure ulcers and	F 241	addressed as it is identified. The Director of Nursing or the Administrator will bring the QI tools to the weekly QI Meeting for review of any areas of concern for 2 weeks, bi-weekly for 2 weeks, and monthly for 2 months. The monthly QI Committee will review the minutes of the weekly QI meeting for the continued need and frequency of monitoring.	

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F 241	Continued From page 11 benign prostrate hypertrophy (BPH). His admission MDS dated 9/8/17 indicated severe cognitive impairment, no behaviors and total assistance with his ADLs. He was coded for a urinary catheter. Resident #127 was care planned on 9/8/17 for a urinary catheter. In an observation on 11/15/17 at 10:45 AM, Resident #127 urinary collection bag was observed attached to the right side of his bed facing the hallway. There was no observed privacy cover and yellow urine could be seen in the collection bag from the hallway. In an observation on 11/15/17 at 3:42 PM, Resident #127 urinary collection bag was observed attached to the right side of his bed facing the hallway. There was no observed privacy cover and yellow urine could be seen in the collection bag from the hallway. In an interview on 11/15/17 at 3:47 PM, Nurse #2 stated he did not notice Resident #127 did not have a privacy cover on his urinary collection bag. He stated he was aware that a privacy cover should be on Resident #127 urinary collection bag for dignity. In an interview on11/15/17 at 4:50 PM, the DON stated it was her expectation that Resident #127 have a privacy cover on his urinary collection bag to ensure dignity.	F 241		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 253		12/10/17

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F 253	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units in sampled rooms on 6 of 6 halls. PTAC units had visible dust on the removable air filters in rooms 105, 114, 211, 303B, 306, 401, 403, 409, 410, 415, 503B and 603. The facility also failed to ensure vent covers on the PTAC units were in place in sampled rooms on 6 of 6 halls. The PTAC units with no vent cover were 104, 107, 109, 110, 116, 201, 205, 301B 304A, 304B, 310, 403, 406, 409, 503A and 606. The findings included: 1. A review of the instructions regarding Heating Ventilation Air Conditioning (HVAC) (PTAC): Inspect, clean air filter, check drainage; revealed that removable air filters were to be replaced or thoroughly cleaned depending on the type of filter every three months . An observation on 11/13/17 at 920 AM revealed visible dust on the removable air filter for the PTAC unit in rooms 105, 114, 211, 303B, 306, 403, 409, 410, 415, 503B and 603. An observation on 11/14/17 at 4:19 PM revealed visible dust on the removable air filter for the PTAC unit in room 401. In an interview on 11/15/17 at 9:15 AM, the Administrator stated the facility had a change in the Environmental Department and a new maintenance supervisor was hired a few months ago. She stated there was a maintenance assistant as well who was hired about a year ago. The Administrator stated the facility did not have	F 253	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F253 Air filters on 6 halls had PTAC units that needed to be cleaned. The individual heating (PTAC) units in rooms 105,114,211,303B,306,401,403, 409,410,415,503B, and 603 had filters cleaned on 11/15/17 by the Assistant Maintenance Director. The Assistant Maintenance Director cleaned 100 % of filters in the air units on 11/15/2017. The individual heating and air units in rooms 205,304A, 304B, 403, and 409 had covers that were broken or missing a vent cover. The Maintenance Director replaced the missing or broken vent cover with a new one on 11/29/17. The Maintenance Director completed a 100 % Audit of all resident rooms for air units that was missing a cover or had one that was broken on 11/16/2017. All	

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F 253	Continued From page 13 a quarterly environmental check off list and that was a problem identified recently. She stated it was a Quality Assurance item that the Environmental Department were working on and the facility had developed work orders that were available at all nurses ' stations and on all housekeeping cart. The Administrator stated it was her expectation that the PTAC filters be cleaned according to the recommended schedule. In an interview on 11/15/17 at 9:30 AM the Maintenance Supervisor stated he had been with the facility only a few months and was playing catch up. He stated at the time he was hired, the previous Maintenance Supervisor had already been terminated the only the Maintenance Assistant was working. He stated he was still sorting through the previous Maintenance Superior ' s paperwork. He confirmed the identified rooms listed had dirty PTAC filters. In a second interview on 11/15/17 at 9:44 AM the Maintenance Supervisor and the Maintenance Assistant provided documentation that the previous Maintenance Supervisor initialed off that the PTAC filters were last cleaned on 7/26/17. Both voiced understanding that the PTAC filter were to be cleaned every 3 months and the PTAC filters had not been cleaned since 7/26/17. 2. A review of the instructions regarding Heating Ventilation Air Conditioning (HVAC) (PTAC): Inspect, clean air filter, check drainage; revealed that removable air filters were to be replaced or thoroughly cleaned depending on the type of filter every three months.	F 253	identified units that had broken or missing air unit covers was replaced on 12/1/17. . Residents air units was inspected by the Maintenance Director to determine if they needed to be cleaned on 11/15/17. The Assistant Maintenance Director cleaned 100 % of filters in the air units on 11/15/2017. The Maintenance Director completed a 100 % audit of all resident rooms for air units that was missing a cover or had one that was broken on 11/16/2017. The Maintenance Director repaired 100 % of air units that had a broken or missing air unit cover on it on 12/01/2017. The Administrator completed an in – service on cleaning the air unit filters and making sure that all air units have a protective covering over the air vents that is not broken with the Maintenance Director on 11/20/17.The Maintenance Director in-serviced the Maintenance Assistant on 11/22/17 on cleaning air unit filters and making sure that all air units have a protective covering over the air vent that is not broken. A QI Tool will be used to monitor for clean filters and broken air unit vents weekly by	

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F 253	Continued From page 14 An observation on 11/13/17 at 9:20 AM, revealed no top vent cover on the PTAC unit in rooms 205, 304A, 304B, 403 and 409. An observation on 11/15/17 at 2:30 PM revealed no top vent cover on the PTAC unit in rooms 201, 301B and 310. An observation on 11/15/17 at 2:43 PM revealed no top vent cover on the PTAC units in rooms 104, 107, 109, 110 and 116. An observation on 11/15/17 at 3:10 PM revealed no top vent cover on the PTAC unit in rooms 406, 503A and 606. In an interview on 11/15/17 at 9:15 AM, the Administrator stated the facility had a change in the Environmental department and a new maintenance supervisor was hired a few months ago. She stated there was a maintenance assistant as well who was hired about a year ago. The Administrator stated the facility did not have a quarterly environmental check off list and that was a problem identified recently. She stated it was a Quality Assurance item that Environmental Department were working on. The Administrator stated it was her expectation that the PTAC units be in proper safe working order and she was aware some units were missing the vent covers. In an interview on 11/15/17 at 9:30 AM the Maintenance Supervisor stated he was aware the some PTAC units were missing the top vent covers and he was in the process of compiling a list of items to be ordered and replaced.	F 253	the Housekeeping Supervisor for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. the QI tool will be turned into the Administrator for review. All areas of concern will be addressed as it is identified. The Administrator will bring the QI tool to the weekly QI Meeting to review for the appropriate interventions for 2 weeks, bi-weekly for 2 weeks and monthly for 2 months. The monthly QA Meeting will review the weekly QI minutes for the continued need and frequency of monitoring for 3 months.	
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		12/10/17

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F 274	Continued From page 15 CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment 14 days after it was determined that there was a significant change or decline in resident's status for 2 of 4 sampled residents reviewed for accidents (Residents # 80 & #120). Findings included: 1. Resident #80 was originally admitted to the facility on 3/10/17 with multiple diagnoses including vascular dementia with behavioral disturbances. The quarterly MDS assessment dated 5/31/17 indicated that Resident #80 needed supervision with bed mobility, transfer, locomotion, and toilet use and he needed limited assistance with personal hygiene and dressing. The quarterly MDS assessment dated 8/26/17	F 274	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F274 Resident number 80 and resident number 120's MDS were not coded for a Significant decline and a change in status. Resident number 80 had their MDS reviewed for a significant change for decline and a change in status by the Assistant Director of Nursing on 11/29/17. A MDS was initiated to capture the decline in ADL's and Behaviors. Resident	

