PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMP	3) DATE SURVEY COMPLETED	
		345144	B. WING _				C 01/2018	
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	ILITATION CENTER	1	70	TREET ADDRESS, CITY, STATE, ZIP CODE 06 PINEYWOOD ROAD HOMASVILLE, NC 27360	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 001 SS=C	CFR(s): 483.73 The [facility, except for comply with all applice emergency prepared [facility] must establis comprehensive emergency must include, but not elements: *[For hospitals at §48 comply with all applice local emergency prephospital must develop comprehensive emergency prephospital must develop comprehensive emergency prephospital must develop comprehensive emergency prepared in the complete section, utilizing an all applicable Federal emergency prepared in CAH must develop are comprehensive emergency prepared in the comprehensive emergency prepared	gency preparedness ne requirements of this ncy preparedness program be limited to, the following 2.15:] The hospital must able Federal, State, and aredness requirements. The o and maintain a gency preparedness ne requirements of this I-hazards approach. 25:] The CAH must comply deral, State, and local ness requirements. The nd maintain a gency preparedness all-hazards approach. is not met as evidenced	E	001	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited;		3/1/18	
		ew and staff interviews the			" The monitoring procedure to ensur that the plan of correction is effective ar			
ARODATORY	DIRECTOR'S OR BROVINER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	-		TITI F		(X6) DATE	

BURATURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

02/25/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		 	С
		345144	B. WING _			1	/01/2018
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	0.720.10
	_			70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
E 001	Continued From page	e 1	E	001			
	facility failed to have				that specific deficiency cited remains		
	1	EP). The EP plan did not			corrected and/or in compliance with the	3	
	include facility and co				regulatory requirements;		
	assessments which in	ncluded missing residents,			" The title of the person responsible	for	
	the facilities resident	population and a process			implementing the acceptable plan of		
		ration with local, regional,			correction.		
	I .	cials. The plan did not have					
	any policy or procedu				E001		
	, ,	provision of needs for staff					
		ation, sheltering of residents			The plan of correcting the specific		
	and staff that remain				deficiency		
	transportation of med	did not address names or			The position of Pine Ridge Nursing and	1	
	contact information for				Rehabilitation center regarding the	1	
		plan did not have a way to			process that lead to this deficiency-fail	ıre	
		d medical documents of a			to complete and implement the		
		facility. The plan failed to			emergency preparedness plan.		
	have a training progra				3 71 1		
					The facility□s risk assessment was		
	Findings included:				updated on 2/5/18.		
					The resident population information wa	S	
		of the EP manual revealed			updated on 2/5/18 to reflect the most		
		ot include a community or			current acuity levels.		
	_	sessment or strategies.			On 2/26/18 the facility will complete a		
		led the manual also did not			compiled list of criteria for residents/sta		
	include missing resid	ents in their EP program.			in the case that we will be sheltered in	tne	
	R: A further review of	the EP manual revealed			facility. On 3/1/18, the name and contact		
		ulation with in the facility was			numbers for all staff will be updated an	d	
		Il as the residents who			placed in emergency plan along with the		
		like oxygen and immobility.			most current contact information for the		
		ress the type of services the			resident□s physicians.		
	1	of providing to the residents			On 2/23/18, a plan was developed that	will	
	during an emergency	situation. The continuity and			indicate how resident information and		
	_	not included in the EP plan			medical documents will be shared with		
		ent for the facility was not			other facilities/health care providers		
	completed.				during an emergency situation.		
					On 2/26/18, the facilities residents, far	ıily	
	C: The review of the	EP manual revealed that			members and/or the resident □s		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		С	
		345144	B. WING _			2/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/01/2010	
				706 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
E 001	Continued From page	e 2	E 0	01			
	there was not any cri	iteria listed for residents or		representative will be made aw	are of the		
		heltered in the facility during		emergency plan process.			
	an emergency. The B	EP manual also did not have		On 2/26/18, all facility staff will	receive		
	any procedure for sh	eltering residents, staff and		training and testing related to the	ne		
	others who needed to	o remain in the facility in the		emergency plan.			
	event evacuation cou	uld not occur.		The procedure for implementin			
				acceptable plan of correction for	or the		
		evealed a lack of policies and		specific deficiency cited			
	· ·	he resident's confidentiality		0 0/0/40 the enduring the treatment	41		
		, how the resident's medical		On 2/2/18, the administrator re			
		ould be protected and how all record would be available		emergency plan and identified that needed to be updated, cor			
	for continuity of care			implemented.	recieu, and		
	transferred to anothe			All facility staff will be in-service	ed by		
	emergency.	in radiiity dariiig air		3/1/18 by the staff facilitator on	-		
				emergency. This in-service will			
	E: A record review of	f the EP manual revealed that		to the orientation for all new hir			
	the communication p	lan did not include name and		The monitoring procedure to er	nsure that		
	contact information of	of all the staff working in the		the plan of correction is effective	e and that		
	facility and the name	and contact information of		specific deficiency cited remain	s corrected		
	the resident's physici	ians.		and/or in compliance with the r	egulatory		
	C. A review of the co	mmunication plan did not		requirements			
		mmunication plan did not procedures that would		The monthly QI committee will	raviow tha		
		t information and medical		emergency plan monthly for 3 i			
		shared with other facilities		identification of updates, furthe			
		iders who would be providing		needs, facility needs, and comp			
		residents who are sheltered		of the plan itself. The administr			
		d at other locations during an		DON will present the findings a			
	emergency situation.			recommendations of the month	ıly QI		
				committee to the quarterly exec	cutive QA		
	G: The EP manual revealed that the			committee for further recomme	ndations		
	communication plan	-		and oversight.			
		how it would share the					
		rmation with the facilities		The title of the person responsi			
	residents, family mer representative.	mbers and/or the resident's		implementing the acceptable p correction.	an of		
	representative.			The administrator is responsible	e for		
	H: A review of the FF	P manual revealed that there		implementing the acceptable p			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345144	B. WING		C 02/01/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	02/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 001	An interview with the 2-1-18 at 3:30pm. The call the maintenance plan. She stated she as to how to prepare meeting scheduled to EP plan correctly. The was that the facility were stated in the state of the plan correctly.	ram or testing requirements	E 00	correction.	
F 558 SS=D	S483.10(e)(3) The rig services in the facility accommodation of re preferences except we endanger the health other residents. This REQUIREMENT by: Pine Ridge Health a Recertification and C 1-28-18	ght to reside and receive with reasonable esident needs and when to do so would or safety of the resident or is not met as evidenced and Rehabilitation Center omplaint investigation	F 55	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the	
	Citation text for tag F558, Fed Regulation 483.10 D2 Kim Chambers Based on record review, staff interviews and resident interviews the facility failed to accommodate the need of 1 of 1 residents (resident #45) by not providing the resident a shower bench to fit the resident resulting in the			processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible	re nd

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _				C / 01/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	01/2010	
				7	06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REH	ABILITATION CENTER		Т	HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 558	Continued From pa	ge 4	F 5	558				
	resident receiving of admission to the factorial	only one shower since cility.			implementing the acceptable plan of correction.			
	Findings included:				F558			
	3-24-17 with multip	admitted to the facility on le diagnoses to include heart ey disease, vascular dementia			The plan of correcting the specific deficiency The position of Pine Ridge Nursing and	d		
	The Minimum Data Set (MDS) dated 11-15-17 revealed that the resident was cognitively intact. Resident #45 was coded as needing total assistance with 2 people for bed mobility, transfers, dressing and toileting, total assistance with one person for personal hygiene.				Rehabilitation center regarding the process that lead to this deficiency of failure to accommodate the need of resident #45 by not providing a showel bench to fit the resident, was a communication deficit.			
	resident #45 had a necessary physical The intervention for	d 11-30-17 revealed that goal of receiving the assistance for ADL's daily. this goal was as follows; if sistance offer another time to			On 2/1/18 a shower bench was ordered accommodate resident # 45 by the supclerk. On 2/26/18 the shower bench ordered accommodate resident # 45 is schedul to arrive. By 2/27/18 resident # 45 will receive a shower.	oply		
	3:06pm. The reside shower since she w stated that due to h	nterviewed on 1-29-18 at ent stated she has had only 1 was admitted to the facility. She er size she would sweat a lot the bed baths she received properly.			The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant revieresidents in facility for showers given in	า		
	on 1-29-18 at 3:12p believed the residen has had only 1 show the facility. She also	e nurse (nurse #7) occurred om. Nurse #7 stated she of was correct in saying she wer since she was admitted to o stated the facility did not ch that would accommodate size.			the last 7 days to ensure no showers we not given due to equipment needs. With no negative findings noted related to equipment needs to accommodate resident. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on communication of resident equipment	h		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING _				C 01/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER	•	706	REET ADDRESS, CITY, STATE, ZIP CODE 6 PINEYWOOD ROAD IOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	She stated she attern on the shower bench facility and that the redue to about "4 inche laying over the side of #7 stated informed the (IDON). An interview with the (IDON) occurred on 2 she was informed that of a larger shower be know who would order may be maintenance Maintenance personat 12:30pm. He state shower bench for restarrive in 10-15 days. The Administrator was 12:30pm. She stated maintenance with the also received an order to evaluate resident is shower. The Administrator was 12:30pm. The Administrator was 12:30pm. She stated maintenance with the also received an order to evaluate resident is shower. The Administrator was 12:30pm. The Administrator was 12:30pm. She stated maintenance with the also received an order to evaluate resident is shower. The Administrator would inform that staff would inform	ewed on 2-1-18 at 9:35am. Inpted to place resident #45 It that was available at the esident complained of pain es" of the resident's skin was of the shower bench. Nurse he Interim Director of Nursing Interim Director of Nursing 2-1-18 at 9:45am. She stated at resident #45 was in need ench but stated she did not er the bench but thought it estated he had ordered the new sident #45 and that it would as interviewed on 2-1-18 at she had supplied esize that was needed and er for Occupational Therapy #45's safety in receiving a strator stated she expected in her when special I so the facility can meet the	F	558	needs, including equipment to accommodate resident s showers, to maintenance using a work order. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks to ensure showers were given a appropriate equipment available to accommodate resident need. This audi will be documented on the Resident Ca Audit Tool. The monthly QI committee will review the results of the resident care audit tool for months for identification of trends, actic taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	d at hat bted by a for he	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345144	B. WING			1	C	
		345144	B. WING _			02/	01/2018	
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE RIDG	SE HEALTH AND REHAB	SILITATION CENTER			06 PINEYWOOD ROAD			
				T	HOMASVILLE, NC 27360			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 558	Continued From page	e 6	F t	558				
					The Director of nursing is responsible f implementing the acceptable plan of correction.	or		
F 561	Self-Determination		F !	561			3/1/18	
SS=E	CFR(s): 483.10(f)(1)-	(3)(8)						
	§483.10(f) Self-deterr	nination.						
	The resident has the	right to and the facility must						
	•	resident self-determination						
		sident choice, including but						
	not limited to the rights specified in paragraph							
	(1) through (11) of this	s section.						
		ident has a right to choose						
		including sleeping and						
		care and providers of health						
		ent with his or her interests,						
	assessments, and pla applicable provisions							
		•						
		ident has a right to make						
	-	s of his or her life in the						
	facility that are signific	cant to the resident.						
	8483.10(f)(3) The res	ident has a right to interact						
		community and participate in						
		ooth inside and outside the						
	facility.							
	§483.10(f)(8) The res	ident has a right to						
	participate in other ac	tivities, including social,						
	•	nity activities that do not						
		ts of other residents in the						
	facility.							
		is not met as evidenced						
	by:	ad an alice of the first			An			
		rd review, staff interview,			An acceptable plan of correction must			
	resident interview and	d resident observation the			contain the following elements:			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345144	B. WING _			C 02/01/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		92.0 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 561	#45) the choice of w failed to provide 2 or and resident #80) sl weeks when review (ADL) and failed to have dinner in the dreviewed for choices. Findings included: 1. Resident #124 was October 10, 2015 which included dysp muscle weakness a Review of the Minim January 16, 2018 remoderately impaired extensive to total as completion of all her except for eating. Review of Resident 2017 revealed no in Resident # 124 to d nor was it observed. During an interview January 28, 2018 at that "we are short stock of the distribution of the with 27 residents!" During an observation 2018 between 5:30p	ride 1 of 3 residents (resident when to be out of bed and f 3 residents (Resident #45 howers for two and a half ed for activities of daily living honor a resident's choice to lining room for 1 of 3 residents is (Resident # 124). The same of the facility on the intervention about taking ining room for meals or dinner on her care guide. The same of the facility on	F	"The plan of correcting deficiency. The plan sho processes that lead to the cited; "The procedure for in acceptable plan of correspecific deficiency cited; "The monitoring procedure that the plan of correction that specific deficiency corrected and/or in compregulatory requirements; "The title of the personal implementing the accept correction. F561 The plan of correcting the deficiency The position of Pine Ridgen Rehabilitation center regent process that lead to this to allow resident choice of bed, shower preference location was knowledge On 2/1/18 and 2/12/18 resident # 45 shower. On 2/6/18 resident # 80 shower. On 2/2/18, 2/5/18, 2/8/18, 2/8/18, 2/3/18,	muld address the ne deficiency mplementing the ction for the redure to ensure is effective and dited remains pliance with the con responsible for table plan of me specific ge Nursing and parding the deficiency-failure of when to be out ces, and dinning deficit. mesident # 45 was resident choice mesident # 45 was resident choice		
	was observed in hell observation Resider	r room. Also during another nt # 124 received her dinner 5:14pm. Resident #124 was		2/13/18, 2/14/18, 2/20/18 resident # 124 was obse eating diner in the dining	8, 2/23/18 erved by GCAs		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING			1	C 01/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360			<u> </u>
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Observed having dinner in her room. During an interview with Resident #124's family on January 29, 2017 at 10:30 am, family revealed that the facility was aware that they liked for Resident #124 to eat in the dining room and it hard for this to happen because during the weekend it's significantly short staffed. Family also revealed that we had been asked to take Resident #124 back to her room because of no staff being in the dining room for meals. During an interview with Nurse # 21 on February 1, 2018 at 2pm revealed that she does not recall being disrespectful to any residents in the facility but she has informed family members to take residents back to their rooms because of inadequate staff in the dining room. During an interview with the Administrator on February 1, 2017 3:30pm, it was revealed that she expected that all halls were adequately staffed to provide the needs and choices of		F	5561	resident preference. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/9/18 the facility consultant interviewed all interviewable residents regarding their ability to get up as they choose. No additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus resident choice to get out of bed, or direction. Five grievances were places regarding resident choice to get out of and dining location. All five grievances were resolved. On 2/16/18 the facility consultant reviewed residents in facility for showers given in the last 7 days for showers provided peresident preference. All negative finding will be addressed by facility staff by 3/1/18. On 2/16/18 during the morning meal the	et e	
	3-24-17 with multiple failure, chronic kidner and diabetes. The Minimum Data S	•			facility consultant spoke interviewable residents to ensure they were having n in location of choice with no negatives noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident choice including resident right to choos when to be out of bed, shower preferences, and dining location. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be adde to the orientation process for all new licensed nurses and CNAs.	neal se	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45444	D. MINIC				С	
		345144	B. WING _			02	2/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE RID	GE HEALTH AND RE	HABILITATION CENTER		7	06 PINEYWOOD ROAD			
I IIVE IXID	SE HEALIN AND INC.	HABIEHAHON GENTER		Т	THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Continued From p	page 9	F 5	561				
	T	g and toileting, total assistance			The monitoring procedure to ensure the	at		
		or personal hygiene.			the plan of correction is effective and t			
	linui ono porosii i	or percental rijgiene.			specific deficiency cited remains corre			
	The care plan dat	ed 11-30-17 revealed that			and/or in compliance with the regulato			
		a goal of receiving the			requirements	•		
	necessary physica	al assistance for ADL's daily.						
	The intervention for	or this goal was as follows; if			The director of nursing, staff facilitator	J		
	resident refuses a	ssistance offer another time to			facility consultant, and/or minimum dat			
	return.				set nurse will audit 20 residents weekly	,		
					4 weeks, then 10 residents per week 8			
		the resident occurred on			weeks to ensure resident out of bed pe			
		n. The resident stated she has			resident choice, showers were given p	er		
		e bed "in at least 4 months". as told by staff that she was too			resident choice, and resident dining in area of choice. This audit will be			
		and that they do not have			documented on the Resident Care Aug	lit		
	1	elp get her out of the bed.			Tool.			
	silvagii stall to lis	inp get iie. eat e. tile bea.			The monthly QI committee will review	the		
	An observation of	resident #45 occurred on			results of the resident care audit tool for			
	1-30-18 at 1:00pm	n. The resident remained in the			months for identification of trends, acti-	ons		
	bed.				taken, and to determine the need for			
					and/or frequency of continued monitor	ng,		
		resident #45 occurred on			and make recommendations for			
		m. The resident stated she was			monitoring for continued compliance.			
		she still had not been able to get			administrator and/or DON will present	the		
		e also stated she asked to get			findings and recommendations of the			
		was told there was not enough			monthly QI committee to the quarterly executive QA committee for further			
	staff to help get he	er up.			recommendations and oversight.			
