STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 1/6/2020 thru 1/9/2020. The facility was found in compliance with the requirment CFR 483.73 Emergency Preparedness. Event ID # NM7Q11.	E 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		2/6/20

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

Electronically Signed | 02/02/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 by: Based on record review, resident interview, and staff interview, the facility failed to provide showers as scheduled for 1 of 2 residents (Resident #54) reviewed for choices. The findings included: Resident #54 was initially admitted to the facility on 6/28/16 and most recently readmitted on 12/24/19 with diagnoses that included respiratory failure and heart failure. The 5-day Minimum Data Set (MDS) assessment dated 11/27/19 indicated Resident #54' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #54 required the limited assistance of 1 for bed mobility, transfers, walking in room, locomotion on/off the unit, dressing, toileting, and personal hygiene. She required physical help in part of her bathing activity. Resident #54 ' s active care plan was reviewed on 1/7/20 and indicated the problem/need of set up to limited assistance for all Activities of Daily Living (ADLs). This problem/need was initiated on 2/18/19 and last reviewed on 9/30/19. The interventions included, in part, assist as indicated with ADLs. During an interview with Resident #54 on 1/7/20 at 2:20 PM she stated that she enjoyed showers, but she was not receiving her showers as scheduled. She explained that sometimes she received a bed bath or a sponge bath instead of her shower. Resident #54 reported her shower days were Tuesday and Friday. She indicated it had been over 3 weeks since she last received	F 561	F561 D- 1. Resident number 54 was provided a shower, per choice, on 01/08/2020 2. All resident have the potential to be affected by the deficient practice. On 01/13/2020 the nursing administration team conducted an in-service with the nursing department regarding the shower schedule and addressed documentation of refusals. On 1/27/2020 and 1/28/2020 an audit of all resident who could participate in an interview was conducted regarding residents receiving showers per the shower schedule. No other residents were identified to have any deficient practice . 3. The facility administrator and nursing administration team will conduct daily shower audits to ensure that residents are receiving a shower or bed bath per their choice as scheduled daily for 2 weeks then, weekly for one month then, monthly for six months. This in service was completed by 1/13/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Results of the shower audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2	F 561		

two showers per week as scheduled and as per her preference.

A review of the Nursing Assistant (NA) hard copy shower sheets and electronic shower/bath documentation for Resident #54 from 11/8/19 through 1/7/20 was conducted. This documentation revealed Resident #54 received a sponge bath rather than her scheduled shower 5 times (11/8/19, 11/29/19, 12/20/19, 12/31/19, and 1/7/20) with no documentation to indicate why the shower was not provided. She received a bed bath rather than her scheduled shower 2 times (12/6/19 and 12/27/19) with no documentation to indicate why the shower was not provided.

An interview was conducted with NA #4 on 1/8/20 at 11:15 AM. NA #4 stated that showers were documented in the electronic record and on the hard copy shower sheets. She reported that if a resident refused a shower that they were to document this refusal. NA #4 indicated she was familiar with Resident #54 and that her cognition was intact, her statements were reliable, and she had no pattern of refusing showers on their scheduled days. Resident #54 ' s shower/bath documentation that indicated NA #4 was assigned to the resident when she received a sponge bath rather than her scheduled shower on 12/20/19 and 1/7/20 were reviewed with NA #4. She stated that she was unable to recall why she provided a sponge bath rather than a shower to Resident #54 on 12/20/19. NA #4 reported that she thought Resident #54 refused her shower on 1/7/20, but that she had not documented this refusal on the shower sheets or in the electronic record.

On 1/8/20 at 11:47 AM NA #2 was interviewed.

coordinator, health information, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3	F 561		

NA #2 stated she worked at the facility for about a month. She indicated that showers were documented in the electronic record and on the hard copy shower sheets. She stated that shower refusals were supposed to be documented. NA #2 reported that she was familiar with Resident #54 and that she had not recalled the resident refusing any of her scheduled showers. Resident #54 ' s shower/bath documentation that indicated NA #2 was assigned to the resident when she received a bed bath rather than her scheduled shower on 12/27/19 was reviewed with NA #2. NA #2 revealed she was unable recall why she had not given the resident her scheduled shower on 12/27/19.