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F 274	Continued From page 16 indicated that Resident #80 needed extensive assistance with bed mobility, transfer, locomotion, eating, personal hygiene, dressing and toilet use. On 11/16/17 at 11:35 AM, MDS Nurse #1 was interviewed. She reviewed the quarterly MDS assessments dated 5/31/17 and 8/26/17 and verified that Resident #80 has more than 2 areas of decline in his activities of daily living (ADL) and acknowledged that a significant change in status MDS assessment should have been completed. On 11/16/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected that a significant change in status MDS assessment be completed when there were 2 or more areas of decline in ADL. 2. Resident #120 was originally admitted to the facility on 3/8/17 and was readmitted on 8/15/17 and 10/16/17 with multiple diagnoses including Alzheimer's disease. The admission MDS assessment dated 8/22/17 indicated that Resident #80's cognition was intact with brief interview for mental status (BIMS) score of 15. The assessment also indicated that Resident #120 had no pressure ulcer and she had no falls. The incident reports and nurse's notes were reviewed and revealed that Resident #120 had a fall on 9/9/17 and 9/29/17. The admission nurse's notes dated 10/16/17 revealed that Resident # 120 has a stage 3 pressure ulcer on the coccyx and a stage 2	F 274	number 120 is hospitalized and upon the return will have an MDS completed by the MDS Nurses and / or the Assistant Director of Nursing. . A 100 percent audit was completed by the MDS Nurses on all residents to determine if they had experience a significant decline or change of status. on 12/06/2017. 2 Significant Changes were identified and appropriate MDS assessments initiated. 6 changes were identified that require monitoring by the MDS Nurse to determine if they meet the requirements stated in the RAI Manual within the specified time frames. The Assistant Director of Nursing competed a 100% In-service with the MDS staff on for what a significant change is to include a significant change for a decline and a change of status on 11/17/17. A QI tool will be used 3 times a week for 4 weeks to monitor coding for MDS to include a significant change for a decline and change of status by the Director of Nursing and / or the Assistant Director of Nursing,	

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F 274	Continued From page 17 pressure ulcer on the heel. The 5 day MDS assessment dated 10/21/17 Indicated that Resident #120 had severe cognitive impairment with BIMS score of 7. On 11/16/17 at 11:35 AM, MDS Nurse #1 was interviewed. She reviewed the admission MDS assessment dated 8/22/17 and verified that Resident #120's cognition was intact and she had no pressure ulcer and she had no falls. MDS Nurse #1 indicated that Resident #120 was readmitted with pressure ulcers and she had history of falls. She also indicated that Resident #120 had severe cognitive impairment after readmission. MDS Nurse #1 acknowledged that a significant change in status MDS assessment should have been completed for Resident #120 due to more than 2 changes in the resident's status. 11/16/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected that a significant change in status MDS assessment be completed when there were 2 or more changes in the resident's status.	F 274	bi-weekly for 2 weeks, and monthly for 2 months. The QI tool will be reviewed at the weekly QI meeting to identify areas of concern and correct any concern identified. The Director of Nursing or the Assistant Director of Nursing will bring the QI tools to the weekly QI Meeting for review of any areas of concern for 2 weeks, bi-weekly for 2 weeks, and monthly for 2 months. The monthly QI Committee will review the minutes of the weekly QI meeting for the continued need and frequency of monitoring.	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		12/10/17

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F 278	Continued From page 18 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) 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 code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Resident #30), hospice and prognosis (Resident #47), and skin conditions (Resident #109) for 3 of 21 residents reviewed. The findings included: 1. Resident #30 was initially admitted to the facility on 2/9/09 and most recently readmitted on 9/26/17 with diagnoses that included major depressive disorder, other mental disorders, and	F 278	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F278 Resident number 30's MDS dated 10/25/17 was modified to include coding for antipsychotic, anticoagulant, opioid, and	

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F 278	Continued From page 19 vascular dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 10/25/17 indicated Resident #30 ' s cognition was moderately impaired. Section N, the Medication Section, indicated Resident #30 was administered antipsychotic medications on 5 of 7 days, anticoagulant medications on 5 of 7 days, opioid medications on 5 of 7 days, and antianxiety medications on 0 of 7 days during the MDS review period. The Antipsychotic Medication Review indicated Resident #30 had not received any antipsychotic medication. This section of the MDS was completed by MDS Nurse #1. A review of Resident #30 ' s Medication Administration Record (MAR) during the 10/25/17 MDS look back period (10/19/17 through 10/25/17) indicated she was administered Risperdal (antipsychotic medication) on 7 of 7 days, Fentanyl Patch (opioid medication) on 2 of 7 days, and Ativan (antianxiety medication) on 1 of 7 days. Resident #30 received no anticoagulant medication during the review period. An interview was conducted with the Director of Nursing on 11/16/17 at 11:40 AM. She stated she expected the MDS to be coded accurately. An interview was conducted with MDS Nurse #1 on 11/16/17 at 12:01 PM. She stated she began working at the facility as an MDS Nurse in September 2017. She indicated this was her first job working with MDS assessments. The Medication Section of the MDS assessment dated 10/25/17 for Resident #30 was reviewed with MDS Nurse #1. The MAR for Resident #30	F 278	antianxiety medications on 11/30/17 by the Assistant Director of Nursing. Resident number 47 had her MDS dated 9/9/17 modified by the Assistant Director of Nursing on 11/30/17 to include hospice services. Resident number 109 had her MDS dated 10/22/17 modified to include skin conditions by the Assistant Director of Nursing on 11/30/17. All modified MDS assessments will be submitted during the next transmittal process. A 100 percent audit was completed by the MDS Nurses, the Clinical RN Supervisor, the Medical Manager, and the Assistant Director of Nursing of all residents MDS being correctly coded on 12/10/14. The audit reviewed medications, diagnosis, and the current plan of care. There were no noted incorrect coding found. The Assistant Director of Nursing competed a 100% In-service with the MDS Nurses on 11/17/17 on the MDS assessment reflecting the current status of a resident. The Administrator completed an in-service with the Assistant Director of Nursing and the Clinical Rn Supervisor on MDS assessments reflecting the current	

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F 278	Continued From page 20 during the look back period of the 10/25/17 MDS was reviewed with MDS Nurse #1. She revealed she had incorrectly coded the MDS for antipsychotic medication, opioid medication, antianxiety medication, and anticoagulant medication. MDS Nurse #1 stated she was still in the process of learning the computer system and she believed that was why she had incorrectly coded the antipsychotic medication and antianxiety medication. She indicated she had incorrectly coded an antiplatelet medication (Plavix) as an anticoagulant medication. She additionally indicated she had some confusion on how to code the Fentanyl patch. MDS Nurse #1 also revealed she completed the Antipsychotic Medication Review incorrectly as Resident #30 had received antipsychotic medication. 2. Resident #47 was readmitted to the facility on 7/20/17 with multiple diagnosis including Alzheimer's disease and aortic stenosis. The significant change in status Minimum Data Set (MDS) assessment dated 9/9/17 indicated that Resident #47 had severe cognitive impairment. The MDS assessment also indicated that Resident #47 did not receive hospice care while a resident at the facility and did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #47's physician's orders were reviewed. On 18/30/17, there was an order to admit Resident #47 to hospice due to terminal aortic stenosis. On 11/15/17 at 3:40 PM, the Assistant Director of Nursing was interviewed. She stated that she completed the significant change in status MDS assessment dated 9/7/17 for Resident #47. She acknowledged that the resident was receiving	F 278	status of a resident on 11/29/17. A QI tool will be used 3 times a week for 4 weeks to monitor correct coding on the MDS by the Director of Nursing and / or the Assistant Director of Nursing, bi-weekly for 2 weeks, and monthly for 2 months. The QI tool will be reviewed at the weekly QI meeting to identify areas of concern. any identified concern will be corrected as it is identified. The Director of Nursing and /or the Assistant Director of Nursing will bring the QI tools to the weekly QI Meeting for review of any areas of concern for 2 weeks, bi-weekly for 2 weeks, and monthly for 2 months. The monthly QI Committee will review the minutes of the weekly QI meeting for the continued need and frequency of monitoring.	

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F 278	Continued From page 21	F 278		

hospice care during the assessment period and she should have coded hospice care and the prognosis but she did not.

On 11/16/17 at 9:03 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be accurate.

3. Resident #109 was admitted 7/1/16 and readmitted 4/17/17. Cumulative diagnoses included right heel osteomyelitis (bone infection).