	An interview with	the nurse (nurse #7) occurred			recommendations and oversight.			
		am. Nurse #7 stated that they			The title of the person responsible for			
		past to get resident #45 up into			implementing the acceptable plan of			
		t after 15 minutes the resident			correction.			
	was "yelling" to ge	et back in the bed. She went on			The Director of nursing is responsible	for		
		k 3 people to assist the resident			implementing the acceptable plan of			
		that they "usually" did not have			correction.			
	enough staff.							
		resident #45 occurred on 2-1-18 sident stated that when staff						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345144	B. WING _			C 2/01/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		2/01/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 561	Continued From pag	ue 10	F 5	561				
	had got her out of be up for 2-3 hours. Sta outside when it was An observation of re-	ed in the past she would stay ted she enjoyed sitting warm and attending bingo. sident #45 occurred on Resident #45 was being						
	assisted by 3 staff members getting out of the bed.							
	at 11:05am. The resi "I feel strange becau such a long time." SI	sident #45 occurred on 2-1-18 ident was smiling and stated use I have not been up in the also stated she was going bingo that afternoon at						
	at 1:15pm. The residence and requested to go	e resident occurred on 2-1-18 lent had finished her lunch back to bed. 3 staff were esident #45 back to the bed.						
	An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected her staff to respond to residents request and ask for additional help if they need it.							
	the resident was sch	#45's care card revealed that reduled to have a shower days and that the resident						
	2-1-18 revealed that shower from 1-17-18	ver chart dated 1-17-18 to resident #45 had not had a 8 to 2-1-18 and that the se any offers for a shower.						
	1-29-18 at 3:06pm. 7	sident #45 occurred on The resident stated that she ower since admission to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345144	B. WING _				C / 01/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, 706 PINEYWOOD F THOMASVILLE,		1 0-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTIO I CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	An interview with the on 1-29-18 at 3:30 president #45 was coalmost a year since. The nurse stated as had not refused a sher. An interview with the 2-1-18 at 3:30 pm. The showers as schedue 3: Resident #80 was 3-2-16 with multiple chronic kidney dise gait and diabetes. The Minimum Data revealed that resident was coassistance with 2 pransfers, extensive for dressing and toil with one person for the care plan dates #80 had a goal of minimum with the following in reposition the residence care as a single proposition the residence incontinence care as a single proposition the residence and the proposition the residence are a single prop	It's stated she had bed baths like to have a shower. Ite nurse (nurse #7) occurred om. Nurse #7 stated that borrect and that it had been the resident had a shower. It is far as she knew the resident shower if one was offered to the Administrator occurred on the Administrator stated that esidents to receive their sled. It is a sadmitted to the facility on the diagnoses which included ase, muscle weakness, ataxic of the second of the Administrator stated that esidents to receive their sled. Set (MDS) dated 12-19-17 ont #80 was cognitively intact, oded as needing extensive explete for bed mobility and the assistance with one person leting and limited assistance	F	561			
	she preferred show	t #80's care card revealed that ers and that she was e a shower every Tuesday					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· ,	ATE SURVEY DMPLETED
		345144	B. WING			C 02/01/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	02/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 561	1-17-18 to 2-1-18 r shower from 1-17-revealed that resid showers. An interview with residual showers. An interview with residual showers. An interview occurred and residual shower. An interview occurred always give them as the shower shower. An interview occurred always give them as the showers. An interview with the showers on antibious she was on antibious she was on antibious she stated the residual she she was on antibious she was on antibious she stated the residual she she was on antibious she stated the residual she she was on antibious she was on	at #80's shower chart dated evealed that she had not had a 18 to 1-30-18. The chart also ent #80 had not refused any esident #80 occurred on an The resident stated she a shower 2 times a week but 3 weeks before she received a red with resident #80 on The resident stated she still wer and had not had one for so stated she was told she a because of the kind of	F 56	51		

			(X3) DATE SURVEY COMPLETED				
		345144	B. WING		C 02/01/2018		
	ROVIDER OR SUPPLIER GE HEALTH AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPROPRIES OF THE APPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF T	D BE COMPLETION		
F 561	Continued From pag	e 13	F 56	1			
	2-1-18 at 3:30pm. Th	Administrator occurred on ne Administrator stated she o receive their showers as					
F 568 SS=B	Accounting and Reco	ords of Personal Funds)(iii)	F 56	8	3/1/18		
	(A) The facility must system that assures separate accounting accepted accounting personal funds entru resident's behalf. (B) The system must of resident funds with funds of any person (C)The individual find available to the resid statements and upor This REQUIREMEN' by: Based on record revinterviews, the facility residents (Residents	riews, staff and resident y failed to provide 2 out of 2 #118 and Resident #8) with of their personal trust funds		An acceptable plan of correction mucontain the following elements: " The plan of correcting the specideficiency. The plan should address processes that lead to the deficiency	ific the		
	Findings include: 1. Resident #8 was a 5/17/16 with diagnos Stroke. A review of I revealed the residen Attorney. A review of record had no docun statement being give six months. A review	admitted to the facility on es that include Diabetes and Resident #8's medical record t is his own Power of Resident #8's medical mentation of a quarterly on to the resident for the past of the Business Office Trust folders revealed copies		cited; " The procedure for implementing acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to enthat the plan of correction is effective that specific deficiency cited remains corrected and/or in compliance with regulatory requirements; " The title of the person responsil	g the sure e and s the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	
		345144	B. WING			004	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/0	01/2018
IVAIVIL OF TH	COVIDENCE ON CONTRIBUTE				06 PINEYWOOD ROAD		
PINE RIDG	E HEALTH AND REHAE	BILITATION CENTER			HOMASVILLE, NC 27360		
	OLIMANA DV. OT	TATEMENT OF DEFICIENCIES	l	•	 T		0.470
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 568	Continued From page	e 14	F	568			
		othly trust fund statements.	'	000	implementing the acceptable plan of		
	An interview was con	-			correction.		
		ent #8. The resident reported			correction.		
		al trust fund with the facility.			F568		
	Resident #8 reported				. 333		
		facility to let him know how			The plan of correcting the specific		
	much he has in his a	-			deficiency		
	2. Resident #118 was	s admitted to the facility on			_		
	4/16/15 with diagnose	es that include seizure			The position of Pine Ridge Nursing and	ı	
		miplegia, and depression. A			Rehabilitation center regarding the		
	review of Resident #				process that lead to this deficiency-failu	ıre	
		t has a Power of Attorney			to provide residents with quarterly		
		view of Resident #118's most			statements of their personal trust funds		
	-	m Data Set) dated 11/20/17			managed by the facility- was knowledge	9	
		terly assessment. The MDS			deficit.		
	Resident #118's med	gnitively intact. A review of			On 2/20/18 resident #118 was provided	10	
		uarterly statement being			statement of their personal trust funds		
	-	for the past six months. A			the social worker.	Jy	
	_	ss Office Manager's Resident			On 2/19/18 resident # 8 was provided a	, l	
		d copies of Resident #118's			statement of their personal trust funds		
		atements. An interview was			the social worker.	- ,	
		8 at 3:20pm with Resident			The procedure for implementing the		
	#118. Resident #118	reported that she has a			acceptable plan of correction for the		
	personal fund with th	e facility. She reported she is			specific deficiency cited		
	not given a statemen	t from the facility letting her					
	know how much she	has in her account. Resident			On 2/19/18 the social worker spoke wit	h	
		DA (Power of Attorney) does			all residents, or resident power of		
		ent either. An attempt was			attorneys, whose trust funds are manag	ged	
		9:00am to reach Resident			by the facility, to ensure they have		
		age was left for the POA with			received a statement of the president□	S	
	no return phone call.				personal trust fund in the last 90 days,		
		nducted with the (BOM)			with no additional negative findings not		
		ager on 1/31/18 at 9:34am.			The social worker was in-serviced by the	ie	
	•	nat the residents who have a			administrator on 2/19/18 regarding	ato	
	· · · · · · · · · · · · · · · · · · ·	rith the facility receive a			delivery of quarterly trust fund statemen		
		th. She reported the facility characteristics the resident who has a			to residents, when the facility manages their trust funds, and documentation of		
	-	rith the facility receives a			this delivery. Any new social worker hir		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPI F	CONSTRUCTION	(X3) DATE	SLIBVEY
	CORRECTION	IDENTIFICATION NUMBER:	I ` ′			` ',	LETED
			7 20.22	_		(
		345144	B. WING				01/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/1	01/2010
				70	06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
		,			DEFICIENCY)		
F 568	Continued From page	e 15	F	568			
		t and if the resident has a			will receive this in-service during		
		led a copy of the statement.			orientation.		
		e facility's policy is that the			The monitoring procedure to ensure the		
	, ,	ands out the statements			the plan of correction is effective and the		
	-	nts and documents that the			specific deficiency cited remains correct		
		to the residents in the social			and/or in compliance with the regulator	у	
	_	in the medical record.			requirements		
		SW was conducted on					
		he SW reported she has			The administrator, or business office		
		with the facility for two			manager will audit 10% of residents		
	T	she "thinks the Business			whose trust funds are managed by the		
	_	ng out resident statements."			facility to ensure delivery of their trust f		
	An interview was con				statements has occurred within the last		
		1/18 at 10:27am. The			quarter weekly x 12 weeks. This audit v	Will	
		d some residents get			be documented on the trust fund audit		
	•	nents and others are mailed			tool.		
		inistrator reported the			The monthly QI committee will review t	ne	
		ivers the personal fund			results of the trust fund audit tool for 3		
	account statements to				months for identification of trends, action	ns	
		d she is not aware whether			taken, and to determine the need for		
		on that the statements are			and/or frequency of continued monitori	ng,	
	given to the residents				and make recommendations for	·L-	
		Activities Director was 3 at 10:37am. The Activities			monitoring for continued compliance. T		
					administrator will present the findings a	illu	
	•	is not sure whether she			recommendations of the monthly QI	^	
		personal funds statements to ported she delivers whatever			committee to the quarterly executive Q committee for further recommendations		
		the mail to be handed out.			and oversight.	,	
	· ·	e to reach the former SW			and oversignt.		
		t the facility until December			The title of the person responsible for		
	2017 on 1/31/18 at 1	-			implementing the acceptable plan of		
		the SW with no return call			correction.		
	received.	alo ovv with no return can			The Administrator is responsible for		
	An interview was con	ducted with the			implementing the acceptable plan of		
	Administrator on 2/1/				correction.		
		d it is her expectation that			COTTCOLIOTI.		
		as a personal trust fund with					
		statement at least quarterly.					
	LITE TACHILY TECEIVE A S	statement at least quarterly.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345144	B. WING		C 02/01/2018
	ROVIDER OR SUPPLIER BE HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	02/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 584 F 584 SS=E	CFR(s): 483.10(i)(1) §483.10(i) Safe Env The resident has a r comfortable and hor but not limited to rec supports for daily liv The facility must pro §483.10(i)(1) A safe homelike environme use his or her perso possible. (i) This includes ens receive care and ser physical layout of the independence and c (ii) The facility shall of the protection of the or theft. §483.10(i)(2) House services necessary is and comfortable inter §483.10(i)(3) Clean	able/Homelike Environment -(7) ironment. ight to a safe, clean, nelike environment, including reiving treatment and ing safely. vide- , clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the refacility maximizes resident loes not pose a safety risk. rexercise reasonable care for resident's property from loss keeping and maintenance to maintain a sanitary, orderly,	F 58	14	3/1/18
	resident room, as sp §483.10(i)(5) Adequ levels in all areas; §483.10(i)(6) Comfo	e closet space in each secified in §483.90 (e)(2)(iv); ate and comfortable lighting rtable and safe temperature			
		ally certified after October 1, a temperature range of 71 to			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345144	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	040144		STREET ADDRESS, CITY, STATE, ZIP CODE	l	02/01/2018
				706 PINEYWOOD ROAD	-	
PINE RID	GE HEALTH AND REH	ABILITATION CENTER		THOMASVILLE, NC 27360		
(V4) ID	SLIMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE
F 584	Continued From pa	ige 17	F 5	84		
	81°F; and					
	sound levels. This REQUIREME	ne maintenance of comfortable				
	interviews, the facilifree environment a windows for 4 out of hall, 300 hall, and 4 Findings include: a. An observation room 200 revealed to the bed closest tight brown spots some the tool hand observation on revealed peeling pactosest to the door sticky, light brown so bathroom had a str	n on 1/29/18 at 10:35am in paint peeling on the wall next o the door. There were sticky cattered throughout the floor. I ammonia like smell in the ster was peeling on the wall		An acceptable plan of correctic contain the following elements "The plan of correcting the deficiency. The plan should adprocesses that lead to the deficited; "The procedure for implement acceptable plan of correction for specific deficiency cited; "The monitoring procedure that the plan of correction is effort that specific deficiency cited recorrected and/or in compliance regulatory requirements; "The title of the person resimplementing the acceptable procorrection. F584	e specific ddress the dciency menting the for the e to ensure effective and emains e with the eponsible for	
	toilet. An observation on revealed peeling pactors to the doord strong ammonia like revealed plaster perform the toilet in the b. An observation room 308 revealed paint on the wall need to brown/grey dirt like An observation on	2/1/18 at 1:30pm in room 200 aint on the wall next to the bed The bathroom revealed a e odor. An observation eling from the wall across		The plan of correcting the specideficiency The position of Pine Ridge Nur Rehabilitation center regarding process that lead to this deficie to provide an odor free enviror repair of walls, floors, and wind communication failure. On 2/19/18 room 200s wall by was repainted repairing the peand plaster repaired to correct	rsing and g the ency-failure nment and dows- was the bed seling paint,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		Ι,	C
		345144	B. WING				01/2018
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINE DID	SELIEALTH AND DELL	A DIL ITATION OFNITED		70	06 PINEYWOOD ROAD		
PINE RIDO	SE HEALIH AND REH	ABILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	DATE
F 584	Continued From pa	age 18	F	584			
	closest to the door.	The bathroom floor had loose			by the toilet by maintenance assistant.		
		material on it. The bathroom			The floors are cleaned daily by the		
		m 308 had scuff marks at the			housekeeping staff. On 2/2/18 the		
	lower quarter of the				bathroom in room 200 was cleaned wh	ich	
		2/1/18 at 1:45pm in room 308			removed the sticky light brown spots		
		aint on the wall next to the bed			scattered on the floor, and ammonia lik	ie l	
		. The bathroom floor had loose			smell by housekeeping.		
	brown/grey dirt like	material on it. The bathroom			On 2/24/18 room 308s wall next to the		
		m 308 had scuff marks at the			bed was painted by the maintenance		
	lower quarter of the			director repairing the scratch marks an	d		
	c. An observation			peeling paint. The bathroom floor in roo	mc		
	room 405 revealed	peeling paint to the wall at the			308 was cleaned by housekeeping on		
	bed closest to the	door.			2/2/18 removing brown/grey dirt like		
	An observation on	1/30/18 at 3:15pm in room 405			material from floor. The bathroom door		
	revealed paint peel	ling on the wall behind both			going into room 308 was repaired and		
	beds in the room.				scuff marks were removed by the		
	An observation on	2/1/18 at 1:47pm in room 405			maintenance director on 2/24/18.		
	revealed paint peel	ling on the wall behind both					
	beds in the room.				On 2/24/18 room 405s wall at the both		
	d. An observation	n on 1/29/18 at 11:36am in			beds were repainted to repair the peeli	ng	
		om revealed a black colored vall approximately 6 inches			paint by maintenance director.		
	from the floor on th	e wall directly across from the			On 2/19/18 room 208s bathroom was		
	toilet.				repainted by the maintenance assistan	t	
	An observation on	1/30/18 at 4:28pm in room			which removed the black colored streat	k	
	208's bathroom rev	realed scuff marks on both			across the wall directly across from the	.	
	bathroom doors at	the bottom and a black			toilet. On 2/19/18 both bathroom doors		
	colored streak on the	he wall opposite of the toilet.			were repaired which removed the scuff		
	An observation on	2/1/18 at 1:40pm in room			marks at the bottom of the doors.		