During an interview with NA #3 on 1/8/20 at 11:52 AM she stated that she worked at the facility for about a month. She reported that she documented showers in the electronic record. She revealed she heard from some other staff that there were hard copy shower sheets that she was supposed to document on as well, but she had not known where these shower sheets were located. NA #3 reported that she was not very familiar with Resident #54. Resident #54 ' s shower/bath documentation that indicated NA #3 was assigned to the resident when she received a sponge bath rather than her scheduled shower on 12/31/19 was reviewed with NA #3. She was unable to recall why she provided Resident #54 with a sponge bath rather than her scheduled shower. She stated that every resident received a sponge bath daily and maybe she had not gotten around to the resident ' s shower that day or she had not known it was her shower day.

An interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 4 Administrator on 1/9/20 at 12:20 PM. He stated that showers were expected to be provided on their scheduled days. He indicated that if a bed bath or sponge bath was provided rather than a shower that the NA ' s documentation should indicate why this occurred.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the hard copy physician ' s order and the electronic physician ' s order for code status matched for 1 of 2 sampled residents (Resident #180) reviewed for advance directives. The findings included: Resident #180 was initially admitted to the facility on 3/12/09 and most recently readmitted on 9/23/19 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation. A hard copy portable Do Not Resuscitate (DNR) Physician's order dated 9/23/19 for Resident #180 was in the medical record. The order was signed by a hospital physician and had no expiration date. An electronic physician's order dated 9/23/19 indicated Resident #180 was a full code status. The quarterly Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #180's cognition was fully intact.	F 578	F578 □D 1. On 1/9/2020 resident number 180 hard copy physician’s order and the electronic physician’s order per code status were corrected and are now equivalent. 2. All residents have the potential to be affected by the deficient practice therefore an ongoing audit was completed on 01/31/2020 using the resident current daily census to ensure that all residents have the correct code status per the hard copy physician’s order and the electronic physician’s order. No other residents were identified to have any deficient practice . 3. The facility administrator nursing administration team conducted an in-service on 01/13/2020 regarding code status accuracy. The nursing administration team and health information coordinator will conduct weekly, to include residents’ admission and readmission, code status audits per the hard copy physician’s order and the electronic physician’s order accuracy of current active residents for one month then monthly for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 Resident #180's active care plan was reviewed on 1/7/20. The care plan indicated Resident #180 was a full code status. This care plan was initiated on 2/6/19 and last reviewed on 9/30/19. A review of the active physician's orders on 1/7/20 indicated the hard copy DNR physician's order dated 9/23/19 and the electronic full code physician's order remained in place for Resident #180. An interview was conducted with Nurse #1 on 1/7/20 at 11:10 AM. She stated that code status orders were located in the hard chart medical record and the electronic medical record. Nurse #1 reviewed both records and she confirmed there was an electronic physician's order dated 9/23/19 for full code status and a hard copy portable DNR physician's order dated 9/23/19 for Resident #180. Nurse #1 additionally pointed out that there was a MOST (Medical Orders for Scope of Treatment) dated 8/10/16 in the hard chart that indicated a full code status. She explained that the facility's normal process was to utilize the MOST form for code status election. She revealed that this needed to be clarified as she was unsure what the correct code status was for Resident #180. An interview was conducted with Clinical Manager (CM) #2 on 1/7/20 at 11:15 AM. He confirmed there were two different code status orders dated 9/23/19 for Resident #180. CM #2 reported that the facility's normal process was to utilize the MOST form for code status election. He stated that frequently, when a resident with a full code status was transferred to the hospital that their code status election was changed to a DNR during the hospitalization. He explained that	F 578	This in service was completed by 1/13/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Results of the code status accuracy audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7	F 578		

