STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 1/28/19 to 1/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # H21X11.	E 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		2/28/19

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

Electronically Signed | 02/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) Form Centers for Medicare Services (CMS) 10123 prior to discharge from Medicare Part A Services for 2 of 3 sampled residents reviewed for beneficiary protection notification review (Residents #87 and #272). Findings included: 1. Resident #87 was admitted to the facility on 12/5/18 with diagnoses which included: Right humerus (upper arm) fracture, generalized weakness, difficulty swallowing, communication deficit, pressure ulcer, and right wrist fracture.	F 582	Pine Ridge Health & Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health & Rehab response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 2 Review of records revealed Resident #87's Medicare Part A services began on 12/5/18 and the last day of Medicare Part A services were on 1/1/19. Resident #87 was discharged from Medicare Part A services with benefit days remaining. An interview was conducted with the Business Office Manager (BOM) on 1/31/19 at 4:17 PM. The BOM stated she had provided the Skilled Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS 10055 to resident #87. The BOM stated she had not provided the NOMNC form CMS 10123 to Resident #87. The BOM stated she was not familiar with the NOMNC form CMS 10123. The BOM stated she had been told by her corporate office to only distribute the SNF ABN and not to distribute the NOMNC anymore. The BOM reviewed the forms she had and stated she did not have a NOMNC 10123 but did have a NOMNC 10095 form. The BOM stated she had not distributed the NOMNC 10095 form in a long time because she had been told to only use the SNF ABN form. The BOM stated she was the only person who distributed the CMS forms at the facility. 2. Resident #272 was admitted to the facility on 12/21/18 and had a planned discharge to home with home health on 1/18/19. The resident's admission diagnoses included: Stroke, arthritis, hemiplegia/hemiparesis (weakness of one side of the body), generalized weakness, cognitive communication deficit, and osteoporosis. Review of records revealed Resident #272's Medicare Part A services began on 12/21/18 and the last day of Medicare Part A services were on 1/17/19. Resident #272 was discharged from Medicare Part A services with benefit days remaining.	F 582	Further, Pine Ridge Health & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F582 F582 The plan of correcting the specific deficiency 2/25/2019 Resident #87 was provided the correct Notification of Medicare Non-Coverage (NOMNC) form by Business Office Manager (BOM) for services ending on 1/1/2019/ 2/25/2019 resident #272 was provided the correct NOMNC form by (BOM) for services ending on 1/17/2019. 2/23/19 Administrator audited all resident on roster who receive Medicare benefits and it was determined that residents with Medicare benefits had not received Medicare services that would require a NOMNC for service ending. The procedure for implementing the acceptable plan of correction for the specific deficiency cited For 2/7/2019 thru 2/21/2019 the administrator audited all residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 3 An interview was conducted with the Business Office Manager (BOM) on 1/31/19 at 4:17 PM. The BOM stated she had provided the Skilled Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS 10055 to resident #272. The BOM stated she had not provided the NOMNC form CMS 10123 to Resident #272. The BOM stated she was not familiar with the NOMNC form CMS 10123. The BOM stated she had been told by her corporate office to only distribute the SNF ABN and not to distribute the NOMNC anymore. The BOM reviewed the forms she had and stated she did not have a NOMNC 10123 but did have a NOMNC 10095 form. The BOM stated she had not distributed the NOMNC 10095 form in a long time because she had been told to only use the SNF ABN form. The BOM stated she was the only person who distributed the CMS forms at the facility.	F 582	received Medicare part A services to ensure the correct NOMNC had been issued by the business office manager (BOM). No residents were receiving Traditional Part A services or discharged from Traditional Part A services. On 2/23/2019 the administrator audited all residents on the Roster list to determine who has Traditional part A services and who received Managed care service, (6) residents have Traditional Part A services but no services had been used. The Managed care provider is responsible for issuing their NOMNC. Systemic Changes 2/21/2019 the administrator in-serviced the BOM, and social workers (SW) on the use of the (NOMNC) for discharges from Medicare part A services. This in-service will be provided to any new BOM during orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, or social worker will audit all residents discharged from Medicare part A services weekly x 20 weeks, to ensure the appropriate NOMNC was issued. This audit will be documented on the NOMNC audit tool. The monthly QI committee will review the results of the NOMNC audit tool for 5 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 4	F 582	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 Administrator is responsible for implementation for this Plan of Correction	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 5 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to maintain an environment free of physical restraints in 1 of 1 sampled residents reviewed for restraints (Resident #58). Findings included: Resident #58 was admitted to the facility on 3/1/2017 and readmitted 8/20/2018 with diagnoses to include vascular dementia, anxiety and hemiplegia. The most recent significant change Minimum Data Set assessment dated 8/28/2018 assessed Resident #58 to be severely cognitively impaired and without behaviors, wandering or rejection of care. Section P of the MDS "restraints" was coded as "0-not used" not used for truck or limb restraints used in a chair. A review of the Care Area Assessment (CAA) for the significant change MDS did not identify a care area concern regarding restraints. The most recent quarterly MDS dated 11/27/2018 assessed her to be severely cognitively impaired and without behaviors, wandering or rejection of care. The MDS assessed Resident #58 to require total assistance from 2 staff members for transfers Section P of the MDS "restraints" was coded as "0-not used" not used for truck or limb restraints used in a chair. A review of the care plans for Resident #58	F 604	F604 The plan of correcting the specific deficiency Resident # 58 was viewed on 2/7/19 by facility consultant without lift pad sling under legs and not tied to wheelchair., free from physical restraints. The procedure for implementing the acceptable plan of correction for the specific deficiency cited All residents audited for possible restraints, all residents at risk, including lift pad slings on 2/7/19 by facility consultant with no negative findings, no physical restraints in use. Systemic Change On 2/9/2019 the staff facilitator (SF) started an in-service with nursing staff, including agency, on the definition of restraints including examples (lift pad tied around legs), risks of restraints, and notification of Director of Nursing (DON) and Administrator of any restraint use. This in-service was completed on 2/25/2019. This in-service was added to the orientation for newly hired nursing staff, including agency. This in-service protects resident #58 and all similar residents, and all other residents, by providing education to correct the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 6 revealed no care plan was in place for the use of restraints. A care plan dated 8/22/2018 was in place for use of a lift and 2-person assistance for transfers. Resident #58 was observed on 1/28/2019 at 4:09 PM sitting in her wheelchair. A green lift sling was noted to be under her and the ends of the sling were pulled between her legs and up and over the top of her thighs. The lift sling was observed to be tied to the wheelchair. Resident #58 was observed on 1/29/2019 at 11:06 AM sitting in her wheelchair. A green lift sling was noted to be under her and the ends of the sling were pulled between her legs and up and over the tops of her thighs. The lift sling was observed to be tied to the wheelchair. Staff were noted to be assisting her to prepare for an activity. An observation of Resident #58 was made on 1/29/2019 at 2:26 PM. A green lift sling was noted to be under her and the ends of the sling were pulled between her legs and up and over the tops of her thighs. The lift sling was observed to be tied to the wheelchair. Staff were observed assisting Resident #58 to wheel down the hallway. An observation of Resident #58 was made on 1/30/2019 at 2:53 PM. A green lift sling was noted to be under her and the ends of the sling were pulled between her legs and up and over the tops of her thighs. The lift sling was observed to be tied to the wheelchair. Staff were assisting her to wheel herself down the hallway. Resident #58 was observed on 1/30/2019 at 4:35	F 604	knowledge deficit related to physical restraints. The knowledge deficit related to physical restraint contributed to nursing staff securing lift pad sling around resident #58 legs thereby physically restraining resident On 2/9/2019 the SF started an in-service with licensed nurses, including agency, on the process for restraint assessment, the process for restraint care planning, and notifications for restraint. This in-service was completed on 02/25/2019. This in-service was added to the orientation for newly hired licensed nurses, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The assistant director of nursing, staff facilitator, unit manager, or director of nursing will audit 10 residents weekly x 12 weeks to ensure no restraints are in use. This audit will occur on random days, to cover all days, at random times, to cover all shifts, and on random halls, to cover all resident types. This audit will be documented on the restraint audit tool. The monthly Quality Improvement (QI) committee will review the results of the restraint 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 administrator and/or DON will present the findings and recommendations of the monthly QI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 7 PM sitting in her doorway reading the newspaper. A green lift sling was noted to be under her and the ends of the sling were pulled between her legs and up and over the tops of her thighs. The lift sling was observed to be tied to the wheelchair. Staff and the Assistant Director of Nursing (ADON) were in the hallway assisting other residents. An interview was conducted with Resident #58 on 1/28/2019 at 4:09 PM. Resident #58 reported the green lift sling was tied around her legs "so I don ' t get out." When Resident #58 was asked, she was unable to untie the green lift sling straps from the wheelchair. Nursing assistant (NA) #4 was interviewed on 1/29/2019 at 2:05 PM. NA #4 reported Resident #58 was transferred from the bed to the wheelchair with a lift because she was unable to stand and bear weight. NA #4 went on to explain the lift sling was left under Resident #58 and the ends were tied to the wheelchair to prevent the ends from dragging on the floor. NA #4 described pulling the sling between Resident #58 ' s legs and across the top of her thighs, then tying the ends to the wheelchair arm rests. NA #5 was interviewed on 1/29/2019 at 3:35 PM. NA #5 reported different aides secured the ends of the lift sling in different manners, and she usually tucked the ends under Resident #58 ' s legs. An interview was conducted with NA #6 on 1/30/2019 at 10:01 AM. NA #6 reported Resident #58 liked the lift sling tied around her legs. An interview was conducted with NA #7 on 1/30/2019 at 4:38 PM. NA #7 reported the lift sling	F 604	committee to the quarterly executive Quality Assurance (QA) committee for further recommendations and oversight. The Director of Nursing is responsible for the Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 8	F 604		

should not be tied around Resident #58 ' s legs because it was acting as a physical restraint and she reported she would fix the lift sling.

An interview was conducted with Nurse #5 on 1/30/2019 at 4:46 PM. Nurse #5 reported she had not observed the lift sling tied to the Resident #58 ' s wheelchair.

The ADON was interviewed on 1/31/2019 at 12:13 PM. The ADON reported NA #7 brought the tied lift sling to her attention yesterday afternoon and the lift sling tied to the wheelchair was a potential restraint. She further reported staff needed to be trained regarding what would be a potential restraint, including lift slings.

The Unit Manager #1 was interviewed on 1/31/2019 at 1:25 PM. The Unit Manager #1 reported she had frequent contact with Resident #58 but had not noticed the lift sling was across the top of Resident #58 ' s legs and tied to the wheelchair. She concluded by agreeing that the lift sling tied to the wheelchair could act as a potential restraint.

The Director of Nursing (DON) was interviewed on 1/31/2019 at 4:08 PM. The DON reported the facility was restraint-free and tying the lift sling could potentially physically restrain Resident #58. She concluded by stating it was her expectation that staff would recognize if a device was acting as a restraint and remove any device that was restraining the resident.