	208's bathroom rev	ealed scuff marks on both					
		the bottom and a black			On 2/25/18 room 210s wall next to the		
		he wall opposite of the toilet.			bed closest to the door was repainted t		
		n on 1/29/18 at 11:51am in			the maintenance director this corrected	.	
		paint peeling off the wall next			the peeling paint. On 2/25/18 the		
		to the door. There was a web			housekeeping supervisor cleaned the		
		e of the right side of the			window outside of room 210 and the w	eb	
	window.				like material was removed from the		
		1/30/18 at 4:22pm in room 210			outside right side of the window. On		
	revealed peeling pa	aint on the wall next to the bed			2/2/18 the floors in room 210 was clear	ned	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	B. WING _				C 01/2018
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	01/2010
DINE DID	05 UEALTH AND DELLA	DU ITATION OFNITED		70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHA	ABILITATION CENTER		T	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	outside of the right sobservation also revon the floor behind the closest to the door. Outside of the right sobservation also revon the floor behind of. An observation also revon the floor behind of. An observation 412 revealed a when grime and dirt like in the metal pieces for revealed the bolt to to the side was missimaterial behind the floor behind the door bolt to her wheelches several weeks. She has been told about laying on the shelf of a An observation on the metal pieces for revealed a wheelch grime and dirt like in the metal pieces for revealed the bolt to to the side was missimaterial behind the floor behind the door behind the door behind the door An observation on the revealed the bolt missimaterial behind the floor behind the bolt missimaterial the solt missimaterial the solt missimaterial the solt missimaterial behind the floor behind the bolt missimaterial behind the floor behind the f	There was a web like material side of the window. The realed loose brown material the door. 2/1/18 at 1:41pm in room 210 mg off the wall next to the bed There was a web like material side of the window. The realed loose brown material the door. on 1/29/18 at 1:02pm in room elchair for Resident #78 with material in the wheels and on the leg rests. It was also hold the left side of the seat sing. There was brown door and a grey streak on the pair has been missing for a reported the administrator at the bolt. She has the old bolt at the sink. /30/18 at 3:22pm in room 412 air for Resident #78 with material in the wheels and on the leg rests. It was also hold the left side of the seat sing. There was brown door and a grey streak on the leg rests. It was also hold the left side of the seat sing. There was brown door and a grey streak on the leg rests. It was also hold the left side of the seat sing. There was brown door and a grey streak on the left.	F	584	by housekeeping which removed the loose brown material on the floor behind the door. On 1/31/18 resident # 78□s wheelchair was repaired by the maintenance director replace the missing bolt and thorough cleaned. On 2/2/18 housekeeping cleaned the flin room 412 which removed the brown material from behind the door and the grey streak on the floor. On 2/24/18 the maintenance director repaired the plaster at the bed closest the door in room 309 which corrected the peeling plaster. On 2/2/18 housekeeping cleaned the bathroom floor in room 309 which removed the loose brown dirt like material. On 2/2/18 the maintenance assistant repaired the bathroom door in room 200 which removed the black colored streat On 2/2/18 the maintenance assistant repaired the wall behind the first bed and repainted the wall which repaired the rough wood and peeling paint. On 2/19/18 the maintenance director repaired the plaster and repainted the value of the plaster and repaired t	r ttor hly oor to he ng e e 6 k.	
	like material in the v pieces to hold the le behind the door had along with a grey st	B's wheelchair. The erved to have grime and dirt wheels and on the metal eg rests in place. The floor I brown loose material on it reak on the floor behind the			at the head of the both beds window in room 110. This corrected the peeling plaster and paint. On 2/24/18 the housekeeping supervisor cleaned the windowsill in room 110 which removed dust like material.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	NG _		,	
		345144	B. WING				01/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINE DID	NE LIEALTH AND DELIA	NII ITATION CENTED		70	06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	SILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 584	Continued From page	e 20	F	584			
	#78. She reported the	e bolt is still missing from her			On 2/24/18 the maintenance director		
		orted no one has come in			replaced the nightstand and bedside ta	ble	
		eelchair since she reported it			at the bed closest to the window in room		
	broken due to bolt ou				213 which removed the rough, wood		
	An observation on 2/	1/18 at 1:50pm in room 412			exposed at the edges. On 2/2/18		
	revealed the bolt miss	sing to the left side of the			housekeeping cleaned the floor in roon	1	
	seat of Resident #78'				213 which removed the loose brown		
		rved to have grime and dirt			material behind the door.		
		neels and on the metal					
		rests in place. The floor			On 2/2/18 the maintenance repaired th		
		brown loose material on it			sink counter in room 205 which remove		
	door.	eak on the floor behind the			the rough jagged edge across the front the sink counter.	OT	
		on 1/29/18 at 2:29pm in room			0.005/40 !! !!		
		peeling on the wall at the			On 2/25/18 the maintenance director		
	bed closest to the do				repainted the wall behind the head of the	1e	
		30/18 at 4:52pm in room 309			bed closet to the window in room 406,		
		ster on the wall at the bed he bathroom floor had loose			which corrected the peeling paint. On 2/2/18 housekeeping cleaned the floor	in	
	brown dirt like materia				room 406 which removed the black spo		
		1/18 at 1:46pm in room 309			on the floor between the bed and winds		
		ster on the wall at the bed			on the noor between the bed and winds	, vv.	
	closest to the door.				On 2/25/18 the maintenance director		
		on 1/29/18 at 2:39pm in room			removed the plastic coating on the doo	r	
		colored streak on the			facing on the right in room 409 which		
	bathroom door appro	ximately 6 inches from the			repaired the jagged plastic coating.		
	floor going all the way	y across the door and					
	peeling paint behind	the first bed with rough wood			On 2/25/18 the maintenance director		
	exposed.				repaired the plastic coating on the botto	mc	
		30/18 at 4:17pm in room 206			left door facing in room 411 which		
		red streak on the bathroom			repaired the jagged plastic coating.		
		ix inches from the floor			0.0040.0		
		oss the door. There was also			On 2/2/18 the maintenance director	_	
		the bed closest to the door			repaired the front piece of plastic on the		
	with rough wood expo				sink counter in room 201 which correct	zu	
		1/18 at 1:35pm in room 206 ared streak on the bathroom			the rough, jagged edge.		
		ix inches from the floor			On 2/24/18 the housekeeping supervis	or	
		oss the door. There was also			cleaned the window in room 101 which		

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE		DATE SURVEY COMPLETED			
		345144	B. WING _			C 02/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	02/01/2010
				706 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From pag	e 21	F 5	584		
1 304	peeling paint behind with rough wood exp i. An observation of 110 revealed paint a at the head of the bean observation on 11/2 revealed plaster pee of both beds. There won the windowsill. An observation on 21/2 revealed plaster pee of both beds along windowsill. j. An observation of 21/3 revealed the nig the window had a route of the peep of both beds along windowsill.	the bed closest to the door	FS	removed the web like mate corner and upper left corner window. On 2/25/18 the maintenan repainted the wall betweer window in room 209 which brown spots and peeling p The procedure for implement acceptable plan of correcting specific deficiency cited On 2/16/18 the maintenan completed a 100% audit of ensure 1. Any areas of sci	ce director in the sink and in corrected the raint. enting the fon for the ce assistant if the facility to uffed, peeling,	
	revealed the nightsta bed closest to the wi exposed at the edge material behind the of An observation on 2/ revealed the nightsta bed closest to the wi exposed at the edge material behind the of k. An observation of 205 revealed a rough front piece on the sin An observation on 1/ revealed a rough and plastic on the front of An observation on 2/ revealed a rough and plastic on the front of I. An observation of 406 revealed paint p	1/18 at 1:43pm in room 213 and and overbed table at the indow had rough, wood is. There was a loose brown door. In 1/30/18 at 9:29am in room in and jagged edge across the ink counter. 30/18 at 4:30pm in room 205 in jagged edge on the piece of it the sink counter. 1/18 at 1:33pm in room 205 in jagged edge on the piece of it in the piece of it jagged edge on the piece of it in the piece		or scratched paint were re orders filled out, 2. No are peeling, or if areas peeling filled out, 3. No bedside ta nightstand has exposed wedges, 4. No doors have speeling plastic coating, 5. Sink cabinets have sharp of floors are clean including that and in bathrooms, 7. Wind with no web like material. On 2/2/18 the administrate the maintenance director or regarding 1.painting, including the free of chipped or peeling scuff marks, 2. Plaster will peeling, 3. No sharp edges wood can be present on be nightstands, or sink cabine 4.wheelchairs must be repotified. Any new maintena will be in-serviced during of	as of plaster work areas ble or ood or sharp cuff marks, or to bathroom edges, 6. The behind doors ows are clean thisert findings. or in-serviced on expectations ding walls be paint and no be free of s, or exposed edside tables, et, waired when ance directors	

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CENTER	S FOR WEDICARE &	CIVIEDICAID SERVICES			OND NO. 0930-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345144	B. WING		02/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINE RIDO	GE HEALTH AND REHA	BILITATION CENTER		706 PINEYWOOD ROAD	
FINE KID	SE HEALIH AND KEHA	BEHATION CENTER		THOMASVILLE, NC 27360	
(X4) ID	1	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	
F 584	Continued From pag	ge 22	F 584	i l	
	spots on the floor be	etween the bed and the		On 2/2/18 the administrator in-se	erviced
	window.			the housekeeping director on	
	An observation on 2	/1/18 at 1:48pm in room 406		expectations related to facility cl	eanliness
	revealed paint peelir	ng behind the head of the bed		including clean floors free of deb	oris, spots,
		w. There were black spots on		windows free of web like materia	
		e bed and the window.		room s odor free. Any new hou	
		on 1/30/18 at 3:21pm		directors will be in-serviced during	ng
		cing on the right at the of jagged plastic coating		orientation.	
		and and an area of jagged		On 2/2/18 the housekeeping sta	ff were
		ng on the bottom of the left		in-serviced by the staff facilitator	
	door facing on room			expectations related to cleaning	
	_	on 1/30/18 at 4:19 pm in		windows, completion of work ord	
		a rough, jagged edge to the		issues with paint are noted or br	
	front piece of plastic			equipment noted. This in-service	
	An observation on 2	/1/18 at 1:31pm in room 201		completed by 3/1/18. All new	
	revealed a rough, jag	gged edge all the way across		housekeeping employees will re	ceive
		astic on the sink counter.		in-service during orientation.	
		on 1/30/18 at 4:41 pm in		0.00404	
		web like material in the right		On 2/2/18 the nursing staff were	
	window.	v and upper left corner of the		in-serviced by the staff facilitator completing a work order when re	
		/1/18 at 1:21pm in room 101		need of paint or broken equipme	
		aterial in the right corner of		rooms must be clean including fl	
		ne upper left corner of the		free of web like material. This in-	
	window.			will be completed by 3/1/18 and	new
	p. An observation	on 1/31/18 at 2:31pm in room		nursing employees will receive in	
		spots and peeling paint on		in orientation.	
		e sink and the window.			
		/1/18 at 1:38pm in room 209		The monitoring procedure to ens	
		ts on the wall between the		the plan of correction is effective	
		. There was also peeling		specific deficiency cited remains	
	paint on the same w			and/or in compliance with the re-	yulatory
		the facility on 2/1/18 at usekeeping Supervisor, the		requirements	
		ousekeeping were confirmed		The administrator, director of nu	rsing
	with the supervisor.	odoonooping word committee		housekeeping director, or mainte	•
		the facility on 2/1/18 at		director will observe 50% of roor	
		intenance Supervisor, the		x 4 weeks then 25% of rooms w	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		D. MINO		С	
	345144	B. WING _		02/01	1/2018
NAME OF PROVIDER OR SUPPLIER	ł.		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDGE HEALTH AND RE	HARII ITATION CENTER		706 PINEYWOOD ROAD		
TIME RIBGE HEALTH AND RE	HABILITATION GENTER		THOMASVILLE, NC 27360		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
by the supervisor An interview was Assistant) #52 on reported if the stathey fill out a maint the bulletin board An interview with 2/1/18 at 2:00pm sees something request on the bustation. An interview was with the Houseke all rooms are expected daily include bathrooms. He reweekly by the floor Housekeeping Sutechnicians are expected when the wheelchairs night him know of a direct that chair is done An interview was with the Maintenathe staff fills out with the bulletin board reported when he prioritizes the new work. The Maintenath as one part time monthly room assecompletes any methe work is documaintenance log. Resident #78's britant in the stage of the stage of the work is documaintenance log.	conducted with NA (Nursing 2/1/18 at 10:32am. NA#52 aff sees a maintenance issue, intenance request and put it on at the nursing station. Nurse #3 was conducted on Nurse #3 reported that if she maintenance needs to fix, she tenance request and put the alletin board at the nursing conducted on 2/1/18 at 2:14pm reping Supervisor. He reported rected to be mopped and auding cleaning furniture and reported the floors are polished or technicians. The apervisor reported floor expected to clean 2-3 thy. He reported if the staff lets ty wheelchair, he will make sure	F 5	weeks for peeling, scuffed, or miss paint; peeling plaster; exposed wo rough edges on bedside tables, be skinks, or nightstands; cleanliness floors (no debris, no spots); no odd web like material in windows. This will be documented on the homelike environment audit tool. The monthly QI committee will revresults of the homelike environment tool for 3 months for identification trends, actions taken, and to deter the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administration of the monthly QI committee to the quarterly executing committee to the quarterly executing committee for further recommendations of the monthly QI committee to the quarterly executing the implementing the acceptable plan correction. The Administrator is responsible for implementing the acceptable plan correction.	od or athroom of or; no audit ae few the at audit of mine or strator QI ve QA ations for of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345144	B. WING		C 02/01/2018	
	ROVIDER OR SUPPLIER GE HEALTH AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	02/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 584 F 600 SS=D	aware of the bolt un able to repair becau in her wheelchair who "with all the other st gotten to it." A revier reports from Septen 2018 showed no reprooms 110, 200, 20213, 308, 309, 405, An interview with the conducted on 2/1/18 Administrator report the facility will be keep ree from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishment any physical or cheep treat the resident's	and. He reported he was not till 1/29/18 but had not been use the resident had been up then he checked. He reported uff going on I just haven't wof the monthly maintenance of the resident programmer of the monthly maintenance of the resident programmer of the monthly maintenance of the resident programmer of the monthly maintenance of the resident property, defined in this subpart. This mitted to freedom from the resident property, defined in this subpart. This mitted to freedom from the resident property of the resident property. It is not resident property, defined in this subpart. This mitted to freedom from the required to of the resident property. It is not resident property, defined in this subpart. This mitted to freedom from the required to of the resident property. It is not resident property, defined in this subpart. This mitted to freedom from the required to of the resident property. It is not resident property, and the resident property of the resident property.	F 56		3/1/18	
	by: Based on resident resident observation failed to provide inc	n; IT is not met as evidenced interview, staff interviews, n and record review the facility ontinence care for 1 of 5 Resident #71) who required		An acceptable plan of correction mus contain the following elements: " The plan of correcting the specific deficiency. The plan should address the specific deficiency.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(c
		345144	B. WING			02/	01/2018
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
				706	PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAB	ILITATION CENTER		THO	DMASVILLE, NC 27360		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600			F 60	00			
	extensive assistance	and who requested			processes that lead to the deficiency		
	incontinence care on	2 different occasions			cited;		
	because she had soil	ed herself.			" The procedure for implementing the	ie	
					acceptable plan of correction for the		
	Findings included:				specific deficiency cited;		
					The monitoring procedure to ensur		
		mitted to the facility on			that the plan of correction is effective a	nd	
	6-21-16 with multiple				that specific deficiency cited remains		
	cerebral infarction, me				corrected and/or in compliance with the	9	
	abnormality of gait an	d vascular dementia.			regulatory requirements;	for	
	The Minimum Data S	et (MDS) dated 12-7-17			" The title of the person responsible implementing the acceptable plan of	101	
	revealed that the resid				correction.		
		Resident #71 was coded as			correction.		
		ance with one person for			F600		
	-	s, locomotion on and off the					
	unit, dressing and per				The plan of correcting the specific		
	extensive assistance	with toileting.			deficiency		
	A review of the care p	lan dated 12-28-17 revealed			The position of Pine Ridge Nursing and	t	
	that resident #71 did				Rehabilitation center regarding the		
	interventions related t	o activities of daily living			process that lead to this deficiency-failu	ıre	
	(ADL).				to provide requested incontinence care	!	
					was failure to follow established facility		
		g Kardex revealed that			policy.		
	there was no instructi						
		ed as using "pull-ups" under			On 2/16/18 the facility consultant		
	the toileting program	section of the Kardex.			observed resident # 71 at 730am, 815a		
	An interview with resi	dont #71 occurred on			and 9am. Resident denied being soiled	1	
		The resident stated she had			and no visible or olfactory signs of incontinence noted.		
		30am to have her pull-up			incontinence noted.		