A wound care note dated 10/18/17 stated Resident #109 had a stage 4 pressure ulcer on the right posterior heel that measured 3.2 centimeters long x 0.9 centimeters wide x 0.2 centimeters depth. There was 15% thick adherent devitalized necrotic tissue, 20% other tissue and 65% granulation tissue.

A Quarterly Minimum Data Set (MDS) dated 10/22/17 indicated Resident #109 was severely impaired in cognition with short and long term memory impairment and severely impaired with daily decision-making. Skin conditions revealed Resident #109 had a stage 1 or higher pressure ulcer. Resident #109 had a stage 4 pressure ulcer with the following measurements--3.2 centimeters long x 0.9 centimeters wide x 0.2 centimeters depth. Tissue type at most advanced stage was noted as granulation tissue--pink or red tissue with shiny, moist, granular appearance.

The nurse who completed the MDS information for the pressure ulcer was not available for interview.

On 11/15/2017at 4:30 PM, an interview was

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F 278	Continued From page 22 conducted with the Assistant Director of Nursing. She stated the information used to complete the Quarterly MDS dated 10/22/17 for the skin condition should have reflected the necrotic tissue and not granulation tissue. On 11/16/2017 at 11:41 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		12/11/17

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F 280	Continued From page 23	F 280		

right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident

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F 280	Continued From page 24 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise care plans in the areas of catheters (Resident #30), activities of daily living (Resident #41), and pressure ulcers (Resident #109) for 3 of 21 residents reviewed. The findings included: 1. Resident #30 was initially admitted to the facility on 2/9/09 and most recently readmitted on 9/26/17 with diagnoses that included Diabetes Mellitus Type 2, hypertension, hyperlipidemia, and dementia. The plan of care for Resident #30 included the problem area of an indwelling catheter initiated on 12/9/15. The care plan for Resident #30 was indicated as last reviewed on 4/25/17. A physician ' s order dated 7/12/17 indicated the removal of Resident #30 ' s catheter. The quarterly Minimum Data Set (MDS) assessment dated 10/25/17 indicated Resident #30 ' s cognition was moderately impaired. She was assessed with no catheter.	F 280	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F280 Resident's care plans had not been reviewed and revised for resident number 30, 41, and 109. Resident number 30's care plan was reviewed and revised by the MDS Nurse to show that a catheter had been removed on 11/29/17 by the Clinical RN Supervisor. Resident number 41 had her care plan reviewed and revised by the Clinical RN Supervisor on 11/29/17 to show that she required extensive Assistance of 2 or more staff with transfers. Resident 109's care plan was reviewed and revised by the Clinical RN Supervisor on 11/29/17 to show a Stage 4 reopened on right heel on	

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F 280	Continued From page 25 An observation was conducted of Resident #30 on 11/14/17 at 11:10 AM. Resident #30 had no catheter. An interview was conducted with MDS Nurse #2 on 11/14/17 at 11:18 AM. The care plan for Resident #30 that indicated she had a catheter was reviewed with MDS Nurse #2. She stated that Resident #30 did not have a catheter. She confirmed the catheter was discontinued on 7/12/17. She revealed Resident #30 ' s care plan should have been revised to indicated the removal of the catheter. An interview was conducted with the Director of Nursing (DON) on 11/16/17 at 11:40 AM. She stated she expected care plans to be revised to accurately reflect the status of the resident. An interview was conducted MDS Nurse #1 on 11/16/17 at 12:01 PM. The care plan for Resident #30 that indicated she had a catheter was reviewed with MDS Nurse #1. The physician ' s order dated 7/12/17 for the removal of Resident #30 ' s catheter was reviewed with MDS Nurse #1. She revealed the care plan should have been revised to reflect the removal of Resident #30 ' s catheter. 2. Resident #41 was admitted to the facility on 1/27/16 and most recently readmitted on 6/13/17 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting the right dominant side and muscle weakness. The quarterly Minimum Data Set (MDS)	F 280	10/18/17 and interventions put into place. . A 100 percent audit was completed by the MDS Nurses, the Director of Nursing, the clinical RN Supervisor, and the Assistant Director of Nursing of all residents care plans on 12/07/17. The audit showed that there were care plans that needed to be reviewed and revised FOR 48 Residents. The Assistant Director of Nursing completed a 100% In-service with the MDS Nurses on 11/17/17 on care plans reflecting the current status of a resident. The Assistant Director of Nursing completed a 100% in-service with nursing staff on MDS accuracy and care plans reflecting the current status of a resident on 12/1/17. The MDS Nurse will use a care plan review Form daily at the clinical meeting for review of any changes in the residents condition that would require a change in their care plan. Care plans will be updated daily as needed and at each assessment by the MDS Nurse.	

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F 280	Continued From page 26 assessment dated 7/10/17 indicated Resident #41 ' s cognition was intact. Resident #41 was assessed as requiring the extensive assistance of 2 or more staff with transfers. The plan of care for Resident #41 related to Activities of Daily Living (ADLs) included the problem area of requiring staff assistance for transfers and ambulation initiated on 5/24/16 and last reviewed on 10/2/17. The interventions included one person assist for transfers. The quarterly Minimum Data Set (MDS) assessment dated 10/5/17 indicated Resident #41 ' s cognition was intact. Resident #41 was assessed as requiring the extensive assistance of 2 or more staff with transfers. An interview was conducted with Nursing Assistant (NA) #3 on 11/15/17 at 2:07 PM. NA #3 stated she was familiar with Resident #41. She reported Resident #41 was dependent on staff for most of her Activities of Daily Living (ADLs). She reported Resident #41 required a mechanical lift for transfers. Resident #41 ' s "Nurse Tech Information Kardex", a care guide for Nursing Assistants (NAs), was reviewed on 11/15/17 at 2:15 PM. The care guide indicated Resident #41 required the assistance of two staff and a full body lift for transfers. An interview was conducted with the Director of Nursing (DON) on 11/16/17 at 11:40 AM. She stated she expected care plans to be revised to accurately reflect the status of the resident. An interview was conducted MDS Nurse #1 on	F 280	A QI tool will be used 3 times a week for 4 weeks to monitor care plans by the Director of Nursing and / or the Assistant Director of Nursing, bi-weekly for 4 weeks, and monthly for 4 months. The QI tool will be reviewed at the weekly QI meeting to identify areas of concern and correct any concern identified. The Director of Nursing and /or the Assistant Director of Nursing will bring the QI tools to the weekly QI Meeting for review of any areas of concern for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months. The monthly QI Committee will review the minutes of the weekly QI meeting for the continued need and frequency of monitoring.	

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11/16/17 at 12:01 PM. The care plan for Resident #41 related to ADLs that indicated the intervention of 1 staff assistance with transfers was reviewed with MDS Nurse #1. The MDS assessments dated 7/10/17 and 10/5/17 that indicated Resident #41 required 2 staff assistance with transfers was reviewed with MDS Nurse #1. The Nurse Tech Information Kardex that indicated Resident #41 required 2 staff assistance with transfers was reviewed with MDS Nurse #1. She revealed the care plan should have revised to reflect Resident #41 ' s status of 2 assistance with transfers.

3. Resident #109 was admitted 7/1/16 and readmitted 4/17/17. Cumulative diagnoses included right heel osteomyelitis (bone infection).

A review of the wound care assessments revealed an assessment dated 8/30/17 that stated the stage 4 pressure ulcer of the right heel was resolved on 8/30/17.

A wound care assessment dated 10/18/17 stated a stage 4 pressure ulcer of the right heel was identified on 10/17/17. The right heel pressure ulcer measured 3.2 centimeters long x 0.9 centimeters wide x 0.2 centimeters depth. Wound was cleansed with normal saline and the area was surgically debrided. Continue collagen dressing every two days, hydrogel every 2 days. Off load wound. Float heels in bed.

A physician's order dated 10/19/17 stated to clean with normal saline. Apply hydrogel and collagen to the stage 4 pressure wound of right posterior heel every 2 days.

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A Quarterly Minimum Data Set (MDS) dated 10/22/17 indicated Resident #109 was severely impaired in cognition with short and long-term memory impairment and severely impaired with daily decision-making. Skin conditions revealed Resident #109 had a stage 1 or higher pressure ulcer. Resident #109 had a stage 4 pressure ulcer with the following measurements--3.2 centimeters long x 0.9 centimeters wide x 0.2 centimeters depth.