The Administrator was interviewed on 1/31/2019 at 5:35 PM. The Administrator reported it was her expectation to meet substantial compliance with state and federal regulations based on a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 9 centered outcome-oriented process and she was not aware that Resident #58 ' s hoyer lift sling was tied to her wheelchair.	F 604		
F 620 SS=B	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge,	F 620		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 10	F 620		

solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 11 disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to include the resident representative identified in the admission agreement in the decision to transport a resident with moderately impaired cognition to the bank to withdraw money to pay his facility bill (Resident #107). Findings Included: Resident #107 was admitted to the facility on 11/16/16 and diagnoses included dementia. Review of the minimum data sets (MDS) dated 1/3/19, 7/7/18 and 4/3/18 for Resident #107 revealed his cognition was moderately impaired. A phone interview on 1/30/19 at 10:04 am with the resident representative (RR) for Resident #107 revealed she was the residents responsible party and power of attorney (POA). She stated she did not see the resident routinely because she lived out of state, but on her last visit she could see that the resident ' s dementia had progressed. The RR stated she was contacted by the facility book keeper in September 2018 and was told the resident owed the facility $8000. The book keeper also told the RR the facility had taken the resident to his bank and tried to withdraw the $8000 he owed the facility. The book keeper had filled out the withdrawal slip	F 620	F620 The plan of correcting the specific deficiency Resident #107'□s responsible party was notified on July 26, 2018 by Business Office Manager that resident was transported to the bank in July 2018 to withdraw money to pay facility bill. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/21/2019 the Administrator interviewed the facility bookkeeper to ascertain if any other residents had been transported to any finical institutions. Insert findings and corrective actions. Systemic Change On 2/21/2019 the administrator in-serviced the BOM,that a resident cannot be assisted to a financial institution without administrator approval who will speak with residents responsible party if appropriate. This in-service was added to the orientation for newly hired bookkeepers and/or business office mangers. The monitoring procedure to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 12 because the resident was too confused to do this, but the bank would not let him withdraw the money because he didn ' t have any identification. The RR stated she didn ' t think the facility had the right to have taken the resident out to the bank with his level of confusion. She added the facility should have notified her prior to taking him and gotten her permission. The RR explained she didn ' t realize the resident had this bank account and that his social security checks were being deposited there. She believed the facility was receiving his social security checks for his portion of the payment. An interview on 1/31/19 at 9:29 am with the facility book keeper (BK) revealed the resident was on a Medicare replacement from admission on 11/16/16 through 12/2/16. She stated he started receiving Medicaid benefits on 12/3/16, but the facility did not receive his monthly liability payment from 12/3/16 through 10/4/17 and he had a balance of $9136.00. The BK explained it took her almost a year to determine the resident ' s social security check was being deposited into a local bank. She stated she had been in contact with the resident ' s RR during this time and the RR was not aware that the resident had a bank account. When the BK identified the bank account for the resident she asked the RR to go to the bank and withdraw the money, but the RR never did this until the resident was going to lose his Medicaid benefits. The BK explained in July 2018 the transportation aide took the resident to the bank to withdraw his money and close out his account. She stated the resident couldn ' t see the bank account slip, so the bank would not allow him to complete the transaction. The BK stated she thought the resident ' s cognition was good enough to be able to understand why he	F 620	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator will audit 2 residents weekly x 12 weeks to ensure resident has not been assisted to a financial institution without responsible party notification, if appropriate. This audit will be documented on the financial audit tool. The monthly QI committee will review the results of the financial 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 13 was going to the bank. She added she did not notify or get permission from the resident ' s RR prior to him being taken to the bank. The admission agreement records for Resident #107 were provided by the BK. The record identified a family member as the resident representative / responsible party. The admission agreement stated "Fiduciary / Responsible Parties shall act on behalf of the resident for all purposes permitted under applicable law. Fiduciary / Responsible Parties shall pay from residents ' assets or estate all fees and charges incurred by or on behalf of the resident during the residents stay at the facility. An interview with the Administrator on 1/31/19 at 5:50 pm revealed it was her expectation to meet substantial compliance with state and federal regulations based on a resident centered outcome-oriented process.	F 620		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 2 of 19 residents resident reviewed for MDS accuracy. Resident #111 was coded inaccurately as to not having experienced a fall prior to the assessment period for the admission comprehensive assessment and the quarterly assessment and Resident #60 was coded inaccurately as to not	F 641	F641 Accuracy of Assessments The plan of correcting the specific deficiency On 2/23/2019 resident 111's minimum data set (MDS) with assessment reference date (ARD) of 10/17/18 was	2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 14 having accurately recorded the number of falls on an annual comprehensive assessment. Findings included: 1. Resident #111 was admitted to the facility on 10/10/18. The resident's cumulative diagnoses included: Anoxic brain damage, generalized weakness, and unspecified convulsions. Review of Resident #111's most recent Minimum Data Set (MDS) comprehensive assessment revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 10/17/18. The resident was coded as having had experienced no falls since admission. Further review of the MDS assessments revealed a quarterly review with and ARD of 1/3/19. The resident was coded as having had experienced no falls since the prior assessment. The resident was coded as having required supervision or being independent with set up help or assistance needed for walking in his room or in the corridor for both assessments. Review of an incident report for Resident #111 dated 10/15/18 and timed 3:56 AM revealed the resident had walked from his room to the nurses' station and informed the nursing staff he had experienced a fall in his room which resulted in an abrasion to his left thigh, left knee, and a skin tear to his left knee. Review of Resident #111's progress notes revealed an incident note dated 10/15/18 and timed 4:48 AM which documented the resident walked from his room to the nurses' station and informed the nursing staff he had experienced a fall in his room which resulted in an abrasion to	F 641	modified by Minimum Data Set Nurse and resubmitted to the national repository to accurately reflect a fall during look back period. On 2/23/2019 resident 111's MDS with ARD of 1/3/19 was modified by MDS nurse and resubmitted to the national repository to accurately reflect a fall during look back period. On 2/18/2019 resident 60's MDS with ARD of 11/28/18 was modified by MDS nurse and resubmitted to the national repository to accurately reflect two falls during the look back period. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Audit of all residents with submitted comprehensive MDS assessments submitted and accepted in last 60 days to ensure falls was accurately coded by facility consultant completed from 2/7/19 to 2/8/19. Two assessments coded inaccurately were modified by MDS nurse on 2/11/2019 and resubmitted to the national repository. Systemic changes The MDS nurse was in-serviced by Corporate Consultant on correctly coding the of the MDS assessment, including falls on 2/19/2019. Any newly hired MDS nurses will be in-serviced by Corporate Consultant to accurately code the MDS assessments to include falls. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 15 his left thigh, left knee, and a skin tear to his left knee. Review of another progress note for Resident #111 reveled a health status note dated 11/26/18 and timed 7:29 AM. The note documented a Nursing Assistant (NA) came to the nurses' station and stated the resident had fallen on the floor, then got up, sat in his chair, and refused any help from staff. An interview was conducted with the Registered Nurse (RN) MDS Coordinator on 1/31/19 at 9:33 AM. The MDS Coordinator stated resident #111 was not coded for falls on the admission assessment with an ARD of 10/17/18. The MDS Coordinator stated the resident should have been coded as having experienced a fall due to him having had a fall on 10/15/18. The MDS Coordinator further stated Resident #111 was not coded for a fall on the quarterly assessment with an ARD of 1/3/19. The MDS Coordinator stated the resident should have been coded as having had a fall due to having experienced a fall on 11/26/18. The MDS Coordinator stated it was her expectation for residents to be coded as having had a fall on their MDS assessment if they had experienced a fall which would be applicable to the assessment period. During an interview with the Administrator on 1/31/19 at 4:31 PM she stated it was her expectation to meet substantial compliance with state and federal regulation based on resident centered outcome-oriented process. 2. Resident # 60 was readmitted to the facility on 05/06/2017 with diagnoses that included disruptive mood dysregulation, depression, anxiety, unspecified psychosis, Bipolar disorder,	F 641	The director of nursing, assistant director of nursing, staff facilitator, and/or unit manager will audit 5 completed MDS assessments weekly x 12 weeks to ensure falls were coded correctly using the MDS Audit Tool. Then monthly x 3 months and quarterly x 2 quarters to ensure solutions are sustained. The monthly Quality Improvement (QI) committee will review the results of the MDS Audit Tool monthly for 6 months then quarterly x 2 quarters 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 administrator and/or director of nursing (DON) will present the findings and recommendations of the monthly QI committee to the quarterly executive Quality Assurance (QA) committee for further recommendations and oversight. The Director of Nursing is responsible for Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 16 insomnia, muscle weakness, epilepsy and a cerebral infarct. A review of an annual Minimum Data Set (MDS) dated 11/28/2018 for Resident # 60 revealed that he had significant cognitive impairment and required extensive staff assist of 1 to 2 for bed mobility, transfers and toileting. Resident # 60 was unsteady without staff assist to move from sit to stand, move on and off the toilet and for surface to surface transfers. Resident # 60 was coded to have sustained 1 fall with no injury since the previous quarterly MDS dated 08/29/2018. A review of facility incident reports revealed that Resident # 60 had sustained an unwitnessed fall on 09/02/2018 and sustained no injury. Resident# 60 also sustained an unwitnessed fall on 11/28/2018. An interview was conducted on 01/31/2019 at 11:28 AM with the MDS nurse revealed that the annual MDS dated 11/28/2018 was coded incorrectly and that Resident # 60 should have been coded with 2 unwitnessed falls with no injury on the annual MDS dated 11/28/2018. The MDS nurse revealed that one fall had not been counted since the most recent MDS dated 08/29/2018 and that it was a coding error. On 01/31/2019 at 2:21 PM an interview conducted with the facility administrator revealed that it was expected that all MDSs be coded correctly as per the Resident Assessment Manual (RAI) and that all state and federal rules and regulations were to be followed.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff and resident interviews, the facility failed to revise the fall care plan interventions for 1 of 2 residents reviewed for care plan revisions (Resident # 60). Findings included: Resident # 60 was readmitted to the facility on 05/06/2017 with diagnoses that included	F 657	657 The plan of correcting the specific deficiency On 2/23/2019 the Director of Nursing (DON) updated resident 60's care plan to accurately reflect interventions for falls including bed in lowest position.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 18 disruptive mood dysregulation, depression, anxiety, unspecified psychosis, Bipolar disorder, insomnia, muscle weakness, epilepsy and a cerebral infarct. A review of an annual Minimum Data Set (MDS) dated 11/28/2018 for Resident # 60 revealed that he had significant cognitive impairment and required extensive staff assist of 1 to 2 for bed mobility, transfers and toileting. Resident # 60 was unsteady without staff assist to move from sit to stand, move on and off the toilet and for surface to surface transfers. Resident # 60 was frequently incontinent of bladder and bowel and had sustained 1 fall with no injury since the most recent MDS (dated 08/29/2018). Resident # 60 received 7 days of an antipsychotic, 7 days of an antidepressant and 7 days of a diuretic. A review of the Care Area Assessment (CAA) for falls dated 12/12/2018 revealed in part that Resident # 60 had impaired balance, cognitive impairment and received psychotropic medications. Resident # 60 was described as at risk of falls due to poor safety awareness, impulsiveness and the use of psychotropic medications. The care plan of Resident # 60 would be reviewed and updated to include safety precautions and monitoring needs. A review of the current care plans in place for Resident # 60 that were most recently updated on 12/13/2018 included that Resident # 60 was at risk for falls due to incontinent episodes, impaired mobility, poor safety awareness, psychotropic medication use, impulsiveness and refused to ask or accept staff assist. The care plan goal was that Resident # 60 would not sustain serious injury through the next review. Care plan	F 657	On 2/23/2019 the DON observed resident 60 and resident 60's room to ensure all interventions for falls were present. No negative findings noted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Audit completed of all residents with fall care plans to ensure interventions were in place from 2/7/19 to 2/8/19 by facility consultant. No negative findings noted. Systemic change On 2/8/2019 the staff facilitator (SF) started an in-service on care plan intervention implementation for licensed nurses and certified nursing assistants (CNA). This in-service included ensuring all interventions related to falls are in place. This in-service was completed on 2/25/2019. This in-service was added to the orientation for new nursing staff, including agency. On 2/8/2019 the SF started an in-service for licensed nurses and CNAs, including agency, on intervention communication (care guide), including fall interventions. The care guide is part of the resident care plan and is accessible by all licensed and non-licensed nursing staff. The care guide contains interventions pertinent to the resident care such as fall interventions. The care guide is started with the baseline care plan and is reviewed and update quarterly, annually, and with significant change in condition by the minimum data set nurse and/or by any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 19 interventions included in part that Resident # 60 would be assisted for transfers and mobility, commonly used items would be kept in his reach, the call light would be in his reach, a non- skid mat or strips would be on the floor in front of his bed, a raised toilet seat would be provided, the bed of Resident # 60 would be maintained in the lowest position and that dysem would be placed under the wheel chair cushion of Resident # 60. An analysis of previous falls to determine whether a pattern or trend could be addressed. On 01/29/2019 at 2:24 PM an interview and observation of Resident # 60 was conducted. Resident # 60 was awake and alert in his low bed. Resident # 60 revealed that he had not had a fall lately and that he had been trying to be more careful and not rush when he transferred in and out of bed. There was no dycem observed under the wheel chair cushion of Resident # 60. On 01/30/2019 at 9:50 AM an interview was conducted with nurse #3. Nurse # 3 revealed that Resident # 60 had a fall care plan in place that included interventions to keep Resident # 60's bed in the lowest position, to monitor him every time we walked past his room door, make sure that he always could reach and used his call light and keep items he requested on his over bed table and in his reach. Nurse # 3 revealed that she did not know how to update or review the care plan interventions for Resident # 60 if he had a fall. Nurse # 3 also revealed that she was not aware of how or when care plans were updated for residents. An observation of Resident # 60' s room on 01/30/2019 at 2:14 PM revealed that Resident # 60 was in bed asleep with his bed was in a low	F 657	licensed nurse. This in-service was completed on 2/25/2019. This in-service was added to the orientation for new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing (ADON), unit manager, and/or SF will audit 5 residents (on random halls, on random shifts to include all 3 shifts, and on random days to include weekends) weekly x 12 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure if a care plan for falls is in place the interventions are present. This audit will be documented on the care plan audit tool. The monthly Quality Improvement (Q)I committee will review the results of the care plan 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20	F 657		

position. There were no floor strips or a fall mat on the floor in front of his bed.