	•	e had urinated. She stated			The procedure for implementing the		
		was because she looked at			acceptable plan of correction for the		
		The resident also stated			specific deficiency cited		
		ssistant that she needed			,		
		ought her breakfast tray.			On 2/16/18 the facility consultant		
	<u> </u>	,			observed all non-interviewable residen	ts	
_	Resident #71 intervier	wed on 1-30-18 at 12:00pm.			for visible or olfactory signs of		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING _			1	C /01/2018
	ROVIDER OR SUPPLIER BE HEALTH AND REHA	BILITATION CENTER		70	TREET ADDRESS, CITY, STATE, ZIP CODE 06 PINEYWOOD ROAD HOMASVILLE, NC 27360	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600		Continued From page 26					
	The resident stated today because staff An interview with restart 1-31-18 at 9:10am. The been waiting since 8 changed. She stated assistant who came tray but that he had An observation of restart 1-31-18 at 9:40am. In not been completed. The observation of restart 1.31-18 at 10:45am.			incontinence at 830am with 3 residents noted soiled. At 845am affected reside were being provided incontinent care is facility staff. On 2/16/18 the facility consultant observed and interviewed all unreview residents regarding incontinence with regative findings noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident providing incontinent care promptly. No licensed nurse or CNA will be allowed work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new	able no		
	noted to be in the re supplies to render A An interview with the on 1-31-18 at 1:08pr resident #71 will let	at 10:45am. The nursing assistant was ted to be in the resident's room gathering oplies to render ADL care. Interview with the nurse (nurse #7) occurred 1-31-18 at 1:08pm. The nurse stated that sident #71 will let staff know when she needs sistance in changing her pull-up. Isident #71 was interviewed on 2-1-18 at 1:5am. She stated she had a bowel movement uring breakfast" and that she told the nurse en the nurse brought her medication. The sident stated the nurse told her she would form the nursing assistant but that no one had en in to "clean me up". Isident #71 was noted to be on her way to the ower on 2-1-18 at 10:15am. Interview with the Administrator occurred on 1-18 at 3:30pm. The Administrator stated she oected incontinence care to be provided in a nely fashion "within 10-15 minutes".			licensed nurses and CNAs. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, staff facilitator,	nat cted ry	
	9:55am. She stated "during breakfast" all when the nurse brown resident stated the rinform the nursing a been in to "clean me Resident #71 was not shower on 2-1-18 at An interview with the 2-1-18 at 3:30pm. Texpected incontinent				facility consultant, and/or minimum dat set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks to ensure resident is clean and This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for months for identification of trends, active taken, and to determine the need for and/or frequency of continued monitoriand make recommendations for monitoring for continued compliance. The administrator and/or DON will present findings and recommendations of the	a y for dry. the or 3 ons ing,	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(C
		345144	B. WING _			02/	01/2018
	ROVIDER OR SUPPLIER SE HEALTH AND REHAE	BILITATION CENTER		70	TREET ADDRESS, CITY, STATE, ZIP CODE 06 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 27	F	600	monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	or	
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)		F	636	correction.		3/1/18
	a comprehensive, acc	duct initially and periodically					
	A facility must make a assessment of a residence goals, life history and resident assessment by CMS. The assess the following: (i) Identification and control (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavit (vii) Psychological were (viii) Physical function (ix) Continence.	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information c. s. or patterns. ell-being. ning and structural problems.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345144	B. WING _		C 02/01/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION E APPROPRIATE DATE
F 636	regarding the addition the care areas trithe Minimum Data S (xviii) Documentation assessment. The assinct direct observation with the resident, as licensed and nonlice members on all shift \$483.20(b)(2) When timeframes prescribe chapter, a facility musassessment of a restimeframes specified through (iii) of this superscribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissis significant change ir mental condition. (Fureadmission" mean following a temporar or therapeutic leave (iii) Not less than one This REQUIREMEN by: Based on record refacility failed to complor 1 of 1 resident (reface).	nts and procedures. ning. n of summary information onal assessment performed ggered by the completion of set (MDS). n of participation in seessment process must vation and communication well as communication with ensed direct care staff is. required. Subject to the ed in §413.343(b) of this just conduct a comprehensive ident in accordance with the d in paragraphs (b)(2)(i) ection. The timeframes ead(b) of this chapter do not ar days after admission, ons in which there is no in the resident's physical or or purposes of this section, is a return to the facility by absence for hospitalization conditions.	F	An acceptable plan of corre contain the following elemen " The plan of correcting the deficiency. The plan should	nts: ne specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 02/01/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.01.11	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		2/01/2018	
TVAIVIL OF T	COVIDER OR OUT FEEL			, , ,	_		
PINE RIDO	E HEALTH AND REHAI	BILITATION CENTER		706 PINEYWOOD ROAD			
				THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 636	Continued From pag	e 29	F 63	36			
	assessment within th	ne required timeframes for 3		cited;			
		ed for resident assessment		" The procedure for impler	nenting the		
		ent #2 and Resident #5.)		acceptable plan of correction	-		
	,	,		specific deficiency cited;			
	Findings included:			" The monitoring procedure	e to ensure		
	· ·			that the plan of correction is e			
	Resident #38 was ac	lmitted to the facility on a		that specific deficiency cited r			
		h multiple diagnoses which		corrected and/or in compliand			
	included urinary tract	t infection, cerebral vascular		regulatory requirements;			
	accident, dementia a	ind neurogenic bladder.		" The title of the person res	sponsible for		
				implementing the acceptable	plan of		
	The Minimum Data S	Set (MDS) dated 11-8-17		correction.			
	revealed that resider	nt #38 had memory issues					
	and was severely co	gnitively impaired. The		F636			
	resident was coded a	-					
		person for bed mobility,		The plan of correcting the spe	ecific		
	_	d personal hygiene. He was		deficiency			
		tensive assistance with 2					
		Resident #38 was not coded		The position of Pine Ridge Nu			
	for falls or restraints.			Rehabilitation center regardin	-		
				process that lead to this defic			
		ent report dated 11-19-17		to complete physical assessm			
		ing note. The rest of the		resident after an unwitnessed			
	•	e nursing note revealed that		complete comprehensive ass			
		nis wheelchair at 3:30am by		within required timeframe- wa			
	the staff breakroom.			failure to follow established po	olicy and		
	The nursing assistan	t (NA) found the resident		procedure.			
		s on the floor in front of his		Resident #38 was sent to em	orgonov		
	_	informed the nurse working		room on 1/31/18 where was a			
				medical physician.	locessed by		
	that evening of the fall and assisted the resident back into his wheelchair. The note also revealed			Resident #6 s comprehensiv	/e		
		not complain of pain or		assessment was completed of			
	communicated how h	·		submitted to the national repo			
	Januariou ilow i			2/6/18 by the MDS nurse.			
	An interview with res	ident #38's representative		Resident #2 s comprehensiv	/e		
	occurred on 1-30-18	•		assessment was completed of			
		I she found out a day later		and locked by the minimum d			
		fallen but that the nurse who		nurse (MDS).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _			l	C 01/2018	
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010	
					06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			HOMASVILLE, NC 27360			
				'	HOMASVILLE, NC 27300		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE COMPLET CED TO THE APPROPRIATE DATE		
F 636	Continued From page	∋ 30	F 6	336				
	called her could not go he fell or what time or representative stated "blood thinner" at the representative added spoken since his last. A review of resident at that the resident was The nursing assistant #38 the night he fell winterview. An interview with the (IDON) occurred on a IDON stated "I don't I the floor I am the MD she had the title of ID that the nurse on shift assessment on residinformed that he fell a checks since no one his head. An interview with the on 1-31-18 at 2:30pm filling in for a nurse the stated she was told on the saw him sitting on the saw not told he had he state that resident #30 the saw him sitting on the saw not told he had he state that resident #30 the saw him sitting on the saw not told he had he state that resident #30 the saw him sitting on the saw not told he had he state that resident #30 the saw him sitting on the saw not told he had he state that resident #30 the saw him sitting on the sa	give her any details as to how f day he fell. The resident's resident #38 was on a		030	Resident #5 s comprehensive assessment was exported and accepte by the natation repository on 2/6/18 by MDS nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed a review of all falls in the pa 30 days to ensure a physical assessment had been completed and documented after all unwitnessed falls with no negatindings. On 2/20/18 the MDS consultant audited current residents to ensure comprehensive assessments have been completed as scheduled for the past 30 days. No outstanding missing assessments were found. All licensed nurses will be in-serviced to 3/1/18 by the director of nursing, or state facilitator on completion of an assessment after each fall and documenting in the medical record. No licensed nurse will allowed to work after 3/1/18 until in-service is complete. This in-service is be added to the orientation for all newly hires licensed nurses. On 2/2/18 the MDS coordinator was in-serviced on completing assessments timely based on the resident assessments in timely based on the resident assessments	st ent tive d all en co		
	himself around and it bed".	kept him from falling out of Administrator occurred on			The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator	nat cted		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE					
DINE DID	SE HEALTH AND REHA	BII ITATION CENTER		70	06 PINEYWOOD ROAD					
FINE KIDO	DE HEALIH AND KEHA	ELIATION CENTER		T	HOMASVILLE, NC 27360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 636	Continued From pag	ge 31	F	336						
		he Administrator stated that if			requirements					
		d a change in condition that								
	her staff complete a	physical/neurological			The director of nursing, or staff facilitate	or				
	assessment.				will audit 100% of unwitnessed falls x 4					
					weeks then 50% of unwitnessed falls for	or 8				
		ent #6"s last annual			weeks to ensure a licensed nurse	L				
		essment identified it was /16. As of 2/1/18 the annual			completed a physical assessment which is documented in the medical record. T					
		sment reference date (ARD)			audit will be documented on the fall au					
		been completed. Sections I,			tool.					
	V and O were still in				The administrator, or director of nursing	3				
					will audit 100% of MDS assessments					
		e MDS nurse on 2/1/18 at			complete and submitted to the national					
	•	e annual MDS with an ARD Resident #6 was close to			repository weekly x 4 weeks then 50%	ata.				
	being completed, bu				weekly x 8 weeks to ensure assessment were submitted timely based on the RA					
	being completed, be	it it was late.			manual. This audit will be documented					
	Resident #2 was ad	mitted to the facility on			the MDS audit tool.					
	1/10/18. As of 2/1/1	8 the initial comprehensive								
		ent with an ARD of 1/23/18			The monthly QI committee will review t	he				
		eted. Sections A, B, C, D, E,			results of the fall and MDS audit tools	_				
), P and Q were still in			monthly for 3 months for identification of					
	progress.				trends, actions taken, and to determine the need for and/or frequency of					
	An interview with the	e MDS nurse on 2/1/18 at			continued monitoring, and make					
		e admission MDS with an			recommendations for monitoring for					
		3 for Resident #2 was in			continued compliance. The administrat	or				
	progress and had no	ot been completed yet.			and/or DON will present the findings ar					
					recommendations of the monthly QI					
	A review of Residen				committee to the quarterly executive Q					
		essment was dated 12/28/16.			committee for further recommendations	3				
		nual MDS with an ARD of completed, but had not been			and oversight.					
	exported.	Sompleted, but had not been			The title of the person responsible for					
	охронов.				implementing the acceptable plan of					
	An interview with the	e MDS nurse on 2/1/18 at			correction.					
		esident #5 ' s annual MDS			The Director of nursing is responsible f	or				
		t been fully completed until			implementing the acceptable plan of					
	1/30/18. She added	that she had gotten behind			correction.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING		C 02/01/2018	
	ROVIDER OR SUPPLIER BE HEALTH AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 636	working as the interir in addition to her MD stated the facility had nurse. An interview with the 4:45 pm revealed it v	PS 's because she was in Director of Nursing (DON) is position. The MDS nurse is recently hired another MDS. Administrator on 2/1/18 at was her expectation that	F 636	6		
F 641 SS=D	required timeframes. Accuracy of Assessn CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENt by:	of Assessments. st accurately reflect the Γ is not met as evidenced	F 64		3/1/18	
	facility failed to accur Data Set (MDS) for h of 1 residents (reside hospice care. Findings included: Resident #120 was a 10-27-2008 with mul- included dementia, p right heels, dysphagi The Minimum Data S revealed that resider and was coded as se Resident #120 was a extensive assistance mobility, extensive as	iew and staff interviews the rately code the Minimum rospice services involving 1 and #120) reviewed for admitted to the facility on ciple diagnoses which ressure ulcers of the left and a and schizophrenia. Set (MDS) dated 1-4-2018 at #120 had memory issues everely cognitively impaired. Ilso coded as needing with 2 people for bed esistance with one person for ance with one person for		An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible implementing the acceptable plan of correction. F641 Accuracy of Assessments The plan of correcting the specific	ne ne ire and	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _			1	C 2/ 01/2018	
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	./01/2010	
					706 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER			THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 33	F	641				
	dressing, eating and assistance with 2 peo	personal hygiene, extensive ople for toileting. The			deficiency			
	resident was not code such as hospice.	ed for any special treatments			The position of Pine Ridge Nursing an Rehabilitation center regarding the process that lead to this deficiency wa			
		1-23-18 revealed a goal that			the staff failure to follow established			
		experience pain without			procedure in accurately coding resider			
	appropriate nursing in				receiving hospice services to reflect life	9		
		goal were as follows; consult in management, encourage			expectancy of 6 months or less.			
		rovide supportive private			On 2/6/18 resident # 120□s MDS date	·d		
	environment for the resident and her family.				1/4/18 was modified by the minimum of			
		ŕ			set nurse (MDS). The modified			
	A review of the physician's orders revealed that				assessment was submitted and accep	ted		
	1	aced on hospice 3-31-17			by the national repository on 2/6/18.			
		ained on hospice as of						
	2-1-18.				The procedure for implementing the			
	An interview with the	Minimum Data Set (MDS)			acceptable plan of correction for the specific deficiency cited			
		1-18 at 8:05am. The MDS			On 2/16/18 the facility consultant audit	ed		
		a "consultant" helping her			all MDS assessments completed and	ou .		
		ssments and that she "must			transmitted in the past 30 days to ensu	ıre		
	have just made a mis	take". She could not			hospice coding was correct with no			
		sultant was helping her at			additional negative findings.			
		so many in and out of here".			On 2/2/18 the MDS Coordinator was			
		tate that resident #120			in-serviced by the facility Consultant o	n		
	should have been co	ded for hospice services.			correctly coding residents receiving			
	An interview with the	Administrator occurred on			hospice services to be coded as havin life expectancy of 6 months or less based as having the services are services to be coded as having the services the s			
		e Administrator stated she			on the resident assessment instrumen			
		m Data Set (MDS) be coded			(RAI) manual. Any newly hired MDS	•		
	I -	t the resident's current health			coordinators will be in-serviced.			
	condition.				The monitoring procedure to ensure th	at		
					the plan of correction is effective and t	hat		
					specific deficiency cited remains corre			
					and/or in compliance with the regulato	гу		
					requirements			
					The administrator or director of nursing will audit completed MDS assessment			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING _			l	C 01/2018
	ROVIDER OR SUPPLIER BE HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		, <u>v-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	1 Continued From page 34			TAG CROSS-REFERENCED TO THE APPRO		6 of I ted he or ed is e. ent	
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The far implement a comprel care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identif	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial fied in the comprehensive nprehensive care plan must	F	6556			3/1/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CC)2/01/2018	
PINE RIDO	GE HEALTH AND REH	HABILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 656	or maintain the resphysical, mental, a required under §44 (ii) Any services thunder §483.24, §4 provided due to thunder §483.10, increatment under §4 (iii) Any specialize rehabilitative serviprovide as a result recommendations findings of the PAS rationale in the respective resphysical provides as a result recommendations findings of the PAS rationale in the respective respansive recommendations findings of the PAS rationale in the respective requiremental provides as a result recommendations findings of the PAS rationale in the respective requiremental provides as a result recommendation of the PAS rationale in the respective requiremental provides as a result recommendation of the PAS rationale in the respective requiremental provides as a result recommendation of the PAS rationale in the respective requiremental provides as a result recommendation of the PAS rationale in the respective recommendation of the PAS rationale respective respective respective recommendation respective respecti	at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and lat would otherwise be required 83.25 or §483.40 but are not be resident's exercise of rights cluding the right to refuse 483.10(c)(6). In the description of the sident's disagrees with the SARR, it must indicate its sident's medical record.	F	556			
	rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan to address activities of daily living (ADL) care, specifically toileting with no goals, measureable objectives or time frames for a dependent resident in 1 of 1 residents (resident #71).			An acceptable plan of corre contain the following elemer "The plan of correcting to deficiency. The plan should processes that lead to the dited; "The procedure for imple acceptable plan of corrections."	nts: he specific address the eficiency ementing the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING _				C 01/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	0.1120.10
DINE DID	SE LIEALTH AND DELIA	DILITATION CENTED		70	06 PINEYWOOD ROAD		
PINE KIDO	SE HEALTH AND REHAE	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	· ·			COMPLETION DATE
F 656	Continued From page	e 36	F	656			
					specific deficiency cited;		
	Resident #71 was ad	mitted to the facility on			" The monitoring procedure to ensur	re	
	6-21-16 with multiple diagnoses to include				that the plan of correction is effective a	nd	
	cerebral infarction, m				that specific deficiency cited remains		
	abnormality of gait ar	nd vascular dementia.			corrected and/or in compliance with the	3	
					regulatory requirements;		
		et (MDS) dated 12-7-17			" The title of the person responsible	for	
	revealed that the resi				implementing the acceptable plan of		
		Resident #71 was coded as			correction.		
		tance with one person for s, locomotion on and off the			F656		
	unit, dressing and pe				The plan of correcting the specific		
	extensive assistance	· ·			deficiency		
		mar tollowing.			denoisiney		
	A review of the care	olan dated 12-28-17 revealed			The position of Pine Ridge Nursing and	t	
	that resident #71 did	not have any goals or			Rehabilitation center regarding the		
	interventions related	to activities of daily living			process that lead to this deficiency was	3	
	(ADL).				the staff failure to follow established		
					procedure in accurately developing a c	are	
		ng Kardex revealed that			plan to address activities of daily living		
	there was no instruct				(ADL) care, specifically toileting with		
		ed as using "pull-ups" under			goals, measurable objectives, and time	;	
	the tolleting program	section of the Kardex.			frame for dependent resident.		
	An interview with the	nursing assistant (NA #52)			On 1/31/18 resident # 71 □s care plan v	was	
	occurred on 1-31-18	at 1:15pm. NA #52 stated			updated by the minimum data set		
		nange resident #71's pull-up			coordinator to accurately reflect		
	, ,	because it was wet. He also			residents□ dependence in ADL care,		
		71 could not change her			specifically toileting, including a goal,		
	' '	d needed assistance in			measureable objective, and time frame	١.	
	proper cleaning of he	r genital area.			The precedure for implementing 41-		
	An intonvious with the	Interim Director of Nursing			The procedure for implementing the acceptable plan of correction for the		
		Interim Director of Nursing I-31-18 at 1:28pm. The			specific deficiency cited		
		the person who creates and			On 2/22/18 the MDS consultant		
		re plans. She reviewed			completed an audit of all residents ADL		
		lan and stated she did not			care plan for toileting to ensure it was	-	
		71 was not care planned for			accurate and included a goal, measura	ıble	
		e should have been.			objective, and time frame. 43 care plan		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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		345144	B. WING _			02/01/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	<u>. </u>
DINE DID	CE HEALTH AND DE	HABILITATION CENTER		706 PINEYWOOD ROAD		
PINE KID	SE REALIR AND RE	HABILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B TO THE APPROPRIA	DATE.