A review of the care plan for Resident #109 revealed the last review of the care plan was 10/2/17. There was a care plan for a stage 4 pressure ulcer to the right heel resolved 12/20/16 and a care plan for potential for skin breakdown and potential for decline to stage 4 pressure ulcer dated 7/27/16. A review of approaches revealed no approaches dated after 7/15/17. The care plan did not identify that Resident #109 had a stage 4 pressure ulcer of the right heel on 10/18/17. The approaches did not reflect any current treatment for the stage 4 pressure ulcer of the right heel.

On 11/15/2017 at 4:58 PM, an interview was conducted with the Assistant Director of Nursing who stated the stage 4 pressure ulcer to the right heel reopened and the care plan added a goal of "will have measurable healing to right heel". She reviewed the care plan and acknowledged the goal was undated. She stated she was not sure why the approaches weren't updated with a new date for the approaches.

On 11/16/2017 at 11:41 AM, an interview was conducted with the Director of Nursing who stated the care plan should have been reviewed, revised and updated when the right heel reopened on

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F 280	Continued From page 29 10/18/17.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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, observation and resident and staff interview, the facility failed to follow the care plan interventions for smoking (Resident #80) for 1 of 1 sampled resident reviewed for smoking and for restraints (Resident # 41) for 1 of 1 sampled resident reviewed for restraint. Findings included: 1. Resident #80 was originally admitted to the facility on 3/10/17 with multiple diagnoses including vascular dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated 8/26/17 indicated that Resident #80's cognition was intact. Resident # 80's care plan dated 9/29/17 was reviewed. One of the care plan problems was "resident at risk for injury related to smoking." The goal was "resident will have no injury related to smoking". The approaches included to educate the resident on dangers of smoking and	F 282	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F282 Resident 80 had status changed as a smoker and intervention had not been updated in the care plan. Resident number 80 was provided with an updated smoking contract and issued a 30 day discharge 0n 11/16/17 by the Administrator and the Social Worker. Resident number 80 smoking status was changed to a supervised smoker on 11/16/17	12/10/17

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F 282	Continued From page 30 to keep smoking materials at nurse's station or in the nurse's medication cart. Resident #80's nurse's notes dated 11/10/17 at 4:21 AM indicated that Resident #80 was found smoking in the dining room. On 11/13/17 at 3:31 PM, Resident #80 was observed up in wheelchair in his room. When interviewed, he stated that he kept his own cigarettes and lighter with him. A lighter and a pack of cigarette were observed in his pocket. There were also 2 packs of cigarettes observed inside the resident's bedside drawer. On 11/14/17 at 4:32 PM and on 11/15/17 at 9:55 AM, Resident #80's room was observed. There were 2 packs of cigarettes observed inside the resident's bedside drawer. On 11/15/17 at 9:56 AM, Nurse #6 was interviewed. Nurse #6 stated that Resident #80 was not supposed to have smoking materials with him. She stated that she was not aware that Resident #80 had cigarettes in his room and was keeping the lighter and cigarettes in his pocket. Nurse #6 was observed to search the room of Resident #80 and found 2 packs of cigarettes. Resident #80's nurse's notes dated 11/16/17 at 12:36 AM indicated that Resident #80 was found smoking in the dining room. On 11/16/17 at 9:30 AM, the Director of Nursing (DON) was interviewed. The DON stated that she was not aware that Resident #80 had cigarettes and lighter in his room/possession. She indicated that she was aware that Resident #80 had been found smoking in the dining room	F 282	by the Administrator and the Social Worker. all smoking equipment for resident number 80 was placed in a secured storage on 11/15/17 by the hall nurse and the Administrator. The Social Worker will perform room checks 2 times a week to monitor for smoking material in resident number80's room until discharge using a QI Tool. The Social Worker reviewed the Smoking Policy with all residents that smoke on 11/14/17. All residents who smoke signed an acknowledgement that they accepted and understood the smoking policy on 11/14/17 with the Social Service Director or the Activity Director. The Administrator, Clinical RN Supervisor, and the Assistant Director of Nursing, completed an 100 % In-service with all staff on residents rights who smoke, supervised smoking, how to assist a resident who Is a supervised smoker to smoke by following the smoking contracts, rules, and on documentation on 11/24/17. A QI tool will be used to monitor that residents who are supervised smokers and can't have	

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F 282	Continued From page 31	F 282		

and he had been educated on the facility's smoking policy. The DON did not indicate that the staff has to monitor the resident and his room for any smoking materials

2. Resident #41 was admitted to the facility on 1/27/16 and most recently readmitted on 6/13/17 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting the right dominant side, muscle weakness, epilepsy, and cognitive communication deficit.

The plan of care for Resident #41 included the problem area of quarter length side rails per resident ' s choice for independence with bed mobility initiated on 3/1/17 and last reviewed on 10/2/17. The interventions included assessing the use of the side rails quarterly and as needed for safety and the continued need for the rails.

The quarterly Minimum Data Set (MDS) assessment dated 10/5/17 indicated Resident #41 ' s cognition was intact. Resident #41 was assessed as requiring the extensive assistance of 2 or more staff with bed mobility.

A review of the side rail assessments indicated no side rail assessment had been completed for Resident #41 for 5 months with the last assessment completed on 6/15/17.

An interview was conducted with Nurse #3 on 11/15/17 at 4:20 PM. She stated she was not sure who was responsible for completing the side rail assessments.

An interview was conducted with the Assistant

their smoking material in their room to ensure
that smoking material is maintained in a in a secured environment and not in the resident's room 2 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 month by the Social Worker. The QI tool will be turned into the Director of
Nursing or the Administrator for review. all areas of concern will be addressed as it is
identified. The Administrator will bring the QI tool to the
weekly QI Meeting to review for the appropriate
interventions for 2 weeks, bi-weekly for 2 weeks and monthly for 2 months. The monthly
QA Meeting Will review the weekly QI minutes
for the continued need and frequency of monitoring for 4 months

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F 282	Continued From page 32 Director of Nursing (ADON) on 11/15/17 at 4:40 PM. She stated she thought MDS Nurse #1 was responsible for completing the side rail assessments. An interview was conducted with the Director of Nursing (DON) on 11/16/17 at 11:40 AM. She stated she expected care plan interventions to be followed and for any assessments to be completed by the MDS nurse at the time the MDS was completed. An interview was conducted MDS Nurse #1 on 11/16/17 at 12:01 PM. The care plan for Resident #41 related to side rails and quarterly assessments was reviewed with MDS Nurse #1. The most recent side rail assessment for Resident #41 dated 6/15/17 was reviewed with MDS Nurse #1. MDS Nurse #1 stated she was unaware she was supposed to be doing side rail assessments. She explained that she began working at the facility in September of 2017 as an MDS Nurse and she had not conducted any assessments since she began in the position.	F 282		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 314		12/10/17

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F 314	Continued From page 33 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to assess and to treat the pressure ulcer in a timely manner for 1 of 3 sampled residents reviewed for pressure ulcer (Resident #120). Findings included: Resident #120 was readmitted to the facility on 8/15/17, 8/29/17 and 10/16/17 with multiple diagnosis including Alzheimer's disease. The admission Minimum Data Set (MDS) assessment dated 8/22/17 indicated that Resident #120's cognition was intact and she did not have a pressure ulcer. The admission nurse's notes dated 10/16/17 indicated that Resident #120 was admitted with a stage 3 pressure ulcer on the coccyx and a stage 2 pressure ulcer on the heel. The notes did not have the assessments (size, presence of eschar/necrosis, exudates) of the pressure ulcers. The care plan for Resident #120 was reviewed. One of the care plan problems was "unstageable to sacrum and right heel". The goal was "resident will have measurable healing of pressure ulcer". The approaches included treatment to pressure ulcers per doctor's order. The physician's orders for Resident #120 were	F 314	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F314 Resident number 120 did not have a wound assessed and treated on admission. Resident number 120 was seen by the wound Physician on 10/25/2017 and 11/15/2017. Resident number 120 was discharged on 11/26/17. . A 100 percent audit was completed by the treatment nurse for current treatment orders on 11/15/2017. A skin assessment was completed on all residents to assess for new skin concerns by the hall nurses on 11/15/2017. There were no noted issues that had not been addressed by the treatment nurse and	