On 01/31/2019 at 11:28 AM an interview was conducted with the MDS nurse. The MDS nurse revealed that it is the responsibility of the direct care nurses or management nurses (unit managers, Assistant Director of Nurses or Director of Nurses) to update resident care plans after each fall. The MDS nurse revealed that she did not attend care plan meetings and that she had not been aware of the need for MDS to review or update the fall care plan interventions for Resident # 60. A review of the fall care plan for Resident # 60 with the MDS nurse revealed that the intervention for dycem to be placed under the wheel chair cushion of Resident # 60 had been ordered in December 2017 and that the intervention for the use of a non- skid mat or floor strips on the floor in the front of Resident # 60's bed had been added to the care plan on 01/02/2018. The MDS nurse revealed that she was not aware that these interventions were currently not in place or not being followed and that she did review the care plans of all residents when she completed each MDS (at least quarterly and as needed) and that she could not explain why these interventions remained on the care plan or if they should be removed.

An interview conducted with the Director of Nurses (DON) conducted on 01/31/2019 at 12:42 PM revealed the direct care nurses or the unit managers attended all care plan meetings and that they were responsible for updating or revising resident care plans at that time. The DON revealed that direct care nurses were to contact her as soon as possible of a resident fall and that at that time she reviewed with the nurse the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21 paperwork to be completed post fall that included that the care plan interventions be updated or revised at that time. The DON revealed that the expectation was that care plans be up dated when there was a fall. On 01/31/2019 at 2:21 PM an interview conducted with the facility administrator revealed the it was the expectation that all care plans be updated as soon as possible and that any care plan changes be communicated with all staff required. The administrator revealed that it was expected that all care plans be updated as per all state and federal regulations and rules.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident	F 688	F688	2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 22	F 688		

and staff interviews, the facility failed to apply a right hand orthotic splint and provide passive range of motion for 1 of 1 sampled residents reviewed for range of motion limitations (Resident #68).

Findings included:

Resident #68 was admitted to the facility on 12/11/2015 with diagnosis to include vascular dementia, diabetes and rheumatoid arthritis. The most recent annual Minimum Data Set assessment dated 12/4/2018 assessed Resident #68 to be severely cognitively impaired without behaviors or rejection of care. The MDS further assessed Resident #68 to have limited range of motion (ROM) of one upper extremity.

A care plan that addressed the risk for further contracture of the right hand dated 1/12/2018 and revised on 12/19/2018 was reviewed. The care plan goal was for Resident #68 to have no further contracture of the right hand with interventions to include application of a resting hand orthotic after passive range of motion (PROM) up to 6 hours per night, 6-7 days per week, assessment of skin integrity under the orthotic splint and documentation of refusal to participate in the splinting and PROM program.

Documentation of Restorative nursing tasks for November 2018 were reviewed. There were 3 documented refusals by Resident #68 for the month of November 2018 and 8 out of 30 days of "0" minutes of PROM provided, 10 out of 30 days with "0" minutes of splint application and 5 days with no documentation.

Documentation of Restorative nursing tasks for

F688
The plan of correcting the specific deficiency

Resident #68's hand splint was applied by certified nursing assistant (CNA) on 2/18/19. Observation of splint on was made by licensed nurse on 2/18/19.
Resident # 68 was provided with range of motion by CNA on 2/18/19. Observation of range of motion was made by licensed nurse on 2/18/19.
Resident #68 was reviewed by the Interdisciplinary team (IDT), including nursing, and therapy, on 2/21/2019 for appropriateness for continued splint and ROM. The IDT determine to refer back to Physical Therapy (PT), Occupational Therapy (OT) and Speech (ST)
Resident #68 Care plan and care guide was reviewed and reflects resident's current need for ROM 3rd shift, passive range of motion to right upper shoulder and hand, 10 repetitions x 1.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited
On 2/4/2019 the facility Consultant reviewed residents currently on restorative case load, to include resident #68, and all residents with splints and ROM for continued appropriateness, including compliance and progress toward goals.
(2) residents were referred to therapy.
The audit revealed there are 10 residents with splints, and 24 residents on ROM plans. Residents, including #68's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 23 December 2018 were reviewed and there were 4 documented refusals by Resident #68 for the month of December 2018 and 6 out of 31 days of "0" minutes of PROM provided, 9 out of 31 days "0" minutes for splint application and 5 days with no documentation. The Restorative Nursing Summary dated 12/4/2018 was reviewed and the interventions review documented that PROM was completed on the right hand, 1-2 exercises, 10 reps (repetitions) 1-2 sets 6-7 days per week and the continued exercises would decrease further contracture of the right hand. Documentation of Restorative nursing tasks for January 2019 were reviewed and there were 5 documented refusals by Resident #68 for the month of January 2019 and 11 out of 31 days of "0" minutes of PROM provided, 16 days out of 31 of "0" minutes for splint application and 4 days with no documentation. A review of the medical record revealed pictures of the splint applied to Resident #68 ' s right hand, showing views from the side, the top and the front of the hand. Resident #68 was observed on 1/29/2019 at 8:35 AM. Resident #68 ' s right fingers were folded into her palm and she had no movement of the 2nd, 3rd, or 4th fingers and was able to minimally pinch her thumb and index finger together. Resident #68 did not have a splint on her right hand at the time of the observation. Resident #68 was interviewed on 1/29/2019 at 4:12 PM and she reported the splint was no longer applied to her right hand. Resident #68	F 688	plan and care guides were reviewed and current to ensure communication to nursing staff is present for ROM and splint plans and wear schedules. The audit, including review of care plans for resident with splints and needed ROM plans identified and protected other possible residents involved. Splints and ROM are provided to residents based on resident preference and/or resident need. Splint wear schedule and/or ROM program description is listed in the resident care plan for communication to necessary nursing staff. Systemic Change On 2/11/2019the staff facilitator (SF) in-serviced the nursing staff, including agency staff, on the restorative program including providing range of motion, splints, and documentation. This in-service was completed on 2/25/2019. This in-service was added to the orientation for new nursing staff, including agency staff. Education provided to nursing staff addressed the nursing staff knowledge deficit related to providing, and documenting restorative program, splint use, and ROM The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit managers, and/or SF will audit 5 residents on the restorative nursing program (including range of motion, and splinting) weekly x 12 week, then weekly x 4 weeks, then monthly 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 24 was able to locate the splint in her bureau stored under multiple layers of clothing. Resident #68 further reported the staff did not perform PROM on her right hand. An interview was conducted with Nursing Assistant (NA) #5 who provided care for Resident #68 on the day shift (7:00 AM to 3:00 PM) on 1/29/2019 at 2:17 PM. NA #5 reported she had not received training to apply the splint to Resident #68 ' s right hand and she had not observed Resident #68 wearing a splint during the day shift. NA #6, who provided care for Resident #68 during second shift (3:00 PM to 11:00 PM) was interviewed on 1/29/2019 at 3:47 PM and she reported she had never seen a splint in use or on Resident #68. An interview was conducted with Restorative Aide (RA) #2 on 1/30/2019 at 9:29 AM. The RA reported Resident #68 was to have PROM to her right hand and splint application to the right hand at bedtime. RA #2 further reported she had not trained NA staff to apply the splint or perform the PROM. The Occupational Therapist (OT) was interviewed on 1/30/2019 at 2:24 PM. The OT reported that after a resident completed occupational therapy, they may continue to be seen by Restorative Nursing for continued range of motion or splinting. The OT went on to explain that she provided training to the RA for PROM and splint application to Resident #68 ' s right hand. The OT concluded by reporting she had not been notified Resident #68 was refusing PROM and the application of the splint.	F 688	months to ensure the resident's designated programs have been completed for the past week. This audit will be documented on the restorative nursing services (RNS) audit tool. . The monthly quality assurance (QA) committee will review the results of the RNS audit tool monthly for 6 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 administrator and/or DON will present the findings and recommendations of the monthly QA committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementation for the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25	F 688		

An interview was conducted via phone call on 1/31/2019 at 5:40 AM with NA #8, who provided care for Resident #68 on night shift (11:00 PM to 7:00 AM) and she reported she had never applied a splint to Resident #68 and she performed PROM for Resident #68, but not on her right hand, only her arms and legs. NA #8 went on to explain that she documented the PROM for Resident #68 for the time she performed PROM on Resident #68 ' s arms and legs.

An interview was conducted via phone call on 1/31/2019 at 5:48 AM with NA #9, who provided care for Resident #68 on the night shift, and she reported she had attempted to apply the splint to Resident #68 ' s right hand and she had performed PROM to Resident #68 ' s right hand when she would permit her. NA #9 went on to explain she had not received training to apply the splint to Resident #68, but the task had showed up in her documentation and she completed the PROM and splint application.

The OT was interviewed again on 1/31/2019 at 1:12 PM. She reported Resident #68 had been discharged to Restorative Nursing and she trained the RA to perform the PROM and the splint application. The OT went on to explain she did not follow RA or perform assessments on residents after they had been discharged from occupational therapy. The OT concluded by reporting she trained nursing staff in PROM and splints if the resident was discharged to nursing and not restorative care, and she did not know if Resident #68 had a change in the right-hand contracture or if her range of motion had decreased.