this code status change was recorded on a hard copy portable DNR physician's order form. He further explained that this portable DNR physician's order was then sent back to the facility with the resident when they were readmitted. CM #2 indicated that there needed to be a process in place to clarify the code status when the resident was readmitted to the facility to determine if they wished to remain a DNR or if they wanted to change back to a full code status. He revealed there was no process in place at this time for code status clarification upon readmission to the facility from the hospital. CM #2 stated that he was going to clarify the code status for Resident #180 today (1/7/20).

During a follow up interview with CM #2 on 1/7/20 at 1:50 PM he reported he spoke with Resident #180 and she elected a code status of DNR. He stated he spoke with the physician and a verbal order was received for a DNR code status for Resident #180. He indicated that an updated MOST form was signed by Resident #180 on 1/7/20 and would be signed by the physician on 1/8/20.

The Administrator was interviewed on 1/9/20 at 12:20 PM. He indicated he began working at the facility at the end of September 2019. He stated that the facility utilized MOST forms for code status election and that he expected the hard copy physician's order for code status to match the electronic physician's order. He indicated that he spoke with CM #2 regarding the need for a process to be implemented to clarify code status for readmitted residents following hospitalizations. The Administrator stated that a 100% code status review was initiated on 1/7/20 and that a new process would be implemented to ensure code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8 status election was verified when a resident was readmitted from the hospital.	F 578		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9	F 623		

under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and resident and Responsible Party (RP) and staff interview, the facility failed to provide a written discharge notice to the resident or to the RP when the resident was discharged to the hospital and failed to send a copy of the discharge notice to the Ombudsman within 30 days after the resident was discharged to the hospital for 4 of 4 sampled residents reviewed for hospitalizations (Resident # 55, #44, #180 & #2). Findings included: 1. Resident #55 was originally admitted to the facility on 6/28/18 with multiple diagnoses including Hypertension and history of traumatic brain injury. The quarterly Minimum Data Set	F 623	F623-C 1. As per the statement of deficiencies residents number 55, 44, 180 and 2 and or their RP's were not given a written notice of transfer/discharge when transferred to the hospital. Also the social worker was not notifying the Ombudsman regularly on a monthly basis with a listing of all resident discharged to the hospital per the transfer/ discharge notice form. 2. All residents have the potential to be affected by the deficient practice therefore the administrative team implemented processes to correspond with Notice Requirements Before Transfer/Discharge, regarding transfer/discharge to the hospital to ensure the accuracy in paper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 (MDS) assessment dated 12/18/19 indicated that Resident #55's cognition was intact. The MDS also indicated that the resident was discharged to the hospital on 11/2/19 and 11/25/19 and was readmitted back to the facility on 11/6/19 and 12/5/19. On 1/7/20 at 2:55 PM, Resident #55 was interviewed. He stated that he was admitted to the hospital twice in November 2019. He indicated that he had not received any written information from the facility staff regarding his discharge. On 1/7/20 at 3:55 PM, the facility's Social Worker (SW) was interviewed. She indicated that she was responsible for notifying the Ombudsman of discharges. The SW reported that she had notified the Ombudsman of discharges every three months. She reported that the last time she had notified the Ombudsman was in September 2019. She reported that she did not have any records that she had notified the Ombudsman of Resident #55's discharges from the facility to the hospital on 11/02/19 and 11/25/19. On 1/8/20 at 11:30 AM, Nurse #1 was interviewed. The Nurse stated that when a resident was transferred to the hospital, she had to notify the resident's RP that the resident was transferred to the hospital by calling him/her. She reported that she had not provided the resident or the RP a copy of the discharge notice when he was transferred to the hospital. On 1/8/20 at 10:10 AM, a follow interview was conducted with the facility's SW. She reported that she didn't know that she had to notify the Ombudsman of discharges at least every 30	F 623	work is sent with the resident and/or given to the RP. On 01/13/2020 the facility administrator in-serviced the facility social worker regarding notification to the ombudsman monthly of the residents transferred to the hospital via the transfer/discharge form. 3. The facility administrator, nursing administrative team, social service director and business office manager will conduct daily audits for one month regarding transfer/discharge notice when a resident is transferred to the hospital. Audits will continue weekly for one month then monthly for three months. The facility social worker will provide the facility administrator with the listing sent to the Ombudsman monthly for six months, then quarterly for four quarters. 4. Results of the transfer/discharge notice accuracy audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12	F 623		