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PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 314	Continued From page 34 reviewed. On 10/23/17, there was a doctor's order to clean sacral pressure ulcer with Normal Saline (NS) and apply Algicell AG (an antimicrobial silver alginate dressing) daily and to cover with foam dressing. On 10/25/17, there was an order to clean right heel with NS and to apply skin prep daily and on 11/3/17, the treatment was changed to Calcium Alginate. The Treatment Administration Records (TARs) for Resident #120 were reviewed. The October 2017 TARs revealed that the sacral pressure ulcer was not treated until 10/23/17 (7 days after admission). The TAR also indicated that the right heel pressure ulcer was not treated until 10/25/167 (9 days after admission). Resident #120's weekly wound assessments were reviewed. The first weekly wound assessment recorded was dated 10/25/17. The assessment revealed an unstageable pressure ulcer to the sacrum measuring 4 centimeter (cm) x (by) 1.9 cm with 60 % necrosis and an unstageable deep tissue injury (DTI) to the right heel measuring 3 cm x 6.2 cm with 50% necrosis. On 11/14/17 at 2:15 PM, Resident #120 was observed during the dressing change. The wound bed of the sacral pressure ulcer was observed to have black necrosis and yellow slough and the right heel pressure ulcer has a dry blister. The Treatment Nurse was observed to clean the sacral pressure ulcer with NS, Algicell AG was applied and was covered with a foam dressing. The right heel pressure ulcer was cleaned with NS, Calcium Alginate was applied and was secured with kerlix gauze. On 11/15/17 at 12:20 PM, Nurse # 5 was	F 314	wound physician. On 11/16/2017 the treatment nurse made rounds with the wound physician. There were no skin issues noted by the wound physician. All new admissions will be assessed by the treatment nurse and / or the hall nurse within 24hours of their admission. During the assessment process for new admissions the treatment nurse/ hall nurse will identify any skin issues and review the orders for treatment orders. If there are no treatment orders written the physician will be notified and treatment orders will be obtained by the treatment nurse. All residents with vascular, Diabetic, or pressure ulcers will be referred to the wound physician. Skin assessments will be reviewed daily at clinical meeting to monitor for any new skin issues by the clinical nursing team. Any identified area will be reported to the treatment nurse for appropriate assessment and treatment. The week-end RN Supervisor will review the skin assessments completed by the hall nurse daily for skin areas.If there are new areas the week-end Supervisor will notify the physician and obtain treatment orders. Any skin assessment that has identified skin issues will be turned	

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F 314	Continued From page 35 interviewed. Nurse #5 stated that he was the nurse who admitted Resident #120 on 10/16/17. He indicated that Resident #120 was admitted with pressure ulcers on the sacrum and on the right heel. Nurse #5 further indicated that he had informed the Treatment Nurse of the pressure ulcers because the resident was admitted on a weekday (Monday) and the Treatment Nurse should have assessed the pressure ulcers and have called the doctor for the treatment orders. Nurse #5 stated that he was not aware that the pressure ulcers were not assessed until 10/25/17 and the treatment orders were not obtained until 10/23/17 for the sacral pressure ulcer and on 10/25/17 for the right heel pressure ulcer. On 11/16/17 at 8:15 AM, Nurse #3 was interviewed. Nurse #3 was the clinical Nurse Supervisor. She stated that she transcribed medication orders for new admit residents but not treatment orders. Nurse #3 indicated that the Treatment Nurse was responsible for the assessment of the pressure ulcers on admission and to call the doctor for treatment orders. Nurse #3 reviewed the physician orders and there were no treatment orders for the pressure ulcers until 10/23/17 and 10/25/17. On 11/16/17 at 8:53 AM, the Director of Nursing (DON) was interviewed. The DON stated that the Treatment Nurse was no longer an employee of the facility. She stated that she had reviewed the records of Resident #120 and there were no treatment orders for the pressure ulcers on admission. The DON further indicated that she expected the treatment nurse to assess the pressure ulcers on admission and to call the doctor for the treatment orders but these did not happen.	F 314	into the Director of Nursing or the Assistant Director of Nursing for review at clinical meeting the next business day. The Assistant Director of Nursing completed a 100% In-service with all nursing staff on 12/1/17 that skin assessments will be completed on all new admissions and that any identified issues will have written orders for treatment. All residents with identified vascular, Diabetic or pressure ulcers will be referred to the wound physician. A QI tool will be used daily for 4 weeks to monitor new admission treatment and, new orders for residents admitted with wounds, by the MDS Nurses daily for 2 weeks, bi-weekly for 4 weeks, and monthly for 2 months. the QI tool will be turned into the Director of Nursing and / or the Assistant Director of Nursing for review. All areas of concern will be addressed as it is identified. The Director of Nursing and / or the Assistant Director of Nursing will bring the QI tool to the weekly QI Meeting to review for the appropriate interventions for 2 weeks, bi-weekly for 2 weeks and monthly for 2 months. All new admissions will be assessed by the treatment nurse and / or the hall nurse	

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F 314	Continued From page 36	F 314	within 24hours of their admission. During the assessment process the treatment nurse/ hall nurse will identify any skin issues and review the orders for treatment orders. If there are no treatment orders written the physician will be notified and treatment orders will be obtained. All residents with vascular, Diabetic, or pressure ulcers will be referred to the wound physician. Skin assessments will be monitored daily ongoing by the clinical team during the daily clinical meeting. Any identified skin issue on the skin assessment tool will be given to the Director of Nursing to review. The Director of Nursing will bring the skin assessment to the weekly QI Meeting for review weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months. The monthly QA Meeting will review the minutes from the weekly QI Meeting for the continued need and frequency of monitoring.	
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible	F 315		12/10/17

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F 315	Continued From page 37 to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to secure a urinary catheter to prevent tension on the insertion site for 1 of 2 (Resident #127) reviewed for urinary catheters. Findings included: Resident #127 was admitted on 9/01/17 with cumulative diagnoses of pressure ulcers and	F 315	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F315	

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F 315	Continued From page 38 benign prostrate hypertrophy (BPH). His admission MDS dated 9/8/17 indicated severe cognitive impairment, no behaviors and total assistance with his ADLs. He was coded for a urinary catheter. Resident #127 was care planned on 9/8/17 for a urinary catheter. In an observation on 11/15/17 at 4:40 PM, Nursing Assistant (NA) #2 pulled back Resident #127 sheet to reveal no securement device attached to his thigh to prevent tension on the urinary catheter insertion site. There was bright red blood observed around the meatus without evidence of tearing. NA #2 stated she was unaware that Resident #127 should have a urinary catheter securement device attached to his thigh to prevent tension on the urinary catheter. In an observation on 11/15/17 at 4:45 PM, Nurse #2 stated he was not aware there was bleeding from Resident #127 meatus and stated there should be a securement device attached to his thigh to prevent injury from tension on the urinary catheter. Nurse #2 stated he would apply one immediately. In an interview on11/15/17 at 4:50 PM, the DON stated it was her expectation that Resident #127 have a urinary catheter securement device attached to his thigh to prevent tension to the insertion site.	F 315	Resident number 127 did not have their catheter secured. Resident Number 127 had their Catheter secured with a catheter strap by the hall nurse on 11/15/17. A 100 percent audit was completed by the RN Clinical Supervisor of all residents catheters to ensure they were secured with a catheter device on 11/21/2017. all catheters were provided a catheter device to secure them in place by the RN Clinical Supervisor on 11/21/2017. There were no concerns noted. The Assistant Director of Nursing and the week-end Supervisor competed a 100% In-sevice with the nursing staff on 12/1/2017 that all catheters must have a device to secure them. A QI tool will be used daily for 2 weeks to monitor catheters being secured with a catheter securing device by the hall Nurses, weekly for 2 weeks, and monthly for 2 months. The QI tool will be turned into the Director of Nursing or the Assistant Director of Nursing to review. any identified areas of concern will be addressed as it is identified. The Director of Nursing or the Administrator will bring the QI tools to the weekly QI Meeting for review of any areas of	

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F 315	Continued From page 39	F 315	concern for 2 weeks, bi-weekly for 2 weeks, and monthly for 2 months. The monthly QI Committee will review the minutes of the weekly QI meeting for the continued need and frequency of monitoring.	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 323	This Plan of Correction is prepared as a	12/10/17