The Unit Manager was interviewed on 1/31/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 26 at 1:42 PM and she reported her goal was to improve staff communication regarding providing care to residents and PROM/splint applications. The Director of Nursing (DON) was interviewed on 1/31/2019 at 4:19 PM and she reported it was her expectation that NA staff were properly trained to apply splints or perform PROM for any resident who had those tasks ordered. The DON reported she was not aware the NA staff had not been trained to apply the splint and perform PROM to Resident #68.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement a fall intervention for 1 of 4 residents reviewed for accidents (Resident #13). Findings Included Resident #13 was admitted to the facility on 11/3/15 and diagnoses included cerebral vascular accident, dementia, failure to thrive, pain and depression. Review of an incident report dated 8/31/18 for	F 689	F689 The plan of correcting the specific deficiency Resident #13 was observed with bed in lowest position on 2/7/19 by facility consultant. The procedure for implementing the acceptable plan of correction for the specific deficiency cited All residents with intervention for bed in lowest position audited to ensure	2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 Resident #13 revealed a staff member reported to the Nursing Assistant (NA) the resident was seen on the floor in his room next to his bed. A code green was paged, and staff went to the scene. The resident was alert, denied pain and had no signs of any distress. The resident ' s family member arrived to visit the resident. He was assisted to his high back wheelchair. His skin was assessed for injury and his right knee was slightly pinkish in color. The resident was instructed to flex and extend his knee. He was cooperative and denied any pain during flexion and extension with his family at his side. An ice compress was applied to the right knee. The Director of Nursing (DON) was notified and the incident was placed in the physician ' s communication board to see on his rounds. The physician will be contacted as needed. Review of an incident report dated 9/26/19 for Resident #13 revealed he was found on the floor next to his bed in a sitting position. The resident was assessed and noted to be alert and responsive. No obvious signs of injury. The family was notified of the injury and suspected the resident had a urinary tract infection. The DON, Physician and Administrator were notified. A care plan for Resident #13 that had been updated 9/27/18 stated the resident was at risk for falls characterized by impaired mobility, vascular dementia, bathroom needs and infection. Interventions included to keep bed in lowest position, transfer with 2-person extensive assistance, keep call bell pinned to gown when in bed and have commonly used articles with easy reach. Review of the resident care guide that was	F 689	intervention in place from 2/7/19 until 2/8/19 with no negative findings. Systemic change On 2/8/2019 the staff facilitator (SF) began an in-service with nursing staff, including agency, on following intervention to prevent accidents and incidents including bed in lowest position. This in-service was completed on 2/25/2019. This in-service was added to the orientation for new nursing staff, including agency. On 2/8/2019 the SF began an in-service with nursing staff, including agency, on reviewing and being familiar with resident care plan and interventions for licensed nurses-care plan, and for certified nursing assistants (CNA)- interdisciplinary care service plan (ICSP). This in-service was completed on 02/25/2019. This in-service was added to the orientation for new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or SF will audit 5 residents (on random halls, on random shifts to include all 3 shifts, and on random days to include weekends) weekly x 12 weeks to ensure if a care plan intervention for bed in lowest position is in place that 1. The bed is in the lowest	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 updated on 9/27/18 for Resident #13 revealed staff and family were to return the residents bed to the lowest position after providing care. An annual minimum data set (MDS) dated 1/15/19 for Resident #13 revealed he required extensive two-person assistance with bed mobility, had not experienced any falls during the look back period and had impaired cognition. An observation of Resident #13 on 1/29/19 at 2:43 pm revealed the resident was lying in his bed asleep. The bed was in the regular height position. An observation of Resident #13 on 1/30/19 at 10:55 am revealed the resident was lying in his bed asleep. The bed was in the regular height position. An interview on 1/30/19 at 10:59 am with NA #5 revealed he was assigned to Resident #13 routinely on first shift. He stated the resident typically stayed in bed per the family ' s preference. NA #5 added he was not aware of the resident having any falls or of any fall interventions that were in place for the resident. An observation of Resident #13 on 1/30/19 at 2:49 pm revealed the resident was awake and lying in bed. The bed was in the regular height position. An interview on 1/30/19 at 2:55 pm with NA #4 revealed she was assigned to the resident routinely on second shift. She stated the resident couldn ' t get out of bed on his own. NA #4 explained the resident ' s family came daily and liked to position pillows around him, so he wouldn	F 689	position, and 2. The nursing staff can verbalize this intervention. This audit will be documented on the fall intervention audit tool. The monthly QI committee will review the results of the fall intervention 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29 ' t roll of bed. She added she was not aware of any fall interventions that were in place for the resident. An observation of Resident #13 on 1/31/19 at 11:06 am revealed the resident was lying in bed asleep. The bed was in the regular height position. An interview on 1/31/19 at 11:08 am with Nurse #5 revealed she was the nurse for Resident #13 today, but she was new to working on this unit. She stated she wasn ' t sure if the resident had falls or had any fall interventions in place. Nurse #5 added she would need to check his care plan. An interview on 1/31/19 at 11:12 am with Nurse #5 and MDS Nurse #1 revealed Resident #13 had a care plan intervention to keep his bed in the low position due to his risk for falls. The MDS Nurse added the nursing staff should be making sure this was done. An interview on 1/31/19 at 4:02 pm with the DON revealed the NAs should be using the resident care guides to provide care for the residents. She stated these were available to the NAs on their iPad. An interview with the Administrator on 1/31/19 at 5:46 pm revealed it was her expectation to meet substantial compliance with state and federal regulations based on a resident centered outcome-oriented process.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 30 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, manufacturer's manual review, and staff interviews, the facility failed to clean respiratory equipment and failed to secure an oxygen cylinder (Resident #59) and the facility failed to ensure a resident received treatment as recommended for a Continuous Positive Airway Pressure (CPAP) or a Bilevel Positive Airway Pressure (BiPAP) machine and failed to clean and maintain a resident's BiPAP machine (Resident #56) for 2 of 3 residents reviewed for respiratory care. The findings included: 1. Resident #59 was originally admitted to the facility on 4/20/18 and most recently admitted on 5/23/18. The resident's cumulative diagnoses included: heart failure, chronic respiratory failure with hypoxia, chronic gout, chronic kidney disease, generalized weakness, dementia, heart disease, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of Resident #59's Medication Administration Record (MAR) for January revealed the resident had an order to receive continuous oxygen at 2 liters per minute 2L/PM via nasal canula. The administration of the	F 695	F695 The plan of correcting the specific deficiency On 1/30/19 Assistant Director of Nursing (ADON) assigned and monitored cleaning of resident #59□s oxygen concentrator filter. On 2/24/2019 resident # 59□s medication administration record (MAR) was reviewed by Director of Nursing (DON) and ADON to ensure oxygen administration had been documented for 2/1/19 thru 2/24/19. On 2/24/19 registered nurse (RN) supervisor wrote a clarification order for resident #59□s oxygen that included the Licensed Nurse and/or Medication Aide must initial that oxygen was provided for shift and oxygen saturation for every shift. This clarification order for resident #59 addressed the negative finding from the audit. On 2/8/2019 resident #56□s bi-pap machine was replaced by contracted company and placed in resident room by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 oxygen was not signed off from 1/1/19 through 1/31/19. Review of Resident #59's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 11/27/19. Review of the assessment revealed the resident was coded as having had severe cognitive impairment and was coded as having received oxygen therapy at the facility. a. A review of the manufacturer's operator's manual for the oxygen concentrator was completed. The review of the Routine Maintenance section of the manual revealed the cabinet filters on each side of the cabinet should be removed and cleaned at least once a week depending on environmental conditions. Review of the facility supplied Oxygen Reading Worksheet revealed the oxygen filters for the oxygen concentrator for Resident #59 were cleaned on 1/5/19. An observation conducted in the room of Resident #59, on 1/28/19 at 3:52 PM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. An observation conducted in the room or Resident #59, on 1/29/19 at 3:43 PM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected	F 695	contracted company. The facility has contract with the provider including replacement and services (settings) for Bi-pap equipment. On 2/8/2019 the contracted company obtained order for resident #56 bi-pap that included settings, and wear frequency. The order for wear frequency was added to the medication administration record (MAR). On 2/24/2019 DON and ADON reviewed the medication administration record for resident #56 to ensure bi-pap use had been documented. Order found not appropriate for documentation. 2/24/2019 The ADON wrote a Clarification order written to check bi-pap at 10pm. Order faxed to pharmacy and placed on MAR. On 1/30/19 the unsecured (E size) oxygen tanks for resident # 59 were placed into secure carts with wheels and moved to the appropriate storage area by facility staff. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 1/30/19 the Maintenance Director audited all residents room with oxygen concentrators to ensure filters were clean. Negative findings were immediately addressed by the maintenance director including cleaning of filters. On 2/24/2019 the DON checked residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 32 to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. An observation conducted in the room of Resident #59, on 1/30/19 at 9:31 AM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. An interview with Nurse #3 and Nursing Assistant (NA) #12 was conducted in conjunction with an observation in the room of Resident #59 on 1/30/19 at 9:39 AM revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. Nurse #3 stated the filters on the oxygen concentrator did not appear to be clean. The nurse stated the maintenance department or central supply was responsible for the cleaning and replacement of filters on the oxygen concentrators. The nurse stated she believed the filters on the oxygen concentrators should be cleaned every 30 days but was not sure. NA #12 also stated she thought it was every 30 days, but she was not sure as well. An interview with the Assistant Director of Nursing (ADON) was conducted in conjunction with an	F 695	using oxygen to ensure physician orders were present for residents with oxygen and that the oxygen order had been transcribed to the medication administration record. On 1/30/19 the ADON audited all residents with bi-pap orders to(1) Ensure treatment has order present with settings, and (2) Documented administered as ordered for past 7 days with no additional negative findings. On 1/30/19 the ADON audited all bi-paps in use in the facility to ensure they were clean and in functioning order with no additional negative findings. On 1/30/19 nursing staff completed an audit of the facility including resident rooms to ensure oxygen tanks, including E size were stored in appropriate racks and/or carts with wheels with no negative findings. Systemic change On 2/09/2019 the staff facilitator (SF) started an in-service with nursing staff (License nurses and certified nursing assistants (CNA) including agency, on cleaning oxygen concentrator filters, transporting of oxygen using correct carts with wheels, and correct oxygen storage. This in-service was completed on 2/25/2019. This in-service was added to the orientation for new nursing staff, including agency. On 2/9/19 the (SF) started an in-service with License nurses, Medication aides including agency on documentation of oxygen delivery and Bi-pap administration (including check of settings) Medical Administration Record (MAR) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 33 observation in the room of Resident #59 on 1/30/19 at 9:46 AM revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. The ADON stated the filters on the oxygen concentrators appeared as if they needed to be cleaned. The ADON stated there was a person who was responsible for cleaning the filters on the oxygen concentrators and that was something which had been discussed in the morning meeting. The ADON stated it was her expectation for the filters on the oxygen concentrators to be maintained in a clean condition. An interview was conducted with the Central Supply Coordinator (CSC) on 1/30/19 at 10:01 AM. The CSC stated the filters on the oxygen concentrator needed to be cleaned. He stated he checked the oxygen concentrators every month and cleaned the filters every 2 weeks. He stated he had cleaned the filters on the oxygen concentrator for Resident #59 two weeks ago. A request was made to the CSC to provide their policy for the frequency of which the filters were checked/cleaned on the oxygen concentrators. The CSC stated the oxygen concentrator for Resident #59 belonged to the facility. An interview was conducted with the Administrator in conjunction with an observation of Resident #59's oxygen concentrator on 1/30/19 at 10:10 AM. The Administrator stated the filters on the oxygen concentrators had been cleaned on 1/5/19 and she stated she had the paperwork.	F 695	physician orders. This in-service was completed on 2-25-2019. This In-service was added to the orientation for newly hired nurses and medication aides including agency. If Bi-pap is not functioning or setting altered the License nurse will notify DON and or unit manager who will notify the contracted provider for assistance in providing the resident treatment as ordered. On 2/13/2019 the Administrator implemented a weekly cleaning for all Oxygen filters. The routine weekly cleaning of oxygen concentrator filters will be documented on the Oxygen Reading Worksheet. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing DON, ADON, unit manager or (SF) will audit 5 residents daily (on random halls to include all residents) daily 3 x per week (on random days to include all 7 days per week) x 12 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure if oxygen, or bi-pap is in use (1) The administration is being documented on the MAR correctly, and (2) The concentrator filters and/or bi-pap machine is clean and functional. This audit will be documented on the respiratory audit tool. The DON, ADON, unit manager, administrator, and SF will audit 5 areas in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 34 Closer observation of the oxygen concentrator revealed a side compartment access removable door which had raised letters which read, "Filter Access and Humidifier Adapter Storage." The Administrator stated she was not aware of the side access door. When the door was removed the inside compartment revealed a paper filter inside of a cannister which appeared to have dust and debris on it and the cannister was a hand-written date of 7/31/17. Further inspection of the interior of the compartment revealed information for the maintenance of the machine which stated the cabinet filters were to be cleaned weekly and replaced as needed. An observation and interview were conducted with the CSC on 1/30/19 at 10:11 AM. The CSC was observed placing clean filters onto the oxygen concentrator of Resident #59. The CSC stated he and NA #3 had been working on the checking the filters monthly. During an interview with the ADON on 1/30/19 at 10:12 AM she stated NA #3 had been working on checking the filters on the oxygen concentrators monthly and had created a spreadsheet. The ADON stated the filters were last changed on 1/5/19. During an interview was conducted with the Director of Nursing (DON) on 1/31/19 2:58 PM she stated it was her expectation for the filters on oxygen concentrators to be checked and cleaned as necessary. During an interview with the Administrator on 1/31/19 at 4:31 PM she stated it was her expectation to meet substantial compliance with state and federal regulations based on resident	F 695	the facility 3 x per week x 12 weeks, then weekly x 4 weeks then monthly x 2 months to ensure oxygen, including E size, is stored correctly. This audit will be completed on the oxygen storage tool. The monthly quality improvement Quality Improvement(QI) committee will review the results of the respiratory and oxygen storage audit tools for 6 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 administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality improvement performance improvement (QAPI) 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 35	F 695		

centered outcome-oriented process. The Administrator further stated it was her expectation to follow the manufacturer's recommendations regarding the cleaning of the filters on the oxygen concentrators.

b. An observation conducted in the room of Resident #59, on 1/28/19 at 3:52 PM, revealed an unsecured oxygen tank (size E 4.3 inches in diameter, 25.5 inches in height, and 7.9 pounds in weight empty and without regulator) sitting vertically on the seat of the resident's wheelchair leaning against the backrest of the wheelchair. In addition, other items sitting in the seat of the wheelchair included 2 pedals or footrests for a wheelchair and a sling lift pad. The resident was observed to have a nasal canula on him which was connected to an oxygen concentrator while the resident was resting in bed.