days. She also indicated that she could not find any documentation or any information that she had notified the Ombudsman of discharges after 9/6/19.

On 1/8/20 at 11:35 AM, the Clinical Manager #2 was interviewed. He stated that the nurses had to call the RP to notify him/her of the reason and the date and time of the transfer. He further reported that the resident or the RP did not get a copy of the discharge notice.

On 1/8/20 at 1:09 PM, the Director of Nursing (DON) was interviewed. She stated that the nurses were notifying the RP when the resident was discharged to the hospital by calling them. The DON indicated that she didn't know that the facility had to notify the resident and the RP in writing when a resident was discharged to the hospital.

On 1/9/20 at 12:30 PM, interview with the Administrator was conducted. He stated that he expected the SW to notify the Ombudsman of discharges as required.

2. Resident #44 was originally admitted to the facility on 10/23/19 with multiple diagnoses including Congestive Heart Failure (CHF). The admission Minimum Data Set (MDS) assessment dated 11/5/19 indicated that Resident #44's cognition was intact. The MDS also indicated that the resident was discharged to the hospital on 11/30/19 and was readmitted back to the facility on 12/3/19.

On 1/7/20 at 2:55 PM, Resident #44 was interviewed. She stated that she was admitted to the hospital in November 2019. She indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13	F 623		

that she had not received any written information from the facility staff when she was transferred to the hospital.

On 1/7/20 at 3:55 PM, the facility's Social Worker (SW) was interviewed. She indicated that she was responsible for notifying the Ombudsman of discharges. The SW reported that she had notified the Ombudsman of discharges every three months. She reported that the last time she had notified the Ombudsman was in September 2019. She reported that she did not have any records that she had notified the Ombudsman of Resident #44's transfer from the facility to the hospital on 11/30/19.

On 1/8/20 at 10:10 AM, a follow interview was conducted with the facility's SW. She reported that she didn't know that she had to notify the Ombudsman of discharges at least every 30 days. She also indicated that she could not find any documentation or any information that she had notified the Ombudsman of discharges after 9/6/19.

On 1/8/20 at 11:30 AM, Nurse #1 was interviewed. The Nurse stated that when a resident was transferred to the hospital, she had to notify the resident's RP that the resident was transferred to the hospital by calling him/her. She reported that she had not provided the resident or the RP a copy of the discharge notice when she was transferred to the hospital.

On 1/8/20 at 11:35 AM, the Clinical Manager #2 was interviewed. He stated that the nurses had to call the RP to notify him/her of the reason and the date and time of the transfer. He further reported that the resident or the RP did not get a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 14	F 623		

copy of the discharge notice.

On 1/8/20 at 1:09 PM, the Director of Nursing (DON) was interviewed. She stated that the nurses were notifying the RP when the resident was discharged to the hospital by calling them. The DON indicated that she didn't know that the facility had to notify the resident and the RP in writing when a resident was discharged to the hospital.

On 1/9/20 at 12:30 PM, interview with the Administrator was conducted. He stated that he expected the SW to notify the Ombudsman of discharges as required.

3. Resident #180 was initially admitted to the facility on 3/12/09 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation.

Review of the medical record indicated Resident #180