F 656	An interview with 2-1-18 at 3:30pm. expected the resident	the Administrator occurred on The Administrator stated she dents care plan to reflect the lent and accurately reflect MDS	F	were altered to accurate residents current ADL objectives, and time fram On 2/2/18 the MDS Coo in-serviced by the facility developing a care plan be residents most recent as newly hired MDS coording in-serviced. The monitoring procedure the plan of correction is specific deficiency cited and/or in compliance with requirements. The administrator, or dim will audit residents with assessments for care pland ADL care specifically toil MDS Audit Tool. 100% of completed assessments weekly x 4 weeks, then swith completed assessments weekly x 4 weeks, then swith completed assessments weeks. The monthly QI committee results of the MDS Audit 3 months for identification actions taken, and to defor and/or frequency of committee in the findings and recommendation and of the findings and recommendations and of the title of the person resimplementing the accept correction.	levels, goals, mes. rrdinator was redinator was redinator was redinator was reased on the seessment. An anators will be re to ensure the effective and the remains correctly the regulator ector of nursing completed MDS an accuracy in leting using the form of the residents with the redidents weekly xeron of trends, termine the new continued ecommendation and compliance or DON will presidents of the quarterly eror further oversight.	at that cted ry g S S e th d thats 8 the for ed ed es ent

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING _				C 01/2018
NAME OF PRO	OVIDER OR SUPPLIER		'	STI	REET ADDRESS, CITY, STATE, ZIP CODE		0 1/20 10
DINE DIDOE	LIEALTH AND DELIAD	II ITATION CENTER		706	6 PINEYWOOD ROAD		
PINE KIDGE	HEALTH AND REHAB	ILITATION CENTER		TH	IOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page		F 6		The director of nursing is responsible for implementing the acceptable plan of correction.	or	
		or Dependent Residents				3/1/18	
E S C C S S R R T T C C S S R R T T C C S S S R R T T C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C S R T T C C C C S R T T C C C C C C C C C C C C C C C C C	but activities of daily leservices to maintain gotersonal and oral hygotersonal and resident observation of the continuation of the co	eservation, resident esew and staff interview the e Activities of Daily Living nce care for 1 of 1 residents mitted to the facility on e diagnoses which included peripheral vascular disease et (MDS) dated 11-22-17 e #51 had memory problems cognitively impaired. The es not rejecting care when esident #51 was coded as esistance with 2 people for esistance with one for and extensive assistance			An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective a that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible implementing the acceptable plan of correction. F677 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure.	e re nd e for	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		,,,	(X3) DATE COMP	SURVEY LETED
		345144	B. WING _			02/0	01/ 2018
NAME OF PI	ROVIDER OR SUPPLIER	l	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010
				70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	SILITATION CENTER			HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 39	F 6	677			
F 677	would not develop a pinterventions for this gaskin daily, encourage positions frequently, pafter each incontinent. Resident #51's repressurvey team on 2-1-1 for the past 3 days shresident and he had be representative stated bowel movement". Show long he had been a continent of the past 3 days shresident and he had be representative stated bowel movement". Show long he had been a continent of the past 3 days shresident and president of the past 3 days shresident and he had been and the past 3 days shresident as sistent of the past 3 days shresident as sistent of the past 3 days shresident as sistent and the past 3 days shresident and the past 3 days shresident as sistent as a sistent and the past 3 days shresident and the past 3 days 3 days 3 days 3 days 3 days 3 da	pressure ulcer. The goal was as follows; assess or assist resident to change provide incontinence care to episode or toileting. Sentative approached the 8 at 5:00pm. She stated that the had come to see the preen in a soiled brief. The she could "smell he had a me stated she did not know in in a soiled brief. Ident #51's Activities of Daily curred on 2-1-18 at 5:05pm. If (NA #55) removed the ited feces was noted in the in as well as down his left leg. Ided on 2-1-18 at 5:15pm. The only nursing assistant is hall that evening and that the eds as soon as she could. It do not know how long the ting in a soiled brief but that while since his feces was kin". Administrator occurred on the Administrator stated her	F	377	to provide requested incontinence care was staff failure to follow established procedure. On 2/16/18 the facility consultant observed resident # 51 at 730am, 815a and 9am. Resident was not soiled and had no visible or olfactory signs of incontinence noted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant observed all non-interviewable residen for visible or olfactory signs of incontinence at 830am with 3 residents noted soiled. At 845am affected reside were being provided incontinent care b facility staff. On 2/16/18 the facility consultant observed and interviewed all unreviewaresidents regarding incontinence with regative findings noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident providing incontinent care promptly. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service	am, ts ants y able no	
		e same as earlier, that her ence care in a timely fashion ".			completed. This in-service will be adde to the orientation process for all new licensed nurses and CNAs. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements	at nat cted	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	B. WING				04/2048
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE			70	TREET ADDRESS, CITY, STATE, ZIP CODE OF PINEYWOOD ROAD HOMASVILLE, NC 27360	02/	01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684 SS=D	S 483.25 Quality of care is a further applies to all treatment facility residents. Basessment of a resident residents receives accordance with professions.	are Indamental principle that Int and care provided to Interest of the comprehensive composition of the comp		677	The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks resident is clean and dry. This audit will be documented on the Reside Care Audit Tool. The monthly QI committee will review to results of the resident care audit tool for months for identification of trends, active taken, and to determine the need for and/or frequency of continued monitoriand make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible firmplementing the acceptable plan of correction.	ent he r 3 ons ng, he he	3/1/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	040144	1		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2018
NAIVIE OF F	ROVIDER OR SUFFLIER						
PINE RIDO	SE HEALTH AND REH	ABILITATION CENTER			06 PINEYWOOD ROAD		
				T	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pa	age 41	F 6	684			
	care plan, and the	-					
	•	NT is not met as evidenced					
	by:						
	Based on record re	eview, resident observation,			An acceptable plan of correction must		
	and resident repres			contain the following elements:			
up daily providing	interviews the facili	ty failed to have the resident			" The plan of correcting the specific		
		elchair for 2 months and not			deficiency. The plan should address th	е	
	providing the reside			processes that lead to the deficiency			
		ng all day for 1 of 1 residents			cited;		
	(resident #38).				" The procedure for implementing the	ie	
					acceptable plan of correction for the		
	Findings included:				specific deficiency cited;	ro	
	Docident #29 was	admitted to the facility on a			" The monitoring procedure to ensu that the plan of correction is effective a		
		vith multiple diagnoses which			that specific deficiency cited remains	IIu	
		act infection, cerebral vascular			corrected and/or in compliance with the	ے	
		and neurogenic bladder.			regulatory requirements;		
					" The title of the person responsible	for	
	The Minimum Data	Set (MDS) dated 11-8-17			implementing the acceptable plan of		
		ent #38 had memory issues			correction.		
	and was severely o	cognitively impaired. The					
	resident was coded	d as needing extensive			F684		
		e person for bed mobility,					
		and personal hygiene. He was			The plan of correcting the specific		
		extensive assistance with 2			deficiency		
	· ·	s. Locomotion on and off the					
		total assist with one person.			The position of Pine Ridge Nursing and	j	
		not coded for falls or restraints.			Rehabilitation center regarding the		
		that the resident was			process that lead to this deficiency-fail		
	discharged from ph	· ·			to have resident up in wheelchair, and		
	occupational therap	py on 1-24-17.			providing activities was knowledge def	CIL.	
	The care plan addr	ressed that the resident was			Resident #38 was not observed up in		
	needing total care.				wheelchair per resident representative		
		view with resident #38			choice.		
	·	8 at 2:00pm. The resident was			Resident #38 was referred to therapy of	n	
		ith his eyes closed but easily			1/31/18 by the director of nursing for		
		name was called. The resident			decreased transfer ability. Resident		
		ak however he was able to			representative discontinued therapy		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		E SURVEY PLETED
						С
		345144	B. WING _		02	2/01/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
				706 PINEYWOOD ROAD		
PINE RID	GE HEALIH AND RE	HABILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
IAG	REGULATOR	ON LOO IDENTIFY TINO INFORMATION)	IAG	DEFICIENCY)		
F 684	Continued From p	nage 42	F 6	94		
	T	-				
		d for the surveyor's hand.		services. Resident #38 was added to it		
		s observed on 1-29-18 at		activity list by the activity dire	ctor on	
		his bed with his eyes closed		2/9/16.		
resting comfortably. did not have a lunch An interview with the	ly. It was noted that the resident					
	nch tray.		The procedure for implement			
				acceptable plan of correction	for the	
		the nursing assistant (NA #56)		specific deficiency cited		
		-18 at 12:35pm. The NA stated				
		s wife brings him his meals so		On 2/16/18 the facility consul		
		lunch tray. During this interview		completed an interview with i		
		t the resident will sleep till his		residents to ensure residents		
		e evenings for the supper meal		out of bed per preference wit		
		wed him to sleep but that they		findings not already addresse		
	did "check" on hir	n throughout the shift.		On 2/23/18 the Activity Direct		
	D #00			the list of resident □s receivin	-	
		s observed on 1-30-18 at		activities to ensure residents		
		his bed with his eyes closed.		to stay in bed are present un		
		ident's room was on but the		choose otherwise. No negative	ve findings	
	resident was not	watering the TV.		were noted. On 2/24/18 the administrator		
	An observation of	resident #38 occurred on				
		n. The resident remained in the		last 60 days of concerns with resident choice to get out of I		
	bed with his eyes			activities. Five grievances we		
	Dea with his eyes	ciosea.		regarding resident choice to	•	
	The nurse (nurse	#1) stated on 1-30-18 at		and activities. All five grievan	-	
		ent #38 "pretty much sleeps all		resolved.	ocs were	
		has not had the resident up in		All licensed nurses, and CNA	s will he	
		t that she did "check" on him		in-serviced by 3/1/18 by the o		
		y and that he was not receiving		nursing, or staff facilitator on		
		by. She also stated that the		residents should be out of be		
		get into his wheelchair regularly		unless they choose differently	•	
	prior to his fall.	,		should be provided with activ		
	1 12 12 13			stimulation, and a change in	•	
	The resident repr	esentative was interviewed on		mobility must be communicate		
		n. During this interview the		licensed nurse or CNA will be		
		ated that resident #38 was more		work after 3/1/18 until in-serv		
		to his fall on 11-19-17 and that		complete. This in-service will		
		in his wheelchair every day and		the orientation for all newly h		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l c		SURVEY LETED
	345144	B. WING _				01/2018
	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		, <u> </u>	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFII TAG	X			(X5) COMPLETION DATE
was able to wheel him also stated staff had in resident back into his returned from the hos also stated she was a into his wheelchair by take him home for 2-3 fall in November but in and can no longer taken has declined so much own anymore". The was residents decline was progression". The residents decline was progression". The residents decline was progression. The residents decline was progression and waving at the surface of the surfa	nself around the halls. She not attempted to place the wheelchair since he spital. The representative able to assist the resident of herself and was able to a days at a time prior to his now she cannot get him up to him home because "he had I can't handle him on my wrife stated she felt that the armormal disease sident was noted to be review with his representative reveyor smiling. nurse (nurse #6) occurred a who stated the resident heelchair "he liked wheeling alls". During the interview of seen the resident in his eturned from the hospital in ted on 2-1-18 at 3:30pm of the assist residents in	F	584	the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, or staff facilitate will audit 20 residents weekly for 4 week then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, activity provided if resident in room, and if change in mobility it is communicated. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrate and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive QC committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	nat cted y or cks, it he or nd A	
Free of Accident Haza	ards/Supervision/Devices	F 6	389			3/1/18
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	Assisted the properties of the	A BUILDI 345144 B. WING ROVIDER OR SUPPLIER SE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 was able to wheel himself around the halls. She also stated staff had not attempted to place the resident back into his wheelchair since he returned from the hospital. The representative also stated she was able to assist the resident into his wheelchair by herself and was able to take him home for 2-3 days at a time prior to his fall in November but now she cannot get him up and can no longer take him home because "he has declined so much I can't handle him on my own anymore". The wife stated she felt that the residents decline was "normal disease progression". The resident was noted to be awake during the interview with his representative and waving at the surveyor smiling. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:50pm who stated the resident was "always" in his wheelchair "he liked wheeling himself around the halls". During the interview she stated she has not seen the resident in his wheelchair since he returned from the hospital in November. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning.	A BUILDING B. WING 345144 ROVIDER OR SUPPLIER SE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Was able to wheel himself around the halls. She also stated staff had not attempted to place the resident back into his wheelchair since he returned from the hospital. The representative also stated she was able to assist the resident into his wheelchair by herself and was able to take him home for 2-3 days at a time prior to his fall in November but now she cannot get him up and can no longer take him home because "he has declined so much I can't handle him on my own anymore". The wife stated she felt that the residents decline was "normal disease progression". The resident was noted to be awake during the interview with his representative and waving at the surveyor smiling. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:50pm who stated the resident was "always" in his wheelchair "he liked wheeling himself around the halls". During the interview she stated she has not seen the resident in his wheelchair since he returned from the hospital in November. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning.	A BUILDING 345144 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOR ROAD THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY PULL RECULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 was able to wheel himself around the halls. She also stated staff had not attempted to place the resident back into his wheelchair since he returned from the hospital. The representative also stated she was able to assist the resident tack him home because "he has declined so much I can't handle him on my own anymore". The wife stated she felt that the resident was noted to be awake during the interview with his representative and waving at the surveyor smilling. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:50pm who stated the resident was a stated she has not seen the resident in his wheelchair since he returned from the hospital in November. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing, or staff facilitate the resident can be resident to the department of the plan of correction in sefficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, or staff facilitate will audit 20 residents weekly for 4 weet then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, activity provided if resident in room, and if change in mobility it is communicated. This audit will be documented on the Resident Care Aud Tool. The monthory QL committee will review the nead for and/or frequency of continued compliance. The administration of the monthly QL committee to the quarterly executive Q committee for further recommendations and	A BUILDING 345144 B WING STREETADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 was able to wheel himself around the halls. She also stated staff had not attempted to place the resident back into his wheelchair since he returned from the hospital. The representative also stated she was able to assist the resident into his wheelchair by herself and was able to take him home for 2-3 days at a time prior to his fall in November 1 now 1sh example of the progression. The resident was noted to be awake during the interview with his representative and waving at the surveyor smilling. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:50pm who stated the resident was "always" in his wheelchair "he liked wheeling himself around the halls". Unring the interview she stated she has not seen the resident in his wheelchair since he returned from the hospital in November. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning. A BULLIANG STREETADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRECIDENCY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY The monitoring procedure to ensure that the plan of corrected and/or in compliance with the regulatory requirements The director of nursing, or staff facilitator will audit 20 residents weekly for 4 weeks, then 10 residents weekly for 4 weeks,

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345144	B. WING			C 2/01/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/01/2010		
				706 PINEYWOOD ROAD				
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 689	Continued From page	e 44	F 68	39				
SS=D	CFR(s): 483.25(d)(1)	(2)						
	supervision and assis accidents. This REQUIREMENT	esident receives adequate stance devices to prevent is not met as evidenced						
	by: Based on observation, record reviews, family and staff interviews the facility failed to provide supervision to prevent falls for 1 of 3 residents (Resident #54) reviewed for accidents.	ne facility failed to provide at falls for 1 of 3 residents		An acceptable plan of correction contain the following elements: " The plan of correcting the sp deficiency. The plan should addr processes that lead to the deficiency.	pecific ess the			
	Findings include:			cited; " The procedure for implement	•			
	9/19/2016 then re-ad Resident #54 was ad diagnoses including N left Kidney and Rena	Malignant Neoplasm of the I Pelvis, Alzheimer's, Chronic 23. Resident # 54 was		acceptable plan of correction for specific deficiency cited; " The monitoring procedure to that the plan of correction is effect that specific deficiency cited rem corrected and/or in compliance we regulatory requirements; " The title of the person respo	the o ensure ctive and ains vith the			
	11/25/2017 revealed severely impaired. The transfers were scored person assist. The ar	um Data Set (MDS) dated that the resident was ne areas of bed mobility and d extensive with a two eas of toileting and hygiene the with two person assist		implementing the acceptable plate correction. F689 The plan of correcting the specific	n of			
	while bathing was tot person assist. During an interview w	al dependence with one vith a Family Member (FM)		The position of Pine Ridge Nursi Rehabilitation center regarding the	ng and ne			
	on 01/29/2018 at 4pm Saturday Resident #5	n FM revealed that on 54 had a fall from his		process that lead to this deficient to provide supervision to prevent	•			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	B. WING			02/	01/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINE DID	SE HEALTH AND REHAE	RII ITATION CENTER		70	06 PINEYWOOD ROAD		
FINE KIDO	SE REALIN AND RENAL	SILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 45	F	689			
	wheelchair and hit the	e right side of his eye,			communication.		
		ye. FM indicated that it was					
	one nursing aide and				Resident #54 was assessed by nurse of	on	
	residents. FM indicat	ed this is all the time during			1/27/18 after fall with superficial lacerate	tion	
	the weekend and sor	netime during the week.			noted.		
					Resident # 54 was referred to therapy		
	Observation was made on 01/29/2018 at 4:45pm 2/19/18 by facility consultant for seating.		g.				
					The procedure for implementing the		
	•	with a black eye on the right			acceptable plan of correction for the		
side. Resident #54 ap		ppeared to be asleep.			specific deficiency cited		
	Review of incident da	ated 1/27/2018 indicated			On 2/16/18 the facility consultant		
		itting in wheel chair leaning			completed a review of all falls in the pa	st	
		sed. Resident bumped right			30 days for any trends with none noted		
	_	orner of the bed side table			All licensed nurses, and CNAs will be		
	during his fall. Repos	itioned resident three			in-serviced by 3/1/18 by the director of		
	separate occasion pr	ior fall."			nursing, or staff facilitator on providing		
					supervision to prevent falls. No license		
	Review of Resident #				nurse will be allowed to work after 3/1/		
		risk for falls characterized by			until in-service is complete. This in-serv	/ice	
		I to impaired mobility, poor			will be added to the orientation for all		
	use of psychotropic n	naware of safety needs, and			newly hires licensed nurses. The monitoring procedure to ensure the	nt	
	use of psycholiopic i	nedications.			the plan of correction is effective and the		
	During an interview w	vith another Family Member			specific deficiency cited remains correct		
	l	ary 30, 2018 at 11:30 am			and/or in compliance with the regulator		
		ason for so many issues and			requirements	,	
		was because not having					
	enough staff on the h	all to meet the needs of the			The director of nursing, facility consulta	ınt,	
		d that we are here and know			or staff facilitator will audit 100% of falls		
		rsing assistant during the			4 weeks then 50% of falls for 8 weeks	to	
		state was here we got two			observe any trends related to lack of		
		back we will be down to			supervision. This audit will be		
	one."				documented on the fall audit tool.		