An observation conducted in the room of Resident #59, on 1/29/19 at 3:43 PM, revealed an unsecured oxygen tank (size E) sitting vertically on the seat of the resident's wheelchair leaning against the backrest of the wheelchair. In addition, other items sitting in the seat of the wheelchair included 2 pedals or footrests for a wheelchair and a sling lift pad. The resident was observed to have a nasal canula on him which was connected to an oxygen concentrator while the resident was resting in bed.

An observation conducted in the room of Resident #59, on 1/30/19 at 9:31 AM, revealed an unsecured oxygen tank (size E) sitting vertically on the seat of the resident's wheelchair leaning against the backrest of the wheelchair. In addition, other items sitting in the seat of the wheelchair included 2 pedals or footrests for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 36	F 695		

wheelchair and a sling lift pad. The resident was observed to have a nasal canula on him which was connected to an oxygen concentrator while the resident was resting in bed.

An interview with NA #12 was conducted in conjunction with an observation in the room of Resident #59, on 1/30/19 at 9:39 AM, revealed an unsecured oxygen tank (size E) sitting vertically on the seat of the resident's wheelchair leaning against the backrest of the wheelchair. In addition, other items sitting in the seat of the wheelchair included 2 pedals or footrests for a wheelchair and a sling lift pad. The resident was observed to have a nasal canula on him which was connected to an oxygen concentrator while the resident was resting in bed. The NA stated she believed the last time the resident was up out of bed was two weeks ago. The NA further stated the oxygen cannister should have been in a canvas bag which would hang on the back of the resident's wheelchair. The NA stated she had needed the canvas bag for another resident in the morning of that day and had removed the oxygen tank from the bag, placed the oxygen tank in the resident's wheelchair, and removed the oxygen bag and applied the oxygen bag to another resident's chair.

An interview with the ADON was conducted in the room of Resident #59, on 1/30/19 at 9:39 AM, The ADON stated she did not think storing an oxygen tank in the seat of the wheelchair was the proper way to store an oxygen tank. The ADON stated a tank sitting in the seat of a wheelchair was not protected from tipping over. The ADON stated there was usually a bag or sleeve which connected to the back of a resident's chair to secure the oxygen tank and keep it from tipping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 37	F 695		

over. The ADON stated it was her expectation for oxygen tanks to be stored securely.

During an interview was conducted with the Director of Nursing (DON) on 1/31/19 2:58 PM she stated it was her expectation for oxygen tanks to be stored safely and securely. The DON further stated it was her expectation for residents who are on oxygen and will be out of bed to have their oxygen tank safely and securely stored in a sleeve or other secure storage device on the resident's wheelchair.

During an interview with the Administrator on 1/31/19 at 4:31 PM she stated it was her expectation to meet substantial compliance with state and federal regulations based on resident centered outcome-oriented process. The Administrator also stated it was her expectation to follow the National Fire Protection Association (NFPA) regulations for secure oxygen tank storage.

2. Resident # 56 was readmitted to the facility on 05/15/2017 with diagnoses that included dementia, syncope, obesity, chronic obstructive pulmonary disease (COPD), anxiety, convulsions and affective mood disorder.

A significant change Minimum Data Set (MDS) dated 11/24/2018 revealed that Resident # 56 was cognitively intact and required limited staffs assist with bed mobility, transfers and eating and required extensive assist to toilet. Resident # 56 received 7 days of an antipsychotic, antianxiety, antidepressant, a diuretic and 2 days of an opioid during the review period. Resident # 56 was coded that he received a non- invasive mechanical ventilator (BiPAP/CPAP) during the review period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38	F 695		

A care plan for Resident # 56 initiated on 05/15/2017 revealed that Resident # 56 wore a CPAP (Continuous positive pressure airway pressure) at bedtime and applied it and removed it independently.

A review of the Medication Administration Records (MARs) dated from 11/01/2018 through 01/30/2019 were reviewed and revealed from 11/01/2018 - 11/30/2018 Resident # 56 had an FYI (for your information) to receive a BiPAP (Bi-level positive airway pressure) at bedtime and that Resident # 56 was to apply and remove by himself and that he may need help at times. The MARs dated 12/2018 and 1/2019 revealed the same FYI information on the MARs. On observation, there were no nurse initials or other documentation including an MD (physician) order date on the 3 MARs reviewed.

A review of the Treatment Administration Records (TARs) dated from 11/01/2018 through 01/30/2019 were also reviewed and revealed Resident # 56 had an FYI (for your information) to receive a BiPAP (Bi-level positive airway pressure) at bedtime and that Resident # 56 was to apply and remove by himself and that he may need help at times. The TARs dated 12/2018 and 1/2019 revealed the same FYI information on the TARs. On observation, there were no nurse initials or other documentation including an MD (physician) order date on the 3 TARs reviewed.

A review of the medical record for Resident # 56 revealed there was no MD order date for the BiPAP, no tubing or mask change schedule and no cleaning schedule for the BiPAP machine or connected tubing and mask.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39	F 695		

On 01/28/2019 at 10:13 AM an observation of Resident # 56 revealed him sitting on the edge of his bed. Resident # 56 had no observed respiratory distress or shortness of breath. On the night stand of Resident # 56 a BiPAP machine was observed with exposed, unlabeled tubing and a face mask hanging over the side of the night stand. The base of the machine was covered on the top right side outside surface to have a strip of duct tape on it. The machine base was opened and revealed that the inside area of the machine had dark brown colored dirt and dust inside of the top cover. The tubing connection at the outside top of the machine was covered in multiple areas of dried food debris.

Resident # 56 revealed on 01/28/2018 at 2:17 PM that it was his breathing machine and he took care of it himself, but it did not seem to work all the time. Resident # 56 would not give more details when prompted.

On 01/28/ 2019 at 2:17 PM an interview was conducted with nurse #2 that included an observation of the BiPAP, mask and tubing in the room of Resident # 56 as well as the MD order documented on the January 2019 MAR for Resident # 56. Nurse # 2 was unable to locate any other MD orders or documentation for the care or maintenance of the BiPAP. Nurse # 2 revealed that upon review of the medical record for Resident # 56 that there were no specific MD orders for the CPAP or BiPAP of Resident # 56 and that Nurse #2 used the terms CPAP and BiPAP interchangeably because she believed that they were the same machines and they both provided the same oxygen needs. Nurse # 2 revealed that she was not certain why the machine was duct taped on the outside of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 40	F 695		

machine or who or when the tubing, mask or machine were cleaned or changed. Nurse # 2 stated that she believed that the CPAP was brought to the facility from the home of Resident # 56. Nurse # 2 revealed that she did observe that the mask and tubing were dirty and did need to be cleaned or replaced and that she would need to find the correct supplies to provide the care.

01/30/2019 at 10:17 AM an interview conducted with nurse # 4 on the secured unit revealed that it was her first day to work on the secured unit. The nurse revealed that when she passed medications earlier that morning, Resident # 56 was in his room and was not wearing any form of oxygen and she had not assessed any respiratory distress. The nurse (nurse # 4) provided a handwritten note received from the nurse on the previous shift (11:00PM - 7:00AM) it was not signed. The note, which nurse # 4 held in her hand was not dated or signed and read in part for the day shift nurse (7:00AM- 3:00PM) was to telephone the medical supply company to report that the BiPAP or CPAP machine that Resident # 56 had was broken. The note also revealed that on the previous day the physician (MD) had been called and had reported that he was not aware of the type of respiratory machine Resident # 56 had and gave direction for the supplier to be informed so that the supplier could come to the facility and service the machine and provide setting information to the facility to give to the MD. Nurse # 4 revealed that she would call the company as soon as she completed her medication pass.

On 01/30/2019 at 10:32 AM an interview was conducted with a nurse assistant (NA) # 1. NA # 1 revealed that Resident # 56 wore his oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 41	F 695		

machine only at bed time and that NA #1 had only observed Resident # 56 become short of breath on 1 or 2 occasions when moved around a lot and if Resident # 56 sat down and rested his breathing got better.

An interview conducted with nurse # 4 on 01/30/2019 at 10:44 AM consisted of a telephone call to the medical equipment supplier of the BiPAP/CPAP machine for Resident # 56. The medical equipment supplier confirmed that Resident # 56 had a BiPAP machine that was issued to the facility on 06/07/2017. The medical supplier revealed that he would need some time to review the BiPAP settings and that the nurse would also have to call him back with any serial numbers on the BiPAP and a report of the broken parts on the BiPAP.

An observation and interview of Resident # 56 on 01/30/2019 at 1:08 PM revealed Resident # 56 sitting on the edge of his bed. He was not wearing his BiPAP mask and no evidence of shortness of breath was observed. Resident # 56 revealed that he was doing fine and had no concerns. During the observation, the facility administrator entered the room and was shown the duct tape on the outside of the BiPAP machine and the dirt and dust on the inside of the machine as well as on the tubing and facial mask.

On 01/30/2019 at 1:27 PM an interview with nurse # 4 revealed that the nurse spoke to the medical supply company again and that she had been informed of the original BiPAP setting for Resident # 56 and that the MD would need to write an order for the supply company to come to the facility, service or replace the machine and check the settings. Nurse # 4 revealed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42 supplier informed her that the machine should be serviced at least every 1.5 years and that a new MD order would be needed each time. Nurse # 4 revealed that nurse management had been made aware of the information. On 01/31/2019 at 12:42 PM an interview was conducted with the Director of Nurses (DON). The DON revealed that she was not aware if Resident # 56 had a CPAP or BiPAP machine and that she was not aware that there were no MD orders for the machine setting or that the machine was broken. The DON also revealed that the expectation was that the machine, tubing and mask should have been cleaned weekly and as needed if soiled and that the information should be recorded with nurse initials on the TAR or MAR. The DON stated that it was also expected that the MD monitored the settings of the machine and that the equipment supply company should come to the facility to service the machine at least every 6 months to a year.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 43 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 11 out of 11 daily posted nurse staffing sheets reviewed and did not report the facility census for 3 out of 11 daily posted staffing sheets reviewed. Findings included: 1. Review of the facility ' s daily nursing staffing forms and daily nursing schedules for 11/1/2018, 11/2/2018, 11/3/2018, 12/1/2018, 12/2/2018, 12/3/2018, 1/27/2019, 1/28/2019, 1/29/2018,	F 732	F732 The plan of correcting the specific deficiency On 2/22/2019 the Administrator observed and verified the posted staffing information was correct. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/22, 2019 and 2/23/2019 the Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 44 1/30/2019, and 1/31/2019 revealed the daily nursing staffing forms were not accurate on the following 11 of 11 days: a. The nursing schedule for the facility dated 11/1/2018 was reviewed and it was noted 4 Licensed Practical Nurses (LPN) were scheduled to work 1st shift (7:00 AM to 3:00 PM) and 13 nursing assistants (NA) scheduled for day shift. The daily posted staffing form indicated 5 LPNs had provided 40 hours of care on that date and 12 NAs had provided 90 hours of care on that date. The nursing schedule for 2nd shift (3:00 PM to 11:00 PM) revealed no Registered Nurses (RN) scheduled to work, 3 LPNs scheduled to work and 13 NA were scheduled to work 2nd shift on 11/1/2018. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care, 4 LPNs had provided 32 hours of care and 11 NAs had provided 82.5 hours of care for 2nd shift on 11/1/2018. The nursing schedule for 3rd shift (11:00 PM to 7:00 AM) noted 6 NAs were scheduled to work 11/1/2018. The daily posted staffing form indicated 7 NA had provided 52.5 hours of care for 3rd shift on 11/1/2018. b. The nursing schedule for 11/2/2018 was reviewed and it was noted 13 NAs were scheduled to work 1st shift. The daily posted staffing sheet indicated 11 NAs had provided 82.5 hours of care. The schedule for 2nd shift noted no RN was scheduled to work and 11.5 NAs were scheduled to work 11/2/2018. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care, and 12 NAs had provided 82.4 hours of care for 2nd shift on 11/2/2018. c. The nursing schedule for 11/3/2018 was reviewed and 4 LPNs and 12.5 NAs were noted	F 732	of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, scheduler, unit managers and house supervisors were in-serviced by the Administrator on the daily nursing staffing posting, including correct census, and accurately reporting licensed and unlicensed staff. This in-service will be part of the orientation process for all newly hired house supervisors. This training will be conducted by Director of Nursing. Unit Managers and house Supervisor are responsible for completing Daily Nurse Staffing Sheets on each shift, to cover all three shifts The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, and/or director of nursing will review the daily nursing staffing posting 5 times weekly(to include all shifts, and 7 days per week) x 12 weeks to ensure it is posted with correct census. This audit will be documented on the staff posting audit tool. The monthly Quality Improvement committee will review the results of the staff posting audit tool 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 administrator and/or Director of Nursing will present the findings and recommendations of the monthly Quality Improvement committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 45 on the schedule to work 1st shift. The daily posted staffing sheet for 1st shift indicated 3 LPNs had provided 24 hours of care and 11.5 NAs had provided 86.25 hours of care. The schedule for 2nd shift noted 1 RN scheduled to work, 3 LPNs and 12 NAs. The daily posted staffing sheet did not indicate the census for 2nd shift, and indicated 3 RNs provided 16 hours of care, 4 LPNs provided 32 hours of care and 11 NAs provided 90.5 hours of care for 2nd shift on that date. d. The nursing schedule for 12/1/2018 was reviewed and no RN and 13 NAs were noted to be scheduled to work 1st shift. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care and 12 NAs had provided 90 hours of care. The nursing schedule for 2nd shift revealed 1 RN and 10 NAs were scheduled to work 12/1/2018. The daily posted staffing sheet indicated 2 RNs had provided 16 hours of care and 12 NAs had provided 90 hours of care on 12/1/2018 for 2nd shift. The nursing schedule for 3rd shift on that date revealed 7 NAs scheduled to work. The daily posted staffing sheet indicated 8 NAs had provided 60 hours of care on 12/1/2018 3rd shift. e. The nursing schedule for 12/2/2018 was reviewed and no RN was scheduled to work 1st shift. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care on that date. The nursing schedule for 2nd shift on 12/2/2018 revealed 2 RNs were scheduled to work. The daily posted staffing sheet indicated 2.5 RNs had provided 20 hours of care on 12/2/2018. The nursing schedule for 3rd shift revealed 4 RNs and 8.5 NAs were scheduled to work. The daily posted staffing sheet indicated 3 RNs had	F 732	to the quarterly executive Quality Assurance committee for further recommendations and oversight. The Director of Nursing is responsible for the Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 46	F 732		