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F 323	Continued From page 40 interview, the facility failed to ensure resident who smokes did not have the smoking materials in their possession and failed to store flammable gas away from the smoking area for 1 of 1 sampled resident reviewed for smoking (Resident #80). Findings included: 1. On 11/14/17 at 4:40 PM, the smoking area was observed. There was a propane gas tank and a grill observed within the smoking area. One resident was smoking during the observation. The gas tank was not secured and was accessible to staff and residents. On 11/15/17 at 11:55 AM, the smoking area was again observed. There was a propane gas tank and a grill observed within the smoking area. The gas tank was not secured and was accessible to staff and residents. On 11/15/17 at 12:55 PM, the Administrator was interviewed. She stated that she was not aware that there was a propane gas tank in the smoking area. She stated that the grill was used by the activity department during cookout. The Administrator indicated that she would remove the gas tank immediately. On 11/15/17 at 12:56 PM, 2 propane tanks were observed removed from the smoking area. One tank was empty and the other tank was half full. Both tanks were not attached to the grill. On 11/16/17 at 9:45 AM, the Activity Director (AD) was interviewed. She stated that she had been the AD for 2 years now and she had not used the grill for cookout.	F 323	Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F323 Facility patio had propane gas tanks stored in an area adjacent to the are specified as the smoking area. The Maintenance Director and the Housekeeper removed the gas grill from the smoking patio on 11/14/17. The Maintenance Director removed the portable propane gas tanks on 11/14/17 from the smoking patio. Resident number 80 was provided with an updated smoking contract and issued a 30 day discharge on 11/16/17 by the Administrator and the Social Worker. All smoking material was removed from the residents room and stored in a secured area on 11/15/17 by the hall Nurse and the Administrator. The Maintenance Director and the Housekeeper removed the gas grill from the smoking patio on 11/14/17. The Maintenance Director removed the portable propane gas tanks on 11/14/17 from the smoking patio.. The Social Worker reviewed the smoking policy with all residents that smoke on 11/14/17. All residents who smoke signed an acknowledgment that they understood and accepted the	

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F 323	Continued From page 41 2. Resident #80 was originally admitted to the facility on 3/10/17 with multiple diagnoses including vascular dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated 8/26/17 indicated that Resident #80's cognition was intact. Resident # 80's care plan dated 9/29/17 was reviewed. One of the care plan problems was "resident at risk for injury related to smoking." The goal was "resident will have no injury related to smoking". The approaches included to educate the resident on dangers of smoking and to keep smoking materials at nurse's station or in the nurse's medication cart. Resident #80's nurse's notes dated 11/10/17 at 4:21 AM indicated that Resident #80 was found smoking in the dining room. On 11/13/17 at 3:31 PM, Resident #80 was observed up in wheelchair in his room. When interviewed, he stated that he kept his own cigarettes and lighter with him. A lighter and a pack of cigarette were observed in his pocket. There were also 2 packs of cigarettes observed inside the resident's bedside drawer. On 11/14/17 at 4:32 PM and on 11/15/17 at 9:55 AM, Resident #80's room was observed. There were 2 packs of cigarettes observed inside the resident's bedside drawer. On 11/15/17 at 9:56 AM, Nurse #6 was interviewed. Nurse #6 stated that Resident #80 was not supposed to have smoking materials with him. She stated that she was not aware that Resident #80 had cigarettes in his room and was	F 323	smoking policy on 11/14/17 with the Social Service Director and / or the Activity Director. A 100 % in-service on storage of propane gas tanks was completed with all staff on 11/21/17 by the Administrator, the RN Clinical Supervisor, the staffing Scheduler, and the Assistant Director of Nursing. A 100% in-service was completed with all staff on residents rights to smoke, supervised smoking, how to assist a resident who is a supervised smoker by following smoking contracts, rules, and on documentation on 11/24/17 by the Administrator, Clinical RN Supervisor, and the Assistant Director of Nursing. A QI tool will be completed by the Maintenance Director and used to monitor all Outside smoking areas for safety and to ensure there are no types of gas around or stored in an area where anyone smoke 3 times a week for 4 weeks, weekly for 2 weeks, and monthly for 2 months. The QI tool will be turned into the Administrator or the Director of Nursing 3 times a week for 4 weeks, weekly for 2 weeks, and monthly for 2 months for review. Any identified area of concern will be addressed as it is identified. A QI tool will be used to monitor resident's who smoke, are supervised smokers, and require that their smoking material be secured by the	

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F 323	Continued From page 42 keeping the lighter and cigarettes in his pocket. Nurse #6 was observed to search the room of Resident #80 and found 2 packs of cigarettes. Resident #80's nurse's notes dated 11/16/17 at 12:36 AM indicated that Resident #80 was found smoking in the dining room. On 11/16/17 at 9:30 AM, the Director of Nursing (DON) was interviewed. The DON stated that she was not aware that Resident #80 had cigarettes and lighter in his room/possession. She indicated that she was aware that Resident #80 had been found smoking in the dining room and he had been educated on the facility's smoking policy. The DON did not indicate that the staff had to monitor the resident and his room for any smoking materials	F 323	Social Worker 2 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The QI Tool will be turned into the Administrator or the Director of Nursing who will bring the QI tools to the weekly QI meeting weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months to monitor for areas of concern. The monthly QI Committee will review the minutes from the weekly QI Meeting for the continued need and frequency of monitoring for 4 months..	
F 325 SS=E	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a	F 325		12/10/17

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F 325	Continued From page 43 nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a protein supplement as ordered by the physician for a period of time greater than 5 months for 1 of 4 residents (Resident #34) reviewed for nutrition. The findings included: Resident #34 was admitted to the facility on 9/9/16 with diagnoses that included Diabetes Mellitus, dementia, and depression. A physician ' s order dated 5/23/17 indicated Prostat (protein supplement) twice daily for nutritional support. The annual Minimum Data Set (MDS) assessment dated 9/2/17 indicated Resident #34 ' s cognition was severely impaired. She was on a therapeutic diet. The Care Area Assessment (CAA) related to nutrition indicated Resident #34 was at risk for weight loss due to a diagnosis of Diabetes, her diet, and cognitive deficits. The plan of care, last reviewed 9/3/17, indicated the problem area of the potential for weight loss for Resident #34. She was noted with impaired cognition, weakness, and a vitamin D deficiency. The Medication Administration Record (MAR) from 5/23/17 through 11/15/17 revealed Resident #34 had received Prostat every other day twice daily instead of every day twice daily. This was a period of 176 days.	F 325	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F325 Resident number 34 did not receive her supplement as ordered. Resident number 34's supplement order was clarified to Prostat 30 cc twice daily by mouth for nutritional supplement on 11/15/17 by the RN Clinical Supervisor The RN Clinical Supervisor completed A 100% audit on medication administration Records on 11/28/17 for medication orders to be complete to include supplements. There were 2 orders that required correction, 1 of which was a duplicate order for Prostat that was discontinued by the RN Clinical Supervisor on 11/28/17. The Director of Nursing, the Assistant Director of Nursing, and the RN Supervisors completed A 100 % in-service with the Nurses on Supplements and Physicians	

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F 325	Continued From page 44 An interview was conducted with Nurse #5 on 11/15/17 at 10:25 AM. The physician ' s order dated 5/23/17 that indicated Prostat twice daily for Resident #34 was reviewed with Nurse #5. The MAR from 5/23/17 through 11/15/17 that indicated Resident #34 had received Prostat twice a day every other day was reviewed with Nurse #5. He verified Resident #34 had not received Prostat as ordered from 5/23/17 through present. He indicated he had not noticed the discrepancy between the physician ' s order and the MAR. He stated he depended on the electronic system to prompt him to give the supplement/medication as ordered. Nurse #5 reported the order must have been input into the electronic system incorrectly on 5/23/17. He pulled up the original order and stated MDS Nurse #2 had input the 5/23/17 order into the electronic system and indicated the frequency as twice a day every other day. An interview was conducted with MDS Nurse #2 on 11/15/17 at 10:45 AM. She revealed she reviewed the medical record and determined she input the incorrect frequency into the electronic system on 5/23/17. She verified Resident #34 had been receiving Prostat twice daily every other day rather than the ordered twice daily every day from 5/23/17 through present. MDS Nurse #2 stated she was going to correct the order in the electronic system. An interview was conducted with Nurse #3 on 11/15/17 at 4:20 PM. She indicated she was the Clinical Supervisor. She stated there was no monitoring system in place to ensure the physician ' s orders matched the MARs for nutritional supplements.	F 325	orders on 12/1/17. The Director of Nursing and the Assistant Director of Nursing will review all new admission and readmission, and any order changes of medication orders daily at clinical meeting. A QI tool will be used by the Director of Nursing and / or the Assistant Director of Nursing to monitor changes and new orders 2 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The QI tool will be reviewed at the weekly QI meeting weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months. The monthly QI Committee will review the minutes of the weekly QI Committee to determine the continued need and frequency of monitoring for 4 months.	