	During an interview w	vith Nursing Assistant (NA)			The monthly QI committee will review t	he	
		2018 at 1pm, she indicated			results of the fall audit tool monthly for		
	_	ne unit but was not assigned			months for identification of trends, action		
		#50 had no knowledge of			taken, and to determine the need for		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUI COMPLET		
		345144	B. WING		0,	C 2/01/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD	02	20172016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	2018at 1:15pm. Indict to any resident becar and following the oth did not observed Resident prevents a property of the country	vith NA #53 on January 31, cated she was not assigned use she was in orientation er NAs. NA #53 revealed she sident #54 on Saturday. view with Nursing Assistant y 31, 2018 at 1:30pm s not assigned to Resident #51 revealed that she fter his incident. vith Nurse # 5 on January 31, we indicated that she recalled alling her to Resident #54 erved Resident# 54 falling Nurse #5 revealed she sotified his family. Nurse #5 at worked on the hall but no was assigned to Resident with the Director of Nursing 1, 2018 at 11am revealed she information, had just got this go. DON indicated she was not #54 fall during the	F 68	and/or frequency of continued and make recommendations for monitoring for continued complete administrator and/or DON will provide findings and recommendations monthly QI committee to the quexecutive QA committee for fur recommendations and oversight. The title of the person responsi implementing the acceptable placorrection. The Director of nursing is responsi implementing the acceptable placorrection.	r iance. The present the of the parterly ther of. ble for an of	

IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
345144	B. WING		C 02/01/2018			
ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	•			
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE COMPLETION			
neet all the resident's needs. Itaff (1)(2) Int Staff. In Staff		An acceptable plan of correctic contain the following elements The plan of correcting the	specific			
	IDENTIFICATION NUMBER:	ABILITATION CENTER STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) TAG THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFY TAGE THE STATEMENT OF THE STATEMENT TAGE THE ST	ABILITATION CENTER 345144 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360 STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FUIL. R LSC IDENTIFYING INFORMATION) GREAT BE 47 Beet all the resident's needs. Staff I)(2) Int Staff. Ve sufficient nursing staff with petencies and skills sets to It related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by this and individual plans of care renumber, acuity and cillity's resident population in the facility assessment required acility must provide services rs of each of the following on a 24-hour basis to provide esidents in accordance with sevel under paragraph (e) of di nurses; and resonnel, including but not ass. pt when waived under se section, the facility must di nurse to serve as a charge of duty. An acceptable plan of correcting contain the following elements: "The plan of correcting the deficiency. The plan should ad	ABILITATION CENTER 345144 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27380 STATEMENT OF DEFICIENCIES BITCHMASVILLE, NC 27380 PREFIX TAG STATEMENT OF DEFICIENCIES BITCHMASVILLE, NC 27380 PROVINCIES BEPRECEDED BY THULL LES DENTIFYING INFORMATION) THOMASVILLE, NC 27380 PROVINCIES BEPRECEDED TO THE SPROPRIATE CROSS REFERENCE TO THE SPROPRIATE DEFICIENCY) THOMASVILLE, NC 27380 PROVINCIES TALAN OF CORRECTION CROSS REFERENCE TO THE SPROPRIATE CROSS REFERENCE TO THE SPROPRIATE DEFICIENCY) THE STATEMENT OF DEFICIENCY THOMASVILLE, NC 27380 PROVINCIES TALAN OF CORRECTION CROSS REFERENCE TO THE SPROPRIATE CROSS REFERENCE TO THE SPROPRIATE DEFICIENCY 3/1/18 THE STATEMENT OF THE SPROPRIATE CROSS REFERENCE TO THE SPROPRIATE DEFICIENCY 3/1/18 3/1/18 THE STATEMENT OF THE SPROPRIATE CROSS REFERENCE TO TH		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		345144	B. WING _			/01/2018	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				706 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND RE	HABILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 725	Continued From p	page 48	F 7	25			
	incontinence care	, toileting, get residents up and		cited;			
	snack for residen	ts who required assistance. This		" The procedure for implem	enting the		
	affected 10 of 32	residents. (Resident #33,		acceptable plan of correction f	or the		
		sident #45, Resident #51,		specific deficiency cited;			
		sident #71, Resident #74,		" The monitoring procedure			
		sident #124 and Resident		that the plan of correction is ef			
	#403).			that specific deficiency cited re			
				corrected and/or in compliance	e with the		
	Findings included	:		regulatory requirements;			
	5504 D	1. 66. 1		" The title of the person res	•		
		ecord review, staff interviews,		implementing the acceptable properties.	plan of		
		s and resident observations the		correction.			
		ovide 1 of 3 residents (resident f when to be out of bed and		F725			
	· ·	of 3 residents (Resident #45		1725			
		showers for two and a half		The plan of correcting the spe	cific		
		ewed for activities of daily living		deficiency	5.11.6		
		o honor a resident's choice to					
		e dining room for 1 of 3 residents		The position of Pine Ridge cer	nter		
		ces (Resident # 124).		regarding the process that lea			
				deficiency-failed to provide nu	rsing staff of		
	F600 Based on r	esident interview, staff		sufficient quantity to provide st	affing of		
	interviews, reside	nt observation and record		sufficient quantity and quality t	o honor		
	review the facility	failed to provide incontinence		resident choices, provide supe	rvision to		
		npled residents (Resident #71)		prevent accidents, provide inc			
	•	ensive assistance and who		care, toileting, get residents up			
		nence care on 2 different		for residents who require assis	stance was		
	occasions becaus	se she had soiled herself.		failure to communicate.			
	F677 Based on re	esident observation, resident		Resident #54 was assessed b	y nurse on		
		erview and staff interview the		1/27/18 after fall with superfici	•		
		ovide Activities of Daily Living		noted.			
	(ADL) care, incon	tinence care for 1 of 1 residents		Resident #38 was not observe	d up in		
	(resident #51).			wheelchair per resident repres	entatives		
	F684 Based on re	ecord review, resident		Resident # 54 was referred to	therapy on		
		resident representative interview		2/19/18 by the facility consulta			
	and staff interview	vs the facility failed to have the		seating.			
	resident up daily i	n his wheelchair for 2 months		On 2/16/18 the facility consulta	ant		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345144	B. WING		0.0	C 2/01/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	02	2/01/2016	
TO UNE OF TH	TO VIDER OR OUT FEET			706 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER					
				THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LECTION (SECTION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From pag	ge 49	F 72	5			
		e resident with activities ent sleeping all day for 1 of 1 f38).		observed resident # 71 at 730am and 9am. Resident was not soile had no visible or olfactory signs incontinence noted.	d and		
	family and staff interprovide supervision residents (Resident F809 Based on obsefamily, staff and resifailed to offer or deliversidents (Resident Resident #73). An observation of the revealed there were present to care for 2 100 hall. There was residents on the 200 present to care for 2 and 1 NA present to	ervation, record reviews, views the facility failed to to prevent falls for 1 of 3 #54) reviewed for accidents. ervations, record reviews, dent interviews the facility ver bedtime snacks to 3 of 3 # 403, Resident # 124, and e facility on 1/28/2018 at 4pm was 1 nursing assistant (NA) 4 residents residing on the 1 NA present to care for 27 hall. There was 1 NA 6 residents on the 300 hall care for 27 residents on the 1 NA on the 500 hall with 27		incontinence noted. On 2/16/18 the facility consultant observed resident # 51 at 730am and 9am. Resident was not soile had no visible or olfactory signs incontinence noted. By 2/27/18 resident # 45 will recesshower. On 2/1/18 and 2/12/18 resident # observed out of bed per resident by LPN. On 2/6/18 resident # 80 received shower. On 2/2/18, 2/5/18, 2/8/18, 2/12/1 2/13/18, 2/14/18, 2/20/18, 2/23/1 resident # 124 was observed by eating diner in the dining room president preference. Resident #430 was offered a bed	n, 815am, ed and of eive a # 45 was choice I a 8, 8 GCAs er		
	An interview on 1/28 revealed "oh my god state is here." Nurse 400 hall has 27 resid #41 stated that there take care of the resid We just do what we An interview on 1/28 who worked on the 4 just does the best sh NA on the hall. She working like this for state of the province of the pro	3/2018 Nurse #41 at 4:10 pm d we are short staff and the e #41 indicated the NA on this dents by herself. The Nurse e just was not enough staff to dents the way they should. can around here. 3/2018 at 4:15 pm with NA #4 400 hall indicated that she he can when she is the only indicated that she had been six months. NA #4 indicated ing the week as well.		snack and accepted on 2/2/18. Resident #124 was offered a bed snack in the dining room and acc 2/2/18. Resident #74 was offered a bed snack but refused on 2/2/18. The procedure for implementing acceptable plan of correction for specific deficiency cited On 2/16/18 the facility consultant completed a review of all falls in 30 days for any trends with none On 2/16/18 the facility consultant completed an interview with interesidents to ensure residents are	dtime cepted on time the the tthe a the past a noted. tryiewable		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45444				С	
		345144	B. WING			2/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DINE DID	SE HEALTH AND REHAE	RII ITATION CENTER		706 PINEYWOOD ROAD			
FINE KIDO	DE HEALIH AND KEHAL	SILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX		SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	APPROPRIATE	DATE	
F 725	Continued From page	e 50	F 72	25			
				out of bed per preference with	no negative		
	An interview occurre	d with the nursing assistant		findings not already addressed	-		
		at 3:10pm. NA #53 stated		On 2/24/18 the administrator a			
		ave the residents their		last 60 days of concerns with t			
		she did try to give the		resident choice to get out of be			
		when they receive their		activities. Five grievances were			
		e so many to do I can't		regarding resident choice to ge			
	always give them a c	hoice". NA #53 indicated we		and activities. All five have been	en resolved.		
	are short staff here a	nd need more help to		On 2/16/18 the facility consulta	ant		
	address the needs of	the residents.		observed all non-interviewable	residents		
				for visible or olfactory signs of			
	On January 31, 2018	at 8:55 am an observation		incontinence at 830am with 3 r	esidents		
	of 500 hall; family me	ember had reported that		noted soiled. At 845am affecte	d residents		
	there was only 1 NA	on the floor to serve and		were being provided incontine	nt care by		
	feed all of the resider	nt breakfast. Family member		facility staff.			
		got her this morning around		On 2/16/18 the facility consulta			
	8:15 there was only 1	NA on the 500 hall; stated		observed and interviewed all u	nreviewable		
	when the breakfast tr	ays came out she went and		residents regarding incontinen	ce with no		
		e weren't enough staff to		negative findings noted.			
		dents. She told them she was		On 2/9/18 the facility consultar			
		state) look at this and once		interviewed all interviewable re			
		ey started sending all kinds		regarding their ability to get up	-		
		nelp with breakfast. Stated		choose. No additional negative	e findings		
		the time. Added that they will		noted.			
		the hall, but they can't feed		On 2/24/18 the administrator a			
		ened liquids, which a lot of		last 60 days of concerns with t			
		hall are on. Stated that she		resident choice to get out of be			
	•	y times about the lack of		location. Five grievances were	•		
	_	pacts care and all the facility		regarding resident choice to ge			
		working on it and trying to		and dining location. All five grid	evances		
	hire people".			were resolved.	ama mandarres el		
	On January 04, 0040	ot 0:00 AM during an		On 2/16/18 the facility consulta			
	On January 31, 2018 at 9:00 AM during an			residents in facility for showers			
		#55 stated he usually works		the last 7 days for showers pro			
	on second shift, only			resident preference. All negative	_		
		one NA was on the 500 halling. Stated 2nd NA was		will be addressed by facility sta	ян бу		
		at 8 -8:30 am but she was		3/1/18. On 2/16/18 during the morning	moal the		
	not at facility yet. Sta			facility consultant spoke intervi			
	inot at identity yet. Ote	ALGG TIG DOILG VGG UTG	1	admity domaditant spoke intervi	CHADIC	1	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345144	B. WING			1	01/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	am. He had reported was only 1 NA on the are 10 plus residents meals. On January 31, 2018 interview with Nursin was a NA for the 500 Stated she was the of the other NA didn't of there was supposed Stated she floats on was trying to get resicame out around 7:4 there are around 12 Stated she really did typically was on the lonly worked on this confidence of the confidenc	to his supervisor that there is hall. Stated he thinks there is that need to be fed their B at 9:20 am during an g Assistant #85 stated she hall; she started at 7:00 am. only NA and didn't know why ome in. She wasn't sure if to be a GCA there or not. different units. Stated she dents up; the breakfast trays 5 am. Stated she believes residents that have to be fed. n't know how the staffing hall because she floats and	F	725	residents to ensure they were having min location of choice with no negatives noted. On 2/16/18 the facility consultant completed an interview with interviewal residents to ensure residents are pleas with their snacks, no additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus snacks. No significant findings were noted. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on residents must be offered snacks including bedting snacks. No licensed nurse or CNA will allowed to work after 3/1/18 until in-service is complete. This in-service where added to the orientation for all newly hired licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion providing supervision to prevent falls. No licensed nurse will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hires licensed nurses. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on complete. This in-service will be added to the orientation for all newly hires licensed nurses. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion residents should be out of bed daily unless they choose differently, resident should be provided with activity to provimulation, and a change in resident mobility must be communicated. No licensed nurse or CNA will be allowed to the orientation for the communicated. No licensed nurse or CNA will be allowed to the orientation for the communicated.	ble ed e e of me e vill / n lo	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345144	B. WING			02/) 01/2018
NAME OF P	ROVIDER OR SUPPLIER	5.6.1.1	1 1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	02/	01/2016
TVAIVIL OF T	NOVIDER OR GOLT EIER			706 PINEYWOOD ROAD	-		
PINE RIDO	SE HEALTH AND REHAE	SILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 725	Continued From page	÷ 52	F 7	work after 3/1/18 until in-service complete. This in-service will the orientation for all newly hir nurses and CNAs. All licensed nurses and CNAs in-serviced by 3/1/18 by the dinursing, or staff facilitator on reproviding incontinent care prolicensed nurse or CNA will be work after 3/1/18 until in-service completed. This in-service will to the orientation process for a licensed nurses and CNAs. All licensed nurses and CNAs in-serviced by 3/1/18 by the dinursing, or staff facilitator on rechoice including resident right when to be out of bed, showed preferences, and dining location licensed nurse or CNA will be work after 3/1/18 until in-service completed. This in-service will to the orientation process for a licensed nurses and CNAs. On 2/2/18 the facility consultation-serviced the administrator and for nursing on staffing must be honor resident choices, provide supervision to prevent accider incontinent care, toileting, get up, and provide snacks. The monitoring procedure to enthe plan of correction is effecting specific deficiency cited remainand/or in compliance with the requirements	will be irector of esident mptly. No allowed to ce I be added all new will be irector of esident to choose roon. No allowed to ce I be added all new ont ce I be added all new ont esident to choose roon. No allowed to ce I be added all new ont esidents ensure that ive and the ins corrections or corrections.	ed oo d or e to de at eat	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345144	B. WING			C 02/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2016
PINE RID	GE HEALTH AND REHA	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From pag	e 53	F	725	The director of nursing, or staff facilitate will audit 100% of falls x 4 weeks then 50% of falls for 8 weeks to observe any trends. This audit will be documented of the fall audit tool. The director of nursing, or staff facilitate will audit 20 residents weekly for 4 weeks then 10 residents per week for 8 weeks ensure resident out of bed per resident choice, activity provided if resident in room, and if change in mobility it is communicated. This audit will be documented on the Resident Care Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks resident is clean and dry. This audit will be documented on the Reside Care Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks to ensure showers were given a appropriate equipment available to accommodate resident need. This audit will be documented on the Resident Ca Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks to ensure resident need. This audit will be documented on the Resident Ca Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly 4 weeks, then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, showers were given per resident choice, and resident dining in area of choice. This audit will be	on or ks, s to it a for ent a for r for	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING				C 01/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010
				706 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND REHAB	BILITATION CENTER			HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 725	Drugs and biologicals	d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be with currently accepted		725	documented on the Resident Care Aud Tool. The administrator or director if nursing review staffing 5 times weekly to includ weekend staffing to ensure staffing is adequate to ensure residents are out obed per choice, showers are given per resident choice, and residents are abledine in location of choice. This audit wibe documented on the sufficient staff audit tool. The monthly QI committee will review the results of the resident care audit tool, for audit tool, and sufficient staff audit tool. The months for identification of trends, actions taken, and to determine the new for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will presente findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	will le f to ll he all for ed ns e. sent	3/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345144	B. WING _		l	C 01/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		01/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 761	F 761 Continued From page 55		F 7	761		
	appropriate accessor instructions, and the applicable.	ry and cautionary expiration date when				
	§483.45(h) Storage of	of Drugs and Biologicals				
	§483.45(h)(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. §483.45(h)(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					
	facility failed to prope medications and unla in 2 out of 2 medicati hall medication stora storage room that is and 400) that are use the residents of the f Findings include: 1. a. An observation at 12:21pm in the me supplies the 100, 200 Nurse #1 present. In	ons and staff interviews, the erly dispose of expired abeled, opened medications ion storage rooms (the 500 ge room and the medication used for halls 100,200, 300, ed to supply medications for acility. In was conducted on 1/31/18 edication storage room that 0, 300, and 400 halls with the locked box for narcotics, I of Morphine 10mg/ml had a		An acceptable plan of correct contain the following element. "The plan of correcting the deficiency. The plan should a processes that lead to the decited; "The procedure for impler acceptable plan of correction specific deficiency cited; "The monitoring procedure that the plan of correction is eather that specific deficiency cited recorrected and/or in compliance regulatory requirements; "The title of the person resimplementing the acceptable	s: e specific ddress the ficiency menting the for the e to ensure effective and remains be with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 2/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/01/2010
				706 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 56	F 76	51		
	•	ation date of October 2017. e vial to be discarded. In		correction.		