provided 24 hours of care and 8.5 NAs had provided 63.75 hours of care on 12/2/2018 3rd shift.

f. The nursing schedule for 12/3/2018 was reviewed and 11.5 NAs were scheduled to work 1st shift. The daily posted staffing sheet indicated 11 NAs had provided 82.5 hours of care for that shift. The nursing schedule for 2nd shift showed 13 NAs were scheduled to work. The daily posted staffing sheet indicated 11 NAs had provided 82.5 hours of care for 2nd shift on that date. The nursing schedule for 3rd shift revealed 9.5 NAs scheduled to work on 12/3/2018. The daily posted staffing sheet indicated 9 NAs had provided 67.5 hours of care on 3rd shift for 12/3/2018.

g. The nursing schedule for 1/27/2019 was reviewed and 2 RNs and 14 NAs were scheduled to work 1st shift. The daily posted staffing sheet indicated 4 RNs had provided 16 hours of care and 11 NAs had provided 82.5 hours of care for 1st shift. The nursing schedule for 2nd shift on 1/27/2019 revealed 14 NAs and 0.5 Medication Assistant (MA) were scheduled to work. The daily posted staffing sheet indicated 11 NAs had provided 75 hours of care and no MA had provided 0 hours of care for 2nd shift on that date. The nursing schedule for 3rd shift on 1/27/2019 revealed 5.5 NAs were scheduled to work. The daily posted staffing sheet indicated 5 NAs had provided 37.5 hours of care on 1/27/2018 for 3rd shift.

h. The nursing schedule for 1/28/2019 was reviewed and 3 RNs and 14 NAs were scheduled to work 1st shift. The daily posted staffing sheet indicated 4 RNs had provided 16 hours of care and 11 NAs had provided 82.5 hours of care. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 47	F 732		

nursing schedule for 2nd shift revealed 1 RN and 11.5 NAs were scheduled to work 2nd shift. The daily posted staffing sheet indicated 2 RNs had provided 16 hours of care and 13 NAs had provided 92.5 hours of care for 2nd shift on 1/28/2019. There was no census documented on the daily posted staffing sheet for 2nd or 3rd shift on 1/28/2019.

i. The nursing schedule for 1/29/2019 was reviewed and 1 RN and no MA were scheduled to work 1st shift. The daily posted staffing sheet indicated 2 RNs had provided 16 hours of car and 1 MA had provided 8 hours of care for 1st shift. The nursing schedule for 2nd shift showed 10 NAs were scheduled to work. The daily posted staffing sheet indicated 13 NAs had provided 97.5 hours of care on 2nd shift for 1/29/2019.

j. The nursing schedule for 1/30/2019 was reviewed and no RN was scheduled to work, 5 LPNs and 16 NAs were scheduled to work 1st shift on that date. The daily posted staffing sheet indicated that 1 RN had provided 8 hours of care, 4 LPNs provided 24 hours of care and 13 NAs provided 97.5 hours of care for 1st shift. The nursing schedule for 2nd shift on that date revealed 4 LPNs and 15.5 NAs scheduled to work. The daily posted staffing sheet indicated that 5 LPNs had provided 40 hours of care and 11 NA had provided 82.5 hours of care on 1/30/2019 for 2nd shift. The nursing schedule for 3rd shift revealed no RN scheduled to work that shift. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care for 3rd shift on 1/30/2019.

k. The nursing schedule for 1/31/2019 was reviewed and no RN, 5 LPNs and no MA was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 48	F 732		

scheduled to work 1st shift. The daily posted staffing sheet indicated 1 RN had provided 8 hours of care, 4 LPNs had provided 32 hours of care and 1 MA had provided 8 hours of care for 1st shift on 1/31/2019. The nursing schedule for 2nd shift revealed 3 LPNs were scheduled. The daily posted staffing sheet indicated 4 LPNs had provided 32 hours of care for 2nd shift on 1/31/2019. The nursing schedule for 3rd shift on 1/31/2019 showed 5 NAs were scheduled to work. The daily posted staffing sheet indicated 4 NAs had provided 30 hours of care for 3rd shift.

An interview was conducted with Scheduler #1 and Scheduler #2 on 1/31/2019 at 1:49 PM. Scheduler #1 reported she had been in the position of scheduler for 1 month. Scheduler #2 reported she had left the position last month to work in another department. Scheduler #1 and #2 reported they had been counting the on-duty facility supervisor as an RN or LPN on the daily posted staffing sheet. Scheduler #1 and #2 further reported they were counting the NA assigned to the non-skilled area of the facility as providing 7.5 hours of care and not subtracting the hours the NA worked on the non-skill area. Scheduler #2 reported the facility on-duty supervisor would make changes to the daily posted staffing sheet for 2nd and 3rd shift and the scheduler would check the numbers with the nursing schedule. Scheduler #1 reported that the missing census was an oversight.
The Director of Nursing was interviewed on 1/31/2019 at 4:20 PM and she reported it was her expectation the daily posted staffing sheet accurately reflected the current staff of nurses and NA for each shift.
2. Review of the facility ' s daily nursing staffing forms and daily nursing schedules 11/1/2018,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 49 11/2/2018, 11/3/2018, 12/1/2018, 12/2/2018, 12/3/2018, 1/27/2019, 1/28/2019, 1/29/2018, 1/30/2019, and 1/31/2019 revealed the daily nursing staffing forms did not report the facility census on the following 3 of 11 days: a. The census was not documented for 2nd shift on 11/2/2018. b. There was no census documented on the daily posted staffing sheet for 1st, 2nd or 3rd shift on 1/29/2019. c. No census was documented for 1st, 2nd or 3rd shifts on 1/31/2019 An interview was conducted with Scheduler #1 and Scheduler #2 on 1/31/2019 at 1:49 PM. Scheduler #1 reported she had been in the position of scheduler for 1 month. Scheduler #2 reported she had left the position last month to work in another department. Scheduler #1 reported that the missing census was an oversight. The Director of Nursing was interviewed on 1/31/2019 at 4:20 PM and she reported it was her expectation the daily posted staffing sheet accurately reflected the facility census for each shift.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 50 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the Consultant Pharmacist, Nurse Practitioner and staff the facility failed to address a pharmacy recommendation for 5 consecutive	F 756	F756 The plan of correcting the specific deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 51 months for 1 of 5 residents reviewed for unnecessary medications (Resident #70). Findings Included: Resident #70 was admitted to the facility on 5/9/18 and diagnoses included Alzheimer ' s disease, anxiety disorder and depression. A quarterly minimum data set (MDS) dated 12/5/18 for Resident #70 revealed the resident received an antipsychotic, antianxiety and antidepressant for 7 days of the look back period. Her cognition was severely impaired, and she had displayed behaviors of rejection of care for 1 to 3 days of the look back period. Review of a care plan dated 5/22/18 for Resident #70 stated the resident used psychotropic drugs with potential for side effects of cardiac, neuromuscular, gastrointestinal systems due to the use of antipsychotic, antidepressant and antianxiety medications. Interventions included pharmacy review of medications monthly or as ordered, notify physician of any significant changes and to evaluate effectiveness and side effects of medications for possible reduction and or elimination of psychotropic drugs. Review of the admission physicians ' orders dated 5/9/18 for Resident #70 revealed an order for Ativan (an antianxiety medication) 0.5 milligrams (mg) every day as needed. The order did not include a determined duration. Review of the monthly pharmacy notes for Resident #70 from admission through December 2018 revealed the pharmacist had identified the order for Ativan 0.5 mg every day as needed	F 756	On 1/24/2019 the order for resident PRN #70□s Ativan order was discontinued by Optum NP. The procedure for implementing the acceptable plan of correction for the specific deficiency cited The DON assigned the pharmacy recommendations for residents on each unit to the assigned unit manager to contact the physician for follow-up. A review of all pharmacy recommendations from the consultant pharmacist visit for January 2019 were completed by 2/25/2019 by DON to ensure all recommendations were completed with physician follow up. Systemic Review On 01/30/2019 the DON in-serviced unit managers regarding their responsibility regarding the pharmacy recommendations, including follow-up with physicians, giving to medical records for scanning and medical records returning completed recommendations to DON. This in-service will be provided to any new unit manager during orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, and/or staff facilitator will audit 50% of pharmacy recommendations monthly x 3 months to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 52 should be evaluated by the physician. Review of the medical record for Resident #70 from admission through 1/31/19 revealed one pharmacy consultant recommendation. This was dated 12/11/18 and stated the resident was admitted with an order for Ativan 0.5 mg every day as needed. Recommend to discontinue this medication as the resident only received the medication once in September and once in October. The physician ' s response to the recommendation was dated 12/11/18 and stated to continue the order for 90 days. Review of a physician ' s order for Resident #70 dated 12/12/18 stated Ativan 0.5mg every day as needed, stop date 3/14/19. Review of a physician ' s order for Resident #70 dated 1/24/19 stated to discontinue the Ativan 0.5 mg every day as needed. An interview on 1/29/18 at 4:34 pm with Nursing Assistant (NA) #6 revealed she was familiar with Resident #70 and had provided care for her. She stated the resident was typically calm and didn ' t display any behaviors. NA #6 explained in the past the resident would get upset when she provided care for her roommate and the resident didn ' t like for her to close the privacy curtain and would try and open it. She added Resident #70 had done this recently. An observation of Resident #70 on 1/29/19 at 4:40 pm revealed she was standing with a rolling walker in the hallway next to her room. She was alert, appeared calm and was responded verbally with noted confusion.	F 756	ensure recommendations received from consultant pharmacist have physician follow-up. This audit will be documented on the pharmacy recommendation audit tool. The monthly QI committee will review the results of the pharmacy recommendation 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 53	F 756		

An observation on 1/30/19 at 10:52 am of Resident #70 revealed she was sitting in a recliner in her room asleep.

An interview on 1/30/19 at 11:10 am with the Nurse Practitioner (NP) revealed she was the medical provider for Resident #70. She stated there was a period that the facility wasn ' t forwarding the pharmacy recommendations to the physicians. The NP explained the Assistant Director of Nursing (ADON) position was vacant and that was who typically had provided them with the pharmacy recommendations. She added she had discontinued the as needed Ativan order for the resident once she did receive the recommendation.