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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 325	Continued From page 45 An interview was conducted with the Director of Nursing on 11/16/17 at 11:40 AM. She stated she expected nutritional supplements to be provided as ordered.	F 325		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		12/10/17

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	345370	A. BUILDING _____ B. WING _____	C 11/16/2017

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F 431	Continued From page 46 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 2 (400/500 and 400/600 hall) of 4 medication carts and 1 (400/500/600 hall) of 2 medication rooms observed. Findings included: 1. On 11/16/17 at 10:00 AM, the medication cart on 400/600 hall was observed with Nurse #7. The following were observed: a. a bottle of Namenda (used to treat dementia) XR 28 milligrams (mgs) capsule with a used by date of 10/12/17. b. an opened bottle of Acetylcysteine 10% solution (used to loosen and to thin mucus ion	F 431	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F431 Facility failed to discard expired medications and to date multi dose medications. The expired bottle of Namenda with an expiration date of 10/12/17 was discarded by hall nurses 12/1/17. The opened bottle of Acetylcysteine 10% solution with no	

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F 431	Continued From page 47 the lungs) with no date of opening. The instruction on the bottle read "discard opened bottle after 96 hours and store in refrigerator after opening". c. an opened bottle of Prostat (protein supplement) with no date of opening. The instruction on the bottle read "discard 3 months after opening". On 11/16/17 at 10:13 AM, Nurse #7 was interviewed. Nurse #7 acknowledged that the Namenda and the Acetylcysteine solution should have been returned/discarded. She also stated that she didn't know that Prostat expired 6 months after opening. On 11/16/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check their medication carts daily for expired and undated medications. She also indicated that she expected the nurses to date multi dose medications when opened and to discard expired medications or to return to the pharmacy. 2. On 11/16/17 at 10:15 AM, the medication cart on 400/500 hall was observed with Nurse # 1. The following were observed: a. a used Breo Ellipta (used to treat Chronic Obstructive Pulmonary Disease) 200/25 inhaler with no date of opening. The instruction written on the box of the inhaler read "discard 6 weeks after opening the moisture protective foil tray". b. a used Symbicort (used to treat Chronic Obstructive Pulmonary Disease) with no date of opening. The instruction on the box of the inhaler read " discard 3 months after opening". c. an opened bottle of Prostat (protein supplement) with no date of opening. The	F 431	date of opening was discarded on 12/1/17 by the hall nurse.The opened bottle of Prostat with no date of opening was discarded on 12/1/17 by the hall nurse. Breo Elipts 200/25 inhaler with no date was discarded on 12/1/17 by the hall nurse. The PPD bottle Without a date was discarded on 12/1/17 by the hall nurse. The hall nurses completed audits of 100 % of med carts and medication rooms on 12/1/2017 for expired medications or multi-dose medications without a date on them. The audit revealed that there were expired medications on 2 halls and undated medications on 5 halls and in 1 med room. A 100 % in-service was completed with all nurses and med techs by the Director of Nursing, the Assistant Director of Nursing, and the RN Clinical Supervisor on 12/1/17 to ensure that there were no expired medications on the cart and that all multi dosed medications were dated when it was opened. The Director of Nursing, the Assistant Director of Nursing , and the RN Clinical Supervisor will use a QI tool to monitor the med carts and the med rooms 3 times	

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F 431	Continued From page 48 instruction on the bottle read " discard 3 months after opening". On 11/16/17 at 10:30 AM, Nurse #1 was interviewed. He stated that Breo Ellipta inhaler, Symbicort inhaler and the Prostat should have been dated when opened but they were not. Nurse #1 added that the pharmacy staff checked the medication carts and the medication rooms randomly and the nurses checked them at times. On 11/16/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check their medication carts daily for expired and undated medications. She also indicated that she expected the nurses to date multi dose medications when opened and to discard expired medications or to return to the pharmacy. 3. On 11/16/17 at 10:19 AM, the medication room on 400/500/600 hall was observed. There was an opened bottle of Purified protein derivatives (PPD) (used in the diagnosis of tuberculosis) with no date of opening. The instruction on the box of the PPD read "discard 30 days after opening". On 11/16/17 at 10:30 AM, Nurse #1 was interviewed. He stated that the PPD bottle should have been dated when opened but it was not. Nurse #1 added that the pharmacy staff checked the medication carts and the medication rooms randomly and the nurses checked them at times. On 11/16/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check their	F 431	a week for 4 weeks, bi-weekly for 2 weeks, and monthly 2 months. The QI tool will be reviewed at the weekly QI Committee meeting for any areas of concern for 4 weeks, bi-weekly for 4 weeks and monthly for 2 months. The monthly QI Committee meeting will review the minutes of the weekly QI Committee to determine the continued need and frequency of monitoring for 4 months.	

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F 431	Continued From page 49 medication carts and medication rooms daily for expired and undated medications. She also indicated that she expected the nurses to date multi dose medications when opened and to discard expired medications or to return to the pharmacy.	F 431		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514		12/10/17

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F 514	Continued From page 50 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately document the administration of Med Pass (supplement) four times daily and the amount of Prostat (protein supplement) administered for one of four residents reviewed for nutrition (Resident #33). The findings included: 1 a. Resident #33 was admitted to the facility 6/28/13 and last readmitted 8/16/17. Cumulative diagnoses included dementia without behavioral disturbance and diabetes. A review of physician's orders revealed an order dated 8/22/17 to provide Prostat twice daily by mouth for low albumin level. The amount of Prostat to be administered was not indicated. A Quarterly Minimum Data Set (MDS) dated 9/26/17 indicated Resident #33 was severely impaired in cognition. She required extensive assistance with eating. Weight was 150 pounds with no weight loss or gain noted. A review of weights revealed Resident #33 weighed 147 pounds on 10/2/17, 140 pounds on 11/2/17 (5% weight loss in one month) and 141 pounds on 11/8/17. A review of the November Medication Administration Record (MAR) revealed Prostat had been administered twice daily at 8:00 AM and	F 514	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. 514 Resident number 33 's supplement order was not documented as given. Resident number 33 had the order clarified to Prostat 30 cc twice a day by mouth for Nutritional supplement. Resident number 33 had her order changed to provide med pass 90 ml four times a day by mouth as supplement on 11/16/17 by the RN Clinical Supervisor. The RN Clinical Supervisor completed a MAR Audit on 11/28/17 for medication orders to be complete to include supplements. The results of the audit showed 2 orders that needed to be addressed, 1 of which was a supplement order that was a duplicate. The Duplicate order was discontinued by the RN Clinical Supervisor on 11/28/17. The Director of Nursing, the	

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F 514	Continued From page 51 8:00 PM. The amount administered was not documented on the MAR. On 11/15/17 at 3:45 PM, an interview was conducted with Nurse #2. She stated she administered Prostat 30 milliliters twice daily to Resident #33. She stated the amount to be given was documented on the electronic MAR. Nurse #2 reviewed the electronic MAR and stated she did not realize that the order for the Prostat did not have an amount to be given. Nurse #2 stated she was just used to giving 30 milliliters of Prostat and that was what she gave to Resident #33. On 11/15/17 at 4:05 PM, an interview was conducted with the Assistant Director of Nursing. She reviewed the physician orders and stated the order for the Prostat should have stated the amount to be given. On 11/15/2017 at 4:18 PM, an interview was conducted with Nurse #3 who stated she was the nurse who usually put the physician orders in the electronic record. She said there was no monitoring system to ensure the supplement orders were put in correctly. Nurse #3 said the Prostat order was not checked on the MAR with the physician orders to verify the order was put on the MAR correctly and no second look to see if the supplement physician orders and MAR were correct. On 11/16/2017 at 8:57 AM, an interview was conducted with the Director of Nursing who stated the person who put the physician ' s order for Prostat in the computer should have made sure an amount was on the physician ' s order. 1 b. Resident #33 was admitted to the facility	F 514	Assistant Director of Nursing, and the RN Supervisors completed A 100 % in-service with the Nurses on Supplements and Physicians orders on 12/1/17. The Director of Nursing and the Assistant Director of Nursing will review all new admission and readmission, medication orders, to include supplement orders, and order changes, on going, to show it was correct daily at clinical meeting. A QI Tool will be used 2 times a week using a QI tool to monitor order changes.. The QI tool will be reviewed at the Weekly QI Committee meeting for any areas of concern for 4 weeks, bi-weekly for 4 weeks and monthly for 2 months. The monthly QI Committee meeting will review the minutes of the weekly QI Committee to determine the continued need and frequency of monitoring for 4 months.	