	•	Humalog vials were open n the vials as to when they		F761		
	with no date noted on the vials as to when they were opened. Nurse #1 removed the vials to be discarded. Two PPD (Purified Protein Derivative) vials were observed to be open with no open date noted on either vial. Nurse #1 removed the vials to be discarded. An observation was made that revealed a pneumococcal vaccine had a manufacturer's expiration date of 1/17/18. Nurse #1 removed the vial to be discarded. b. An observation was conducted on 1/31/18 at 2:50pm in the medication storage for the 500 hall with Nurse #2 present. An observation revealed seventeen pneumococcal vaccine vials			The plan of correcting the spec deficiency	ific	
				The position of Pine Ridge Nur Rehabilitation center regarding process that lead to this deficie to properly dispose of expires unlabeled, opened medication medication storage rooms- wa failure to follow policies for labo opened medication and proper expired medication.	y the ency-failure and s in 2 of 2 s the staff eling of	
	1/17/18. Nurse #2 red discarded. In the cab	eture expiration date of moved the vials to be inet, it was revealed three what were opened but not boved the vials to be		On 1/31/18 the staff nurse rem of expired morphine, two Human which were open with dates, to protein derivative (PPD) vials, pneumococcal vaccine from the medication storage room 1 and	alog vial vo purified one expired e	
	1/31/18 at 12:40pm. nurse reported that a be dated with the dat opened. Nurse #1 re reach the manufactur be discarded. She re of the nurses, medica	During the interview, the ll opened medications are to e the medication was exported all medications that rer's expiration date are to exported it is the responsibility ation aides, and pharmacist on dates of the medications rage rooms.		of per facility policy. On 1/31/18 the staff nurse rem seventeen expired pneumococ vaccines, and three open but uvials of sterile water and disportacility policy. The procedure for implementing acceptable plan of correction for specific deficiency cited	noved ecal undated sed of per ng the or the	
	1/31/18 at 2:55pm. D reported it is the nurs should be checking the	rse #2 was conducted on uring the interview, Nurse #2 es and pharmacists that he manufacturing expiration ions in the medication		On 2/9/18 the facility consultar completed an audit of both me storage rooms including refrige cabinets. All expired, and oper undated medications were disper facility policy.	dication erators, and n but	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		PLETED
		345144	B. WING			C 02/01/2018	
	ROVIDER OR SUPPLIER BE HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		1 02/	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	medications should reported all expired discarded by the exp. An interview with the conducted on 2/1/18 administrator reporte medications that are date opened. During administrator reporte the nursing staff and medications in the si	e #2 reported all opened be dated with open date. He medications should be biration date. e Administrator was at 4:00pm. The ed it is her expectation that all e opened are labeled with the	F	761	On 2/2/18 an in-service was started by staff facilitator (SF) on labeling of open medications, and removal disposal of expired medications per facility policy fall licensed nurses. This in-service will complete by 3/1/18. This in-service will included with orientation for all newly hicensed nursing staff. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of medication storage rooms weekly x 4 weeks then 50% weekly x 8 weeks to ensure no expired or open but undated medication are present. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 3 months for identificated of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrational and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive QI committee to the quarterly executive QI committee for further recommendations and oversight.	ed or be be ired at nat cted y a ns he ion ine	
					The title of the person responsible for implementing the acceptable plan of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVE	ΞΥ	
		345144	B. WING _		02/01/20	18
	ROVIDER OR SUPPLIER BE HEALTH AND REHAE	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	, 32/3/120	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	(X5) PLETION PATE
F 761	Continued From page 58 Menus Meet Resident Nds/Prep in Adv/Followed		F 7	correction. The Director of nursing is respo implementing the acceptable placorrection.		
F 803 SS=F	Menus Meet Resider CFR(s): 483.60(c)(1)		F8	03	3/1/1	8
	§483.60(c) Menus ar Menus must-	nd nutritional adequacy.				
	. ,,,,	he nutritional needs of nce with established national				
	§483.60(c)(2) Be pre	pared in advance;				
	§483.60(c)(3) Be follo	owed;				
	reasonable efforts, the ethnic needs of the re	t, based on a facility's ne religious, cultural and esident population, as well as esidents and resident				
	§483.60(c)(5) Be upo	dated periodically;				
		iewed by the facility's cally qualified nutrition tional adequacy; and				
	construed to limit the personal dietary choi This REQUIREMENT by: Based on observation	r is not met as evidenced ons, record reviews, staff and the facility failed to follow the		An acceptable plan of correctio contain the following elements: " The plan of correcting the s		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С		
		345144	B. WING _			۰۵	2/01/2018	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	270 1720 10	
					06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND RE	HABILITATION CENTER			HOMASVILLE, NC 27360			
	01111111	V 07475M5M7 05 D55(0)5M0/50			·			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 803	Continued From p	page 59	F 8	803				
	provided were no	t of similar nutritional value as			deficiency. The plan should address th	ne		
	•	ı. This was evident in 1 of 2			processes that lead to the deficiency			
	meals observed.				cited;			
					" The procedure for implementing t	he		
		e kitchen on Sunday January			acceptable plan of correction for the			
		om revealed the planned menu			specific deficiency cited;			
		al was cream of potato soup,			" The monitoring procedure to ensu			
		ndwich melt, tator tots, beet &			that the plan of correction is effective a	and		
	onion salad and F	lawalian iruit cup.			that specific deficiency cited remains corrected and/or in compliance with the	ι Δ		
	During an intervie	w with Cook #1 at 4:40 pm on			regulatory requirements;	C		
		she revealed she didn't see any			" The title of the person responsible	e for		
		available in the kitchen to			implementing the acceptable plan of			
	make the ham & o	cheese melt so she substituted			correction.			
	chicken salad. Co	ook #1 also indicated she only						
		eets and no onions so she			F803			
	_	beans for this. She stated she						
		er supervisor about the menu			The plan of correcting the specific			
	_	had not written the changes on titution log. Cook #1 added that			deficiency			
		king at the facility about 3			The position of Pine Ridge Nursing an	ıd		
		etimes she had to change the			Rehabilitation center regarding the	ŭ		
		e food wasn't available.			process that lead to this deficiency-fail	led		
					to follow the planned menu and the fo			
		w with Dietary aide #1 at			substitutions provided were not of sim-	ilar		
		ry 28, 2018 she stated "the			nutritional value as the planned meal.			
	kitchen is always	running out of food."						
	A	00.0040.6			On 2/16/18 the facility consultant			
		rvation on January 28, 2018 of ervice at 4:50pm until 7pm. The			observed the breakfast menu which w	as		
		bowl behind the steam table.			served according to menu. The procedure for implementing the			
		n table, green beans, tator tots,			acceptable plan of correction for the			
		atballs, and soups. Saltine			specific deficiency cited			
		cup was also on the side of			,			
	steam table.				On 2/20/18 the dietary consultant			
					in-serviced the dietary manager on 1.			
		g the plating of the resident's			Following the approved menu, 2. If			
		n salad ran out and was			needed following the substitutions lists			
	substituted with tu	ına salad. At 6:10pm the green			and 3. Ensuring food items needed to			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII	1 0		1	С	
		345144	B. WING _			1	01/2018	
NAME OF P	ROVIDER OR SUPPLIER	_		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010	
					6 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND RE	HABILITATION CENTER			HOMASVILLE, NC 27360			
(VA) ID	SLIMMAD	V STATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 803	Continued From p	page 60	F 8	F 803				
	beans ran out and	I were replaced with corn			provide approved menu were available	in		
		ed cream style type corn that			the facility.			
	was fried). At 6:40) pm the corn nuggets ran out			On 2/20/18 the dietary manager			
	and were replaced	d with vegetable sticks (a			in-serviced the dietary staff on 1.			
		f mixed vegetables that were			Following the approved menu, 2. If			
		kers that were being served to			substitutions are needed the correct			
		ant ran out and a slice of bread			process, and 3. When to notify the diet	ary		
		meal trays. There were 30			manager when food items are not			
	,	rs served with no bread,			available. This in-service will be compl			
	crackers or bread	alternative.			by 3/1/18. The in-service will be part of	tne		
	During an intervie	w with Posidont #62 on January			orientation process for all newly hired dietary staff.			
	_	w with Resident #62 on January ne revealed that the dinner he			dictary stair.			
		t was cold and nasty. Resident			The monitoring procedure to ensure th	at		
	_	cannot eat fish and he was			the plan of correction is effective and the			
		s tray. Resident # 62 indicated			specific deficiency cited remains corre			
		on the menu for tonight.			and/or in compliance with the regulator			
		-			requirements			
		w with Resident #33 on January						
		om she revealed her dinner was			The dietary manager, or administrator			
		ked like milk and like nothing.			observe 5 meals weekly x 12 weeks to			
	Resident #33 stat	ed 'What a dinner."			ensure meals are provided according t			
					approved menu. This audit will occur o			
	_	w with Resident #74 on January			random days, at different meal times.			
		om she revealed the food was ke it was thrown together.			audit will be documented on the menu			
		cated she was looking forward			audit tool. The monthly QI committee will review to	the		
		and cheese sandwich that was			results of the menu audit tool monthly			
	_	onight but she received tuna			3 months for identification of trends,	IOI		
	salad instead.	ornight but one received tand			actions taken, and to determine the ne	ed		
					for and/or frequency of continued			
	During an intervie	w with Resident #430 on			monitoring, and make recommendation	ns		
	_	at 8 am she revealed her meal			for monitoring for continued compliance			
	· ·	vered to her last night (Sunday,			The administrator and/or DON will pres			
	January 28, 2018). Resident #430 indicated that			the findings and recommendations of t	he		
		I not lukewarm but cold and so			monthly QI committee to the quarterly			
		s. She was unsure what the			executive QA committee for further			
		ut it was cold. Resident #430			recommendations and oversight.			
	also indicated that	t on Friday night January 26,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345144	B. WING				C /01/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360			0112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 803	2018 she did not rece Resident #430 was to food. She stated she 8:00 pm. Resident #4 have that the facility of the night since her plant During an interview wa 2018 at 9:30 am she should be held and si temperatures. The Different food should not be put same time to hold the stated she wanted all satisfied with their me their food would be sic correctly. The DM als the cook follow the pl That if a menu substi	eive a dinner tray at all. old the kitchen ran out of received a sandwich after 430 also indicated that she does not offer snack during acement on Friday. with the DM on January 29, revealed that all foods	F	803	The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible timplementing the acceptable plan of correction.	or	
F 804 SS=F	nutritional value. During an interview w February 1, 2018 at 4 expectation that all m were palatable and a temperature. Nutritive Value/Appea CFR(s): 483.60(d)(1) §483.60(d) Food and Each resident receive §483.60(d)(1) Food p conserve nutritive val	ar, Palatable/Prefer Temp (2)	F	804			3/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0.0177		STREET ADDRESS, CITY, STATE, ZIP COI	•	2/01/2018	
NAME OF T	NOVIDEN ON 301 1 EIEN			706 PINEYWOOD ROAD	JL		
PINE RIDO	GE HEALTH AND RE	HABILITATION CENTER					
	ı			THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 804	Continued From page 62		F 80	04			
	attractive, and at	a safe and appetizing					
	temperature.	3					
		ENT is not met as evidenced					
	by:						
	_	ations, record reviews, resident		An acceptable plan of correct	ction must		
	and staff interview	s the facility failed to serve food		contain the following elemen	ts:		
		e and at an acceptable		" The plan of correcting th	ie specific		
		of 5 residents (Resident #32,		deficiency. The plan should a			
		sident #62, Resident #72 and		processes that lead to the de	eficiency		
		nat were reviewed for food		cited;			
	palatability.			" The procedure for imple			
		_		acceptable plan of correction	for the		
	Findings included	:		specific deficiency cited;	ro to onouro		
	An observation w	as made of the steam table in		" The monitoring procedule that the plan of correction is			
		nuary 28, 2018 at 4:25pm. The		that specific deficiency cited			
		already on the steam table and		corrected and/or in complian			
		she had placed the food on the		regulatory requirements;	oc war are		
		30pm. Cook #1 stated the soup		" The title of the person re	esponsible for		
		en placed on the steam table for		implementing the acceptable			
	_	hour to cook. She also stated		correction.	•		
	that she usually to	ook the food temperatures					
	around 4:30 to 4:4	45 pm. Cook #1 started taking		F804			
		ures but she left during the					
	•	Dietary Manager (DM)		The plan of correcting the sp	ecific		
		the temperatures using a		deficiency			
		meter. The temperatures were:					
		degrees F, tuna salad 38		The position of Pine Ridge N	•		
		ots 145 degrees F, soup 204		Rehabilitation center regarding	•		
	_	ed potatoes 163 degrees F,		process that lead to this defic	•		
		grees F, corn nuggets 163		to serve food that was palata	ible and at an		
	uegrees r and gr	een beans 163 degrees F.		acceptable temperature.			