A phone interview on 1/30/19 at 3:02 pm with the Consultant Pharmacist (CP) revealed the facility had changed the process for handling the pharmacy recommendations several times. She believed the changes had been related to the multiple staff changes in nursing and administration. She stated there was a period when the facility wanted her to e-mail her recommendations to the Director of Nursing (DON) and Administrator after each visit. The CP explained her visits were not done on consecutive days and management at that time wanted it done that way. She added this was changed by a new facility Administrator who requested she e-mail her pharmacy recommendations monthly after her last visit was completed. The CP stated she had addressed that the pharmacy recommendations were not being responded do in her monthly executive summaries. The CP stated she had provided recommendations to address the use of Resident #70 ' s as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54 Ativan on 5/16/18, 6/18/18, 7/9/18, 8/16/18, 9/18/18, 10/17/18 and 11/17/18 and received no response. An interview on 1/31/19 at 10:54 am with the DON revealed there was a period that she was the only person in nursing management. She believed it was from April 2018 through December 2018. The DON explained she would receive the pharmacy recommendations and distribute them to the floor nurses to follow-up with the physicians. She added there were often agency nurses working and they just didn ' t do the follow-up. The DON stated she did identify this as a concern on 1/7/19 and started a corrective action plan. The DON provided the corrective action plan she had started for pharmacy recommendations. It included to hire unit managers, disburse pharmacy recommendations to the unit managers, unit managers to gather the paper recommendations, return to the DON for final quality check, DON to provide a copy to medical records and provide a copy to the pharmacy consultant for review on next visit. The plan did not include a root cause analysis, education components or a monitoring system. An interview on 1/31/19 at 5:54 pm with the Administrator revealed it was her expectation to be in substantial compliance with state and federal regulations based on resident centered outcome-oriented process.	F 756		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services	F 791		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 55	F 791		

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

§483.55(b) Nursing Facilities.
The facility-

§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 56 reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide timely dental services for a resident who desired dentures and had trouble chewing with his current edentulous state. This was evident for 1 of 3 residents reviewed for dental services (Resident #80). Findings Included: Resident #80 was admitted to the facility on 5/1/18 and diagnoses included alcohol cirrhosis, dysphagia, gastroesophageal reflux disease, peripheral vascular disease, polyneuropathy and pain syndrome. A quarterly minimum data set (MDS) dated 12/12/18 for Resident #80 identified he had no dentures and his cognition was intact. Review of an oral surgeon progress note dated 9/25/18 for Resident #80 revealed he had all his teeth extracted. Review of an oral surgeon progress note dated 10/23/18 for Resident #80 revealed he was seen for a post-operative appointment. His sutures were removed and was healing well. He was referred to a dental service to have dentures made. Review of a dental service progress note dated 11/2/18 for Resident #80 revealed the resident had all his teeth extracted and wanted dentures made. He was informed they would need	F 791	F791 The plan of correcting the specific deficiency On March 12, 2019 resident has a dental appointment related to dentures. The procedure for implementing the acceptable plan of correction for the specific deficiency cited 2/22/2019 Social Work interviewed residents with a BIMS score of 13 or above to ensure any dental requests had been addressed timely. Any negative findings were immediately addressed by auditor. On 2/23/2019 Social Work along with additional staff member reviewed residents with a BIMS score of 12 or less to ensure any concerns voiced or documented in last 14 days related to dental had been addressed timely. Any negative findings were immediately addressed by auditor. Systemic change On 2/25/2019, the administrator in-serviced the social workers that facility must provide/arrange for timely dental services to residents, including when a resident requests dentures and follow-up to ensure services were provided to meet resident dental need. This in-service will be part of the orientation process for all newly hired social workers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 57 Medicaid approval before they could proceed. An interview with Resident #80 on 1/28/19 at 1:02 pm revealed he had all his teeth pulled several months ago and he still hadn ' t had his denture impressions made. He stated he hadn ' t been provided an update and he didn ' t know what was going on. Resident #80 added he was having trouble chewing foods and he wanted to get his dentures. Review of the medical record for Resident #80 from 11/2/18 through 1/30/18 revealed no information regarding the status of the resident ' s dentures. An interview on 1/30/19 at 4:52 pm with the Social Worker (SW) revealed she had worked at the facility for 2 years and she was responsible for arranging dental services for Resident #80. She stated there had been an issue with the dentist listed for the resident with Medicaid. The SW added she had contacted the resident ' s case worker at Medicaid to get this changed but she didn ' t know when she did this and hadn ' t documented this anywhere. She added she would need to follow-up and determine the status of the resident ' s dentures. An interview on 1/31/19 at 5:56 pm with the Administrator revealed it was her expectation to be in substantial compliance with state and federal regulations based on a resident centered outcome-oriented process.	F 791	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, director of nursing, assistant director of nursing, and/or unit managers will audit 5 residents weekly (on random halls to include all halls) x 12 weeks to ensure any voiced or documented concerns related to dental status have been addressed timely. This audit will be documented on the dental audit tool. The monthly QI committee will review the results of the dental audit tool 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 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.	
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 58 properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the area surrounding the dumpster free from trash and debris. This was evident in 1 of 1 observation of the dumpster area. Findings Included: An observation on 1/31/19 at 12:30 pm with the Assistant Dietary Manager of the dumpster revealed there were many empty soda cans, plastic gloves, papers, cigarette butts and food on the ground surrounding the dumpster. These trash items were noted to have also blown up against the tree line which was approximately 25 to 50 feet from the dumpster. An interview with the Assistant Dietary Manager on 1/31/19 at 12:35 pm revealed either the maintenance department or housekeeping staff were responsible for making sure the dumpster area was clean and free from trash. An interview on 1/31/19 at 1:15 pm with the Administrator revealed the dietary department was responsible for keeping the dumpster area clean. She stated the departments were confused about who was responsible for cleaning this area. The Administrator added it was her expectation that the dumpster area was kept clean.	F 814	F814 The plan of correcting the specific deficiency On 2/18/2019 the dumpster was visualized by Administrator with no debris around or near on the ground. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/18/2019, the administrator in-serviced the dietary manager that the dumpster and surrounding area must be free of debris. This in-service will be completed with any new dietary manager during orientation. On 2/24/2019 & 2/25/2019 the dietary manager in-serviced dietary staff that the dumpster and surrounding area must be free of debris. This in-service will be completed with any new dietary staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, director of nursing, assistant director of nursing, maintenance director and/or unit managers will audit the dumpster and surrounding area 5 x weekly (random days including all 7 days) x 12 weeks to ensure dumpster and surrounding area is clean. This audit will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 59	F 814	be documented on the dumpster audit tool. The monthly QI committee will review the results of the dumpster audit tool 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 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.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to identify and address the use of antibiotic medication prescribed on an indefinite basis, without stop dates, for 1 of 1 resident (Resident #59) reviewed for infection. The findings included: A review was completed of the facility's Antibiotic	F 881	F881 The plan of correcting the specific deficiency On 01/30/2019 the Staff Facilitator clarified the Flagyl order for resident # 59. The Flagyl was clarified to stop on date 02/19/2019. The procedure for implementing the	2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 60 Stewardship Policy, last revised 1/22/18. Under the heading, Core Elements, were the bullet points the facility would monitor and analyze antibiotic use. Under the heading, Monitoring Antibiotic Use and Resistance, it was documented the monitoring of antibiotic prescribing use, use, and resistance may include but is not limited to: Prescribing documentation (dose, duration, indication). Further review revealed the following under Antimicrobial Stewardship; As a component of an effective infection prevention and control program, the utilization and effective management of antibiotics prescribed for residents should be monitored and the monitoring was to include: duration of antibiotic therapy. Resident #59 was originally admitted to the facility on 4/20/18 and most recently admitted on 5/23/18. The resident's cumulative diagnoses included: heart failure, chronic respiratory failure with hypoxia, chronic gout, chronic kidney disease, generalized weakness, dementia, heart disease, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of Resident #59's physician's orders revealed an order dated 1/11/19 which read as follows: 1) Discontinue Current Wound Care. 2) Clean the left heel with wound cleanser, pat dry, crush metronidazole (an antibiotic) 250 milligrams (mg), mix with surgical lubricant (make paste), apply to wound bed, cover with a foam dressing, and change daily. Review of the description of Topical Options for Wound Odor from the web site www.Advancedtissue.com revealed metronidazole was used to treat as an anti-odor	F 881	acceptable plan of correction for the specific deficiency cited On 2/18/2019 the Staff Facilitator reviewed all current residents medication administration records (MAR) to ensure all orders for antibiotics have a stop date. No negative findings. Systemic changes On 01/29/2019 the Staff Facilitator started an in-service with current nurses, on antibiotic stewardship, including antibiotic must have stop dates. This in-service was completed 02/08/2019. This in-service was added to the orientation for newly hired nurses, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Unit Manager will audit 10 resident Medical Administration Records weekly x 12 weeks to ensure if resident is on antibiotic the antibiotic has a stop date. This audit will be documented on the infection control audit form. The monthly Quality Improvement committee will review the results of the infection control audit form 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 administrator and/or Director Of Nursing will present the findings and recommendations of the monthly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 61	F 881		

topical treatment. The antibiotic could be used until the wound was healed, or up to two weeks of continual use.

Review of Resident #59's Treatment Administration Record (TAR) for January 2019 revealed the resident received metronidazole 250 mg crushed to the wound on the left heel from 1/12/19 through 1/31/19, except for 1/24/19, where the administration was not initialed as completed.

An interview was conducted with Nurse #3 on 1/30/19 at 9:28 AM. The nurse stated she had just completed the dressing change to the heel of Resident #59. The nurse stated the treatment to the left heel consisted of applying crushed metronidazole mixed in a surgical lubricant to the wound on the left heel. The nurse stated the order for the antibiotic was ordered about two weeks ago.

An interview and record review were conducted with the Staff Development Coordinator (SDC) on 1/30/19 at 4:44 PM. The SDC stated she was also the Infection Control nurse for the facility. The SDC provided a list of residents who she stated she was monitoring for having been on antibiotics at the facility. Review of the list of residents receiving antibiotics revealed Resident #59 and the use of metronidazole was not on the list. The SDC stated she was familiar with the antibiotic order for resident #59 but had not had included the resident and the use of the antibiotic on the list of residents receiving antibiotics. The SDC stated she monitored the use of antibiotics through review of physician's orders and participation in a daily clinical review meeting, which took place Monday through Friday. The

Improvement committee to the quarterly executive Quality Assurance committee for further recommendations and oversight.

The Director of Nursing is responsible for the plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 62	F 881		

SDC stated she was familiar with antibiotic stewardship and antibiotic medications were to have a stop date.

A second interview with and review of Resident #59's physician's orders was conducted with the SDC on 1/30/19 at approximately 4:55 PM. The SDC stated the resident had an order dated 1/11/19, for the resident to receive metronidazole as a topical treatment to a wound on the resident's heel. The SDC stated hospice had ordered the antibiotic treatment to the heel wound to assist with odor control. The SDC stated metronidazole was an antibiotic and there was no stop date for the order for the antibiotic.

During an interview conducted with Nurse #6 on 1/31/19 at 9:51 AM, who administered Resident #58's metronidazole during dressing change, she stated she had started working at the facility in October 2018 and she was an agency nurse. She stated she had not received any training regarding antibiotic stewardship until today.

An interview with Nurse #6 was conducted during an observation of the dressing change to the left heel of Resident #59 on 1/31/19 at 11:58 AM. The nurse was observed to have applied crushed medication, which she stated was the metronidazole, mixed in surgical lubricant to the wound on the resident's left heel and covered the wound with a dressing. The nurse stated she did not recall an odor emanating from the resident's wound.