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F 514	Continued From page 52	F 514		

6/28/13 and last readmitted 8/16/17. Cumulative diagnoses included dementia without behavioral disturbance and diabetes.

A review of physician's orders revealed an order dated 11/3/17 for Med Pass 90 milliliters four times a day by mouth as a supplement.

A Quarterly Minimum Data Set (MDS) dated 9/26/17 indicated Resident #33 was severely impaired in cognition. She required extensive assistance with eating. Weight was 150 pounds with no weight loss or gain noted.

A review of weights revealed Resident #33 weighed 147 pounds on 10/2/17, 140 pounds on 11/2/17 (5% weight loss in one month) and 141 pounds on 11/8/17.

A review of the November Medication Administration Record (MAR) revealed Med Pass 90 milliliters had been administered twice daily at 8:00 AM and 8:00 PM.

On 11/15/17 at 3:45 PM, an interview was conducted with Nurse #2. She stated she administered Med Pass 90 milliliters four times a day with meals and at bedtime and documented that on the electronic MAR. Nurse #2 reviewed the electronic MAR and stated she was not aware the order for Med Pass was only twice daily on the electronic MAR.

On 11/15/17 at 4:05 PM, an interview was conducted with the Assistant Director of Nursing. She reviewed the physician orders and stated the order for the Med Pass should have been noted on the MAR as four times daily.

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F 514	Continued From page 53 On 11/15/2017 at 4:18 PM, an interview was conducted with Nurse #3 who stated she was the nurse who usually put the physician orders in the electronic record. She said there was no monitoring system to ensure the supplement orders were put in correctly. Nurse #3 said the Med Pass order was not checked on the MAR with the physician orders to verify the order was put on the MAR correctly and no second look to see if the supplement physician orders and MAR were correct. On 11/16/2017 at 8:57 AM, an interview was conducted with the Director of Nursing who stated, if the Med Pass was scheduled to be given four times a day, she expected nursing staff to document that it was administered four times a day on the MAR. She stated the person who put the order in the computer should have ensured the correct number of times on the MAR matched the physician's order.	F 514		
F 520 SS=E	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		12/10/17

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F 520	Continued From page 54 individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify 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, observation and resident and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and to monitor the interventions that the committee put into place following the 6/8/17 complaint investigation survey for 1 recited deficiency in the area of complete and accurate resident records (F 514) and following the 11/3/16 recertification survey for 5 recited deficiencies in the areas of accuracy of the Minimum Data Set (MDS) assessments (F278), review and revise care plan	F 520	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F520 The Facility's Quality Assurance	

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F 520	Continued From page 55 (F280), follow care plan interventions (F282), nutrition (F325) and pharmacy services (F431). These deficiencies were cited again on the current recertification survey of 11/16/17. The continued failure of the facility during the 2 or more 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: 1. F 514 - Accurate and complete resident records - Based on medical record review and staff interviews, the facility failed to accurately document the administration of Med Pass (supplement) four times daily and the amount of Prostat (protein supplement) administered for one of four residents reviewed for nutrition (Resident #33). During the complaint investigation survey of 6/8/17, the facility was cited F514 for failure to document nursing evaluation and status each shift of the Peripherally Inserted Central Catheter (PICC) line. During the recertification survey of 11/16/17, the facility was again cited for F514 for failure to accurately document the administration of the supplements. 2. F278 - Accuracy of resident assessment - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Resident #30), hospice and prognosis (Resident #47), and skin conditions (Resident #109) for 3 of 21 residents reviewed. During the recertification survey of 11/3/16, the facility was cited F278 for failure to accurately	F 520	Committee Failed to maintain implemented procedures And to monitor the interventions that the Committee put into place following the 6/8/17 complaint investigation survey and Following the 11/3/16 recertification survey In order to sustain compliance. All residents Residing in the facility have the potential To be affected. On 12/07/2017 the V.P. of Operations in-Serviced the department managers related To the appropriate functioning of the Monthly QA Committee (Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Maintenance Director, Dietary Manager, Social Worker, Medical Records, Housekeeping Supervisor, Admissions Coordinator, Staff Nurse, RN Clinical Supervisor and Nursing assistant) And the purpose of the committee to Include identifying issues related to quality Assessment and assurance activities as Needed and developing and implementing Appropriate plans of action for the Identified facility concerns. Findings and the results of the QI tools will be reviewed by the weekly QI Committee for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months to determine the facility's progress in correction of deficient practices or identified concerns to include	

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F 520	Continued From page 56 code the MDS assessment in the areas of urinary catheter, weights, height, limitation in range of motion, ambulation and medications. During the recertification survey of 11/16/17, the facility was again cited for F278 for failure to accurately code the MDS assessments in the areas of medications, hospice, prognosis and skin condition. 3. F 280 - Review/revise care plan - Based on observation, record review, and staff interview, the facility failed to review and revise care plans in the areas of catheters (Resident #30), activities of daily living (Resident #41), and pressure ulcers (Resident #109) for 3 of 21 residents reviewed. During the recertification survey of 11/3/16, the facility was cited F280 for failure to review and revise the care plan in the areas of pressure ulcer and medications. During the recertification survey of 11/16/17, the facility was again cited for F280 for failure to review and revise the care plan in the areas of catheters, activity of daily living and pressure ulcer. 4. F282 - Implement resident care plan - Based on record review, observation and resident and staff interview, the facility failed to follow the care plan interventions for smoking (Resident #80) for 1 of 1 sampled resident reviewed for smoking and for restraints (Resident #) for 1 of 1 sampled resident reviewed for restraint. During the recertification survey of 11/3/16, the facility was cited F282 for failure to follow the care plan intervention for nutritional supplements. During the recertification survey of 11/16/17, the facility was again cited for F282 for failure to follow the care plan intervention for smoking and	F 520	medication orders, MDS Assessments, revise and review care plans, follow care plan interventiosn, nutrition, and pharmacy services. The Quarterly Quality Assurance Committee will continue to review one or more of the identified areas to determine continued compliance and the need to revise or update any issues as a part of their quarterly meeting going forward. The results of the audits and progress will be documented in the minutes of the meeting. The Administrator will be responsible for ensuring that the QA Committee concerns and recommendations are addressed through further training or other interventions. The QA Committee will be advised of the results of the training or other interventions at the next scheduled QA meeting by the Administrator or the Director of Nursing.	

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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 520	Continued From page 57	F 520		

for restraint.

5. F325 - Nutrition - Based on record review and staff interview, the facility failed to provide a protein supplement as ordered by the physician for a period of time greater than 5 months for 1 of 4 residents (Resident #34) reviewed for nutrition.

During the recertification survey of 11/3/16, the facility was cited F325 for failure to notify the Registered Dietician of significant weight loss and failed to provide the supplement as ordered. During the recertification survey of 11/16/17, the facility was again cited for F325 for failure to provide the protein supplement as ordered by the physician.

6. F431 - Pharmacy Services - Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 2 (400/500 and 400/600 hall) of 4 medication carts and 1 (400/500/600 hall) of 2 medication rooms observed.

During the recertification survey of 11/3/16, the facility was cited F431 for failure to date multi dose medications and failed to discard expired glucometer testing solution. During the recertification survey of 11/16/17, the facility was again cited for F431 for failure to date multi dose medications and to discard expired medications.

On 11/16/17 at 12:10 PM, the Administrator was interviewed for QAA. The Administrator was aware that F514, F278, F280, F282, F325, and F431 were repeat deficiencies from the previous surveys. She stated that the repeat tags on MDS assessments and care plan were due to the

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 11/16/2017

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 520	Continued From page 58 changes in staffing. The MDS Coordinator, who was a Registered Nurse (RN) just started 2 months ago and was still learning the process. The Administrator also indicated that the facility has been randomly monitoring the transcription of orders and there were no issues identified in the past. She also stated that nurses were responsible for checking their medication carts and medication rooms for expired and undated medications and the administrative staff to monitor randomly.	F 520		