	Δ test tray was no	epared at 6:34 pm on January		On 2/16/18 the facility consu	Itant		
		kitchen steam table and		observed the breakfast meal			
		of tots, corn nuggets, cream of		served according to menu, a			
		salad and tropical fruit. The test		tray was served to hall at 910			
	1	to the 200 hall with 15 resident		reported his food was warm			
		pm. The last resident meal tray		good.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _				01/ 2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	0.720.10	
				7	06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER		Т	HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 804	1.3		F 8	304				
					The procedure for implementing the acceptable plan of correction for the specific deficiency cited			
	temperatures were: nuggets 96.5 degree 119 degrees F, and food items were tast surveyor. The tator t corn nuggets tasted greasy, the cream o and tasted warm, the cool. During an interview 28, 2018 at 7:35 he received that night w #62 indicated he can served tuna on his to that tuna was not or During an interview	teter. The internal food tator tots 103 degrees F, corn es F, cream of potato soup tuna salad 53 degrees F. The ed by the Administrator and ots tasted barely warm, the cool, were chewy and f potato soup was very thin e tuna salad and fruit tasted with Resident #62 on January revealed that the dinner he was cold and nasty. Resident mot eat fish and he was ray. Resident # 62 indicated the menu for tonight.			On 2/20/18 the dietary consultant in-serviced the dietary manager on 1. In process for placing food onto the steam table to maintain food temperatures, 2. Food quantity will be sufficient to serve residents, 3. Trays will be served at the appropriate temperature. On 2/20/18 the dietary manager in-serviced the dietary staff on 1. The process for placing food on the steam table to maintain temperature, 2. The need temperatures for each food type, Quantity must be sufficient to feed all residents, 4. Trays must be served time and according to the established meal schedule. This in-service will be comp by 3/1/18. The in-service will be part of orientation process for all newly hired dietary staff.	all		
	cold, the soup looked like milk and like nothing. Resident #33 stated 'What a dinner." During an interview with Resident #32 on January 28, 2018 at 7:45 pm she revealed her dinner was "cold and nasty, nothing good." During an interview with Resident #74 on January 28, 2018 at 7:57 pm she revealed the food was cold and looked like it was thrown together. Resident #74 indicated she was looking forward to having the ham and cheese sandwich that was on the menu for tonight but she received tuna salad instead. During an interview with Resident #430 on				The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The dietary manager, or administrator observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature and food is palatable. This audit will occur on random days, at different meal times. This audit will be documented on the menu audit tool. The monthly QI committee will review the results of the menu audit tool monthly of th	nat cted ry will ble s		

l l		
345144 B. WING_		C 02/01/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	02/01/2016
DINE DIDGE HEALTH AND DEHABILITATION CENTED	706 PINEYWOOD ROAD	
PINE RIDGE HEALTH AND REHABILITATION CENTER	THOMASVILLE, NC 27360	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 804 Continued From page 64 January 29, 2018 at 8 am she revealed her meal was cold when severed to her last night (Sunday, January 28, 2018). Resident #430 indicated that the soup was cold not lukewarm but cold and so were the tator tots. She was unsure what the other item was, but it was cold. Resident #430 also indicated that on Friday night January 26, 2018 she did not receive a dinner tray at all. Resident #430 was told the kitchen ran out of food. She stated she received a sandwich after 8:00 pm. During an interview with the DM on January 29, 2018 at 9:30 am she revealed that all foods should be held and served at the required temperatures. The DM also indicated that all the food should not be put on the steam table at the same time to hold the temperatures. The DM stated she wanted all of the residents to be satisfied with their meals and she expected that their food would be served hot and cooked correctly. During an interview with the Administrator on February 1, 2018 at 4:30 pm she stated it was her expectation that all meals were served timely, were palatable and at an appropriate temperature. F 809 SS=D Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) \$483.60(f) Frequency of Meals \$483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	3 months for identification of trends, actions taken, and to determine the new for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible from the implementing the acceptable plan of correction.	ns e. sent ne

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		345144	B. WING _			C 02/01/2018		
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP COL	ΣE	, 02/		
DINE DID	SE HEALTH AND REHAE	RII ITATION CENTED		706 PINEYWOOD ROAD				
PINE KIDO	SE REALIN AND RENAL	SILITATION CENTER		THOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 809	Continued From page 65 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 3 of 3 residents (Resident # 403, Resident # 124, and Resident #74). Finding included:		F 8	An acceptable plan of correct contain the following element "The plan of correcting the deficiency. The plan should a processes that lead to the decited; "The procedure for implest acceptable plan of correction specific deficiency cited;	etion must ts: e specific address the ficiency menting th for the	e ne		
	passing out snack an	Opm, no one was observed d/or offering Residents n the 200 hall, 300 hall and		" The monitoring procedur that the plan of correction is a that specific deficiency cited corrected and/or in compliand regulatory requirements;	effective ar remains	nd		
	During an interview with Resident #74 on Janua 28, 2018 at 7:57 pm he revealed the food was cold and looked like it was thrown together. Resident #74 indicated he was looking forward having the ham and cheese sandwich that was on the menu for tonight but he received tuna salad instead. During a second interview with Resident #74 on			" The title of the person re implementing the acceptable correction. F809 The plan of correcting the spedeficiency	plan of	for		
		3:30pm, he revealed that		The position of Pine Ridge N	ursing and	t		

I` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _				C 01/2018	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010	
				70	06 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER			HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 809	F 809 Continued From page 66		F	809				
	night. "We need more wait for everything ar	d or passed out during the e staff here." We have to ound here. Resident #74 that the facility was low on			Rehabilitation center regarding the process that lead to this deficiency-fail to offer or deliver bedtime snacks is knowledge deficit.	ure		
	snacks left in her roomer Resident #124 up in 18:35pm. Second observation in January 28, 2018 at 9:10pm in passed out between a revealed that dinner whave one Nursing Assimore staff." During an interview whave cold when sever January 28, 2018). Resident was cold nowere the tator tots. So other item was, but it also indicated that one 2018 she did not received the sound was total she did not received the she	ent #124's room revealed no m, observation revealed bed and looking around at n Resident #124's room on oppm revealed no snacks left with Nurse #22 on January evealed that snacks are 8pm and 9pm. Nurse #22 was late tonight and we only sistance. "We just need with Resident #430 on 8 am she revealed her meal ed to her last night (Sunday, esident #430 indicated that at lukewarm but cold and so he was unsure what the was cold. Resident #430 in Friday night January 26, eive a dinner tray at all. old the kitchen ran out of received a sandwich after			Resident #430 was offered a bedtime snack and accepted on 2/2/18. Resident #124 was offered a bedtime snack in the dining room and accepted 2/2/18. Resident # 74 was offered a bedtime snack and refused on 2/2/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed an interview with interviewa residents to ensure residents are pleas with their snacks, no additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus snacks. No significant findings were noted. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on residents must be offered snacks including bedti snacks. No licensed nurse or CNA will allowed to work after 3/1/18 until in-service is complete. This in-service	ble sed re ne s of me be		
	not offered her snack placement on Friday. During an interview of	Indicated that the facility had as during the nights since her on January 29, 2018 at 9am ar who indicated that we are			be added to the orientation for all newl hired licensed nurses and CNAs. The monitoring procedure to ensure th the plan of correction is effective and the specific deficiency cited remains correction in compliance with the regulator requirements	at nat cted		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345144	B. WING _		_	C 02/01/2018
	ROVIDER OR SUPPLIER BE HEALTH AND REHAE	ILITATION CENTER		STREET ADDRESS, CITY, STA 706 PINEYWOOD ROAD THOMASVILLE, NC 2736		02/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·		
F 809	indicated that she had Residents to get bedt that "we only have on get to your relatives at During an interview was January 29, 2018 at 9 snack are prepared of facility and the NA on passing out the snack and 9pm. During an interview was February 1, 2018 at 4	night for my relative. FM d asked several time for ime snacks and was told e NA on the hall and she will s soon as possible." with Dietary Manager on 0:30 am, she revealed that daily for all residents in the the hall are responsible for c on the hall between 8pm	F8	The director of nurs will audit 20 resident then 10 residents per ensure resident is on This audit will be done Resident Care Audit The monthly QI compresults of the reside monthly for 3 month trends, actions take the need for and/or continued monitorin recommendations for continued compliant and/or DON will preprecommendations or committee to the quecommittee for further and oversight. The title of the person implementing the accorrection. The Director of nursimplementing the accorrection that a correction is a correction of the person implementing the accorrection.	offered bedtime snace ocumented on the it Tool. Inmittee will review the ent care audit tool as for identification of en, and to determine frequency of eng, and make or monitoring for eace. The administrate esent the findings and the monthly QI parterly executive QA er recommendations on responsible for ecceptable plan of esing is responsible for estimated to the end of	k. le f
F 867 SS=F	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F 8	correction.		3/1/18
	§483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct identification.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345144	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	040144	5:0 -		STREET ADDRESS, CITY, STATE, ZIP CODE	02	/01/2018	
NAIVIE OF FI	NOVIDER OR SUFFLIER							
PINE RIDO	SE HEALTH AND REHAI	BILITATION CENTER			706 PINEYWOOD ROAD			
				ı	THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 867	Continued From pag	e 68	F 8	367				
	by:							
		view, and record review the			An acceptable plan of correction mus	t		
		essment and Assurance			contain the following elements:	•		
		iled to maintain implemented			" The plan of correcting the specific	•		
	, ,	itor interventions that the			deficiency. The plan should address the			
	committee put into pl				processes that lead to the deficiency	10		
	surveys:	ace for the following			cited;			
	ourveyo.				" The procedure for implementing t	he		
	1: 1-27-17 annual red	certification survey. This was			acceptable plan of correction for the			
		cies in the areas of: Accuracy			specific deficiency cited;			
		s F278 and now F641),			" The monitoring procedure to ensu	ıre		
		nent activities (Was F520 and			that the plan of correction is effective a			
		ermination (Was F242 and			that specific deficiency cited remains			
	now F561), and Safe				corrected and/or in compliance with th	е		
	environment (Was F				regulatory requirements;			
	Develop/Implement of	comprehensive care plan			" The title of the person responsible	e for		
	(Was F279 and Now	F656).			implementing the acceptable plan of correction.			
	2: The complaint inve	estigation dated 9-20-17 had						
	2 recited deficiencies	s in the areas of: Sufficient			F 867 QAPI Committee			
	nursing staffing (Was	s F353 and now F725) and						
	ADL care for a deper	ndent resident (Was F312			The plan of correcting the specific			
	and now F677).				deficiency			
		estigation dated 9-7-17 had by in the area of: Sufficient			The position of Pine Ridge Health and			
		s F353 and now F725).			Rehabilitation center regarding the process that lead to this deficiency-fai	ed		
	Truising stailing (Was	5 1 303 and now 6/20).			to maintain implemented procedures a			
	4. The complaint in:	estigation dated 6-29-17 had			monitor interventions- was failure to fo			
		estigation dated 6-29-17 had by in the area of: Sufficient			established facility policy related to QA			
		s F353 and now F725).			Cotabilorica facility policy related to Q	u I.		
		vere cited again on the						
		n investigation survey of			The procedure for implementing the			
		led failure of the facility			acceptable plan of correction for the			
		irveys of record showed a			specific deficiency cited			
		's inability to sustain an			appoint denoting offer			
	effective QAA progra				On 2/15/18 the facility QAA Committee	2		
	oncoure with progra				held a meeting to review the purpose			
	Findings included:				function of the QAA committee and re-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 02/01/2018		
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010	
					06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER			HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	ge 69	F:	867				
	This tag is cross refe				on-going compliance issues. The Administrator, DON, MDS nurse, staff facilitator, maintenance director, and			
		Accuracy of assessments -			housekeeping supervisor will attend Q			
		view and staff interviews the			Committee Meetings on an ongoing ba			
		rately code the Minimum hospice services involving 1			and will assign additional team member as appropriate.	15		
		ent #120) reviewed for			as appropriate.			
	hospice care.				On 2/20/18 the corporate facility			
	r				consultant in-serviced the administrato	r		
	During the recertification	ation survey dated 1-27-17,			related to the appropriate functioning o	f		
	the facility was cited	for F278 for failing to			the QAPI Committee and the purpose	of		
	accurately code the	Minimum Data Set (MDS)			the committee to include identify issue:	S		
		3 residents to reflect hospice			and correct repeat deficiencies related	to		
	•	3) and accurately code on the			F641-accuracy of assessments,			
		us for 2 of 3 residents			F867-QAPI/QAA, F561 self-determinat			
		Resident #70). During the			F584- clean homelike environment, 65			
		tification survey dated			develop/Implement comprehensive car			
		ailed to accurately code the			plan, F725- sufficient nursing staff, and			
	-	MDS) for hospice services			F677- ADL care for dependent residen	IS.		
	reviewed for hospice	dents (resident #120)			On 2/20/18 the administrator in-service	od.		
	reviewed for flospice	e care.			the department heads related to the	;u		
	2: F867 (was F520)	QAPI/QAA improvement			appropriate functioning of the QAPI			
	, ,	staff interview, and record			Committee and the purpose of the			
		Quality Assessment and			committee to include identify issues an	d		
	_	ee (QAA) failed to maintain			correct repeat deficiencies related to	~		
	implemented proced				F641-accuracy of assessments,			
		e committee put into place			F867-QAPI/QAA, F561 self-determinat	ion,		
	following the 1-27-1	7 annual recertification			F584- clean homelike environment, 65			
	survey.				develop/Implement comprehensive car	e		
					plan, F725- sufficient nursing staff, and			
		ation survey dated 1-27-17			F677- ADL care for dependent residen	ts.		
		for F520 - failing to monitor						
		e facility put into place			As of 2/20/18 after the facility consultar			
		ne 2016 and July 2016.			in-service, the facility QAPI Committee			
	•	nnual recertification survey			begin identifying other areas of quality			
		acility failed to maintain			concern through the QI review process	,		
	implemented proced	iures and monitor			for example: review of rounds tools,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		
		345144	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343144	B: Willo	CTDEET ADDRESS	S, CITY, STATE, ZIP CODE	02/	01/2018
NAME OF F	KOVIDER OR SUFFLIER						
PINE RID	GE HEALTH AND REH	ABILITATION CENTER		706 PINEYWOOD			
				THOMASVILLE,	, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From pa	ge 70	F 8	67			
F 807	interventions that the following the 1-27-2 survey. 3: F561 (was F242 on record review, sinterview and resided failed to provide 1 of the choice of when provide 2 of 3 resident #80) show when reviewed for and failed to honor dinner in the dining reviewed for choice. During the recertification the facility was cited the wishes of resided discontinue obtaining the control of the facility was cited the wishes of resided discontinue obtaining the control of the control	ne committee put into place 17 annual recertification 1 Self-Determination - Based 18 taff interview, resident 19 tent observation the facility 19 of 3 residents (resident #45) 19 to be out of bed and failed to 19 tents (Resident #45 and 19 tents (Resident #10 and 19 tents 19 tents (Resident #10 and 19 tents 20 tents (Resident #10 and 19 tents 21 tents (Resident #10 and 19 tents 22 tents (Resident #10 and 19 tents 23 tents (Resident #10 and 19 tents 24 tents (Resident #10 and 19 tents 25 tents (Resident #10 and 19 tents 26 tents (Resident #10 and 19 tents 26 tents (Resident #10 and 19 tents 27 tents (Resident #10 and 19 tents 28 tents (Resident #10 and 19 tents 29 tents (Resident #10 and 19 tents 20 tent	F &	review of w Click Care of review of resident of reside	cork orders, review of Point (Electronic Medical Record) esident council minutes, review of reports, and review of region sultant recommendations. If QAPI Committee will meet of monthly and Executive mittee meeting a minimum of identify issues related to essment and assurance is needed and will develop a ng appropriate plans of action disciplify action has been taken for the oncerns related to racy of assessments, I/QAA, F561 self-determinate	iew nal : at of nd on	
	current annual rece 1-28-18 the facility residents (resident out of bed and faile (Resident #45 and and a half weeks w daily living (ADL) a choice to have dinr residents reviewed 4: F656 (was F279 comprehensive car review and staff int develop a care plar living (ADL) care, s goals, measureable	ertification survey dated failed to provide 1 of 3 #45) the choice of when to be d to provide 2 of 3 residents resident #80) showers for two then reviewed for activities of a failed to honor a resident's the rein the dining room for 1 of 3 for choices (Resident # 124). Develop/Implement a the plan - Based on record		F584- clear develop/Implan, F725-F677- ADL The monito the plan of specific def and/or in correquiremen The execution continue to Quarterly, a	n homelike environment, 65 plement comprehensive car sufficient nursing staff, and care for dependent residen oring procedure to ensure the correction is effective and the ficiency cited remains correction with the regulator	6- re d ts. at nat cted	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345144	B. WING _				C 01/2018
NAME OF PI	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2010
DINE DID	DE LIEALTH AND DELLA	ADULTATION CENTED		70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHA	ABILITATION CENTER		TI	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	the facility was cited care plan for a residents (resident annual recertificatio facility failed to deve activities of daily livitoileting with no goat time frames for a deresidents (resident asserting to the facility failed to provide an walls, floor and wind hall, 200 hall, 300 h. Complaint investigation or representative interviews facility failed to provide an	ation survey dated 1-27-17 If for F279 - failing to create a lent for weight loss for 1 of 4 #169). During the current In survey dated 1-28-18 the elop a care plan to address Ing (ADL) care, specifically Its, measureable objectives or ependent resident in 1 of 1 #71). Safe/Clean home like If on observation, staff and the facility failed to provide an ent and in walls, floor and If 5 halls (100 hall, 200 hall, III). ation survey dated 1-27-17 If or F253 for failing to have ors in resident rooms #207, If failed to have clean filters in conditioning units (room #400, If is evident in 2 of 5 resident the current annual y dated 1-28-18 the facility odor free environment and in dows for 4 out of 5 halls (100 all and 400 hall).	F	867	The Executive QAPI Committee, include the Medical Director, will review quarter compiled QAPI report information, reviet trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility sprogress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementation of the acceptable plan correction.	rly ew e e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345144	B. WING _				C (01/2018
NAME OF PROVIDER OR SUPPLIER				STREE	TADDRESS, CITY, STATE, ZIP CODE		
DINE DID	SE HEALTH AND REHAE	RII ITATION CENTER		706 PIN	NEYWOOD ROAD		
PINE KIDO	SE REALIN AND RENAL	SILITATION CENTER		THOM	ASVILLE, NC 27360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 867	Continued From page	e 72	F 8	367			
	Continued From page 72 During the complaint investigation dated 9-20-17 the facility was cited for F312 - the facility failed to provide ADL care. During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide Activities of Daily Living (ADL) care, incontinence care for 1 of 1 residents (resident #51). 2: F725 (was F353) Sufficient nursing staff - Based on observations, record reviews, staff, family and resident interview the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403) During the complaint investigation dated 9-20-17 the facility was cited for F353 - The facility failed to provide sufficient nursing staff. During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #34, Resident #45, Resident #40,						
	Based on observation	ns, record reviews, staff,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED C 02/01/2018	
		345144 B. WI					
NAME OF PROVIDER OR SUPPLIER PINE RIDGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO. 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		1210112016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		SHOULD BE COMPLETION	
F 867	provide, staffing of sit to honor resident's cl supervision to preven incontinence care, to residents who require 8 of 131 residents. (Resident #51, Resident #74, Resident the facility was cited to provide nursing straulity to provide the with eating for 1 resident with eating for 1 resident #11) and provide a d 1 resident (resident #11) and provide a d 1 resident (resident for annual recertification dated 1-28-18 the fareful facility resident's choices, fareful facility resident's choices, fareful facility and sirequired assistance. residents. (Resident	nterview the facility failed to ufficient quantity and quality noices, failed to provide it accidents, failed to provide ileting, and snack for ed assistance. This affected Resident #33, Resident #45, ent #54, Resident #71, ent #80, and Resident #403) investigation dated 9-7-17 for F353 - The facility failed aff of sufficient quantity and required assistance needed dent (Resident #3), apply d to maintain range of s (resident #1 and resident ignified dining experience for eare. During the current /complaint investigation cility failed to provide staffing and quality to honor illed to provide supervision to illed to provide incontinence nack for residents who This affected 8 of 131 #33, Resident #45, Resident #71, Resident #74, esident #403)	F8				
	Based on observation family and resident in provide, staffing of staffing or staffing of staffing or staffing of staffing or s	Sufficient nursing staff - ns, record reviews, staff, nterview the facility failed to ufficient quantity and quality noices, failed to provide nt accidents, failed to provide					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 02/01/2018	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		270172010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 867	8 of 131 residents. (Resident #51, Resident Resident #74, Resident Reside	leting, and snack for a dissistance. This affected desident #33, Resident #45, and #54, Resident #71, and #80, and Resident #403) investigation dated 6-29-17 for F353 - The facility failed ficient quantity and quality to care and for residents who with meals. This effected 7 resident #1, resident #5, #8, resident #9, resident #10 aring the current annual int investigation dated filed to provide, staffing of diquality to honor resident's wide supervision to prevent rovide incontinence care, for residents who required cated 8 of 131 residents. Find #71, Resident #51, and #71, Resident #74, resident #403). Administrator occurred on the Administrator stated that the sconsist of the Director of Director, activities and the stated that the last and the next scheduled as During the interview the that the department heads as concerns and issues the quarterly meeting and that me would meet in February to	F	367			