An interview was conducted with the Director of Nursing (DON) on 1/31/19 at 2:58 PM. The DON stated it was her expectation for antibiotics to have a stop date and for the antibiotic log to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 63 accurate and complete.	F 881		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove visible dust from 3 over head ceiling fans and blades 1 located in the dining room, 1 located in day room and 1 located at nurse station of the 500 hall. The facility failed to remove visible dust from 6 ceiling lights in the hallway, 5 ceiling lights in the day room and 4 ceiling lights in the nurse station on the 500 hall. Findings included: On 01/29/2019 at 12:10 PM an observation of the dining room on the 500 hall revealed 1 ceiling fan mounted on the ceiling in the center of the room which had visible dust on the fan base and the fan blades. Residents were observed seated at tables under the fan. The 500 hall day room revealed 1 ceiling fan with visible dust at the base of the fan and on the blades of the fan. The 5 ceiling lights in the day room were observed with dust hanging from the outer light covers. An observation of 6 ceiling mounted lights in the hallway of the 500 hall revealed that 6 ceiling mounted lights had dust hanging from the outer covers of the lights. The ceiling fan behind the nurse station of the 500 hall was observed with the base of the fan and the fan blades had visible dust hanging from them. The 4 ceiling mounted	F 921	F921 F921 The plan of correcting the specific deficiency: 1/30/2019 Dust was removed from ceiling fan in the 500 Unit Dining Room, 500 Unit Day Room and Unit 500 nurses station. 1/30/3019 Dust was removed from 500 Unit ceiling lights in hallway, 500 Unit ceiling lights in day room and 500 unit ceiling lights nurses station. 1/30/2019 Dust was removed from 500 unit air vents in the 500 Unit Dining Room, 500 Unit hallway and 500 unit dayroom. 2/2/2019 Environmental Service Manager (EVS) implemented scheduled room assignments that detail what rooms and common area are assigned to housekeeper and floor techs. Staff hours for 1st shift is 6:30am to 2:30pm which consist of (5) housekeepers, (1) floater	2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 64 lights behind the nurse station revealed that there was visible dust hanging from the outer covers of the lights. On 01/30/2019 at 7:51 AM an interview and tour of the 500 hall day room, dining room and hallway was conducted with the 500 hall housekeeper. The house keeper revealed that she was the permanent housekeeper of the 500 hall and revealed that it was the responsibility of the floor technician to dust and clean the ceiling mounted fans located in the day room, dining room and at the nurse station as well as the ceiling mounted lights in the hallway, day room and at the nurse station of the 500 hall. The housekeeper revealed that she believed that those items were to be dusted weekly by the floor technician. On 01/30/2019 at 2:55 PM a tour of the 500 hall and interviews were conducted with the maintenance director, housekeeping supervisor and the facility administrator. The maintenance director, housekeeping supervisor and administrator observed and acknowledged the dust on the 3 ceiling fans and blades located on the 500 hall and the dust hanging from the ceiling lights behind the nurse station, in the day room and in the hallway. The housekeeping supervisor revealed that she had been employed for 3 weeks and had not had the opportunity to complete housekeeping rounds as she would like to in all areas of the facility. The housekeeping supervisor revealed that she believed that the house keepers were responsible to dust all ceiling fans and ceiling lights as part of the task list that they were to follow. The maintenance director revealed that he believed that the floor technicians were responsible for dusting the ceiling mounted fans and the ceiling mounted	F 921	Monday thru Friday. (1) Floor techs for Monday and Friday, Tuesday, Wednesday and Thursday (2) floor techs. 2nd shift Hours are 4:00pm to 11:00pm. Monday and Friday has (1) floor tech 2nd shift. Wednesday, Thursday and Friday have (2) Floors on 2nd shift. Routine room cleans consist of: • Clean bathrooms sinks, toilet, inside and out, top to bottom. • Fill up paper towels. • Clean stainless steel with stainless steel cleaner. • Change trash, leave (3) bags in bottom of can. • Leave (2) rolls of toilet paper/tissue. • Dust vents. • Sweep. • Mop. • Dust blinds. • Dust window seals. • Dust tables and furniture. • Clean under and behind dressers and night stands. • Check soap in residents' bathroom. • Dust bed ails and under beds with duster. • Wipe down walls and cabinets. Deep Cleaning Resident Rooms: • Deep cleaning of the rooms are done at least once a month. Deep cleaning schedules will be scheduled by the EVS Manager and will be coordinated with the Nurses and other department. • Clean all corners and baseboards. • Clean walls and mini-blinds. • High dust including vents and top of the drawer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 65 lights. On 01/30/2019 at 4:03 PM the housekeeping supervisor provided a housekeeping check list that she planned to implement in the future. The list revealed that the housekeeping staff was responsible to dust vents, light and furniture, but it did not give an expected schedule of when this was to be completed. The housekeeping supervisor revealed that she was not able to provide any completed check lists. An interview was conducted with the administrator, the housekeeping supervisor and the maintenance director on 01/31/2019 at 3:02 PM. The housekeeping supervisor revealed that each housekeeper was expected to complete light dusting of the ceiling fans and ceiling mounted light fixtures in their assigned areas and that the floor technicians were to perform a weekly deep cleaning of the ceiling fans and ceiling mounted lights in their assigned areas. The administrator revealed that the expectation was that the facility environment was to be maintained in a healthy, clean and safe manner always in all areas and that the facility complies with all state and federal rules and regulations.	F 921	• All the fixtures are to be wiped down and sanitize. • Mattress needs to be wipe down and sanitize on the both side. • Bed frames wiped down and sanitize on all 4 corners. • Furniture and beds are moved so they can be cleaned behind. • Remove and wash privacy curtains, inspect for stains or damaged and replace if necessary. • Floor stripping when needed. Floor cleaning schedule consist of: • Floor techs runs the auto scrubber to clean the floors at least once a day. • Floor techs buffs the floors frequently. • Wet floor signs are placed for protection. Eating areas and hallways cleaning schedule: • Wipe tables. • Dust window seals. • Clean windows. • Change trash. • Dust air conditioner • Sweep. • Mop. • Vacuum all carpet areas. • Spot mop halls. • Wipe down walls • Dust rails. • Dust pictures. • Dust down TV areas. • Wipe down door handles. • Clean after breakfast and lunch. • Clean fans. Nursing station cleaning schedule:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 66	F 921		

• Wipe down cabinets and walls in nourishment room.
• Wipe down microwave.
• Check soap.
• Check paper towel.
• Clean bathroom, sink and toilet inside and out, top to bottom.
• Change trash.
• Leave two (2) rolls of toilet tissue.
• Clean mirrors, windows and doors.
• Wipe down nurses station .
• Dust pictures.
• Dust rails.
• Dust vents.
• Wipe down walls.
• Sweep
• Mop.
• Clean fans.

2/1/2019 EVS Manager implemented Physical Plant/Environmental Cleanliness Checklist that managed by EVS Manager.

The procedure for implementing the acceptable plan of correction for the specific citied:

2/8/2019 All departments were in-serviced on any/all housekeeping issues should be addressed when found. If not able to correct notify the supervisor. All new employees will be educated with Orientation.

2/8/2019 All departments were in serviced that any environmental issues should be addressed when found. If unable to correct you must enter a work order in TELSs or notify the unit manager who will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 67	F 921		

then enter the work order into TELs system. All new employees will be educated with Orientation.

2/13/201p Department heads were assigned room observation assignments to be completed 5 times per week.

2/23/2019 Housekeeping staff and floor techs were educated by EVS Manger on routine cleaning of residents' rooms. This in-service will be completed by 2-25-2019. The EVS Manager will in-service all new housekeeping employees.

SYSTEMIC CHANGES:

2/8/2019 the Staff Facilitator started an in-service, including agency on identification of housekeeping issues and how to communicate the issues not fixable by staff. This in-service will be completed by 02/25/2019. This in-service will be part of the orientation process for all newly hired staff.

Manager on Duty checklist is completed on weekends that encompasses room/facility rounds.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 68	F 921	The administrator, director of nursing, assistant director of nursing or maintenance director will review 25% of room observations forms assigned to facility staff x 5 times per week x 12 weeks including Weekend Manager On Duty checklist, then 3 x a week including Manager on Duty checklist x 12 weeks, then once a week for 12 weeks including Manager on Duty checklist. The monthly quality assurance (QA) committee will review the results x 6 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 administrator and/or DON will present the findings and recommendations of the monthly QA committee to the quarterly executive QA committee for further recommendations and oversight. The administrator is responsible for implementation of the plan of correction.	
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		2/28/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 69 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure nursing staff were properly trained and competent on physical restraints to maintain an environment free of physical restraints. The facility also failed to provide nursing staff with annual in-service training on dementia management and resident abuse prevention. Findings included: 1. This citation is cross-referenced to F604: The resident has the right to be free from physical restraints. Based on record review, observations, resident and staff interviews, the facility failed to maintain an environment free of physical restraints in 10f 1 sampled residents reviewed for restraints (Resident #58). A review of the facility 2018 nursing in-service log (which included nursing assistants) revealed it reflected no annual training on physical restraints was provided to nursing staff. An interview was conducted with Nursing Assistant (NA) #6 on 1/30/2019 at 10:01 AM. She	F 947	F947 The plan of correcting the specific deficiency On 2-8-2019 staff facilitator (SF) began in-service for current nursing staff for training on restraints and facility wide on abuse prevention. In-services to be completed on 2-25-2019. On 2-24-2019 the Administrator began In-service for staff including agency on annual dementia training. In service to be completed by 2-25-2019 The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2-8-2019, the SF began in-services for current nursing staff, including agency, on restraints and facility wide on abuse prevention. Both in-services were completed on 2-25-2019. Abuse in-services is included in all new hire, including agency, orientation process. Restraint education is included for all new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 70 reported she had worked at the facility for more than 10 years, but she did not recall receiving any training on physical restraints during the past year. A phone interview was conducted with NA #8 on 1/31/2019 at 5:40 AM. She reported she had worked at the facility for 10 years and she did not recall receiving annual training regarding restraints in the past year. A phone interview was conducted with NA #9 on 1/31/2019 at 5:48 AM. She reported she had worked for the facility for over 10 years, but she did not recall receiving an any in-service on physical restraints in the past year. The staff development coordinator (SDC) was interviewed on 1/31/2019 at 3:10 PM. The SDC explained she started working as the facility ' s SCD on 1/10/2019 and the in-services provided during 2018 were collected in a folder. The SDC confirmed there was no documented information available in the folder that reflected the facility provided NA staff with any type of training on physical restraints in 2018. The Director of Nursing (DON) was interviewed on 1/31/2019 at 4:20 PM and she reported the facility did not have a list of mandatory annual in-services and while she felt certain the restraint in-services had been provided to staff, but she had no evidence of the in-services to submit. The DON reported it was her expectation that annual in-services were provided for all nursing staff, including an in-service on physical restraints. 2. A review of the facility ' s 2018 nursing in-service log (which included nursing assistants)	F 947	nursing staff, including agency for all new hires. On 2-24-2019, the Administrator began annual in-service training for dementia. Dementia in-service completed 2-25-2019. This in-service is included in orientation for new hires, including agency. Dementia training is provided annually. On 2-8-2019, the SF scheduled yearly in-services as followed (2) in February 2019 (Restorative Care and Antibiotic Stewardship). Then (1) in-service per month through December 2019, including abuse prevention, and dementia. SF will keep records for all In-services for employee files. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, director of nursing (DON), or assistant director of nursing (ADON) will audit 5 random employee files weekly x 12 weeks, then x 5 monthlyx3 month, 5 quarterly x 2 quarters to ensure the nursing employee has documentation of completion of annual training of dementia and abuse prevention, and a training related to restraints. This audit will be documented on the staff training audit tool. SF will keep a log of all In-services to monitor annual training. The monthly Quality Improvement (QI) committee will review the results of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 71	F 947		

revealed it reflected no training was provided to nursing staff regarding abuse prevention and dementia management.

An interview was conducted with Nursing Assistant (NA) #6 on 1/30/2019 at 10:01 AM. She reported she had worked at the facility for more than 10 years, she did not recall an annual training on abuse prevention and dementia management in 2018.

A phone interview was conducted with NA #8 on 1/31/2019 at 5:40 AM. She reported she had worked at the facility for 10 years, but she did not recall receiving annual training on abuse prevention and dementia management in 2018.

A phone interview was conducted with NA #9 on 1/31/2019 at 5:48 AM. She reported she had worked for the facility for over 10 years, but she did not recall an annual training on abuse prevention and dementia management in 2018.

The staff development coordinator (SDC) was interviewed on 1/31/2019 at 3:10 PM. The SDC explained she started working as the facility ' s SDC on 1/10/2019 and the nursing in-services provided during 2018 were collected in a folder. The SDC confirmed there was no documented information available in the folder that reflected the facility provided NA staff with any type training on abuse prevention and dementia management in 2018.

The Director of Nursing (DON) was interviewed on 1/31/2019 at 4:20 PM and she reported the facility did not have a list of mandatory annual in-services and while she felt certain the annual abuse in-services had been provided to staff, she

staff training audit tool 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 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 Director of Nursing is responsible for this Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/31/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 72 had no documentation of in-services were provided to staff. The DON reported it was her expectation that annual in-services, including abuse, were provided for all nursing staff.	F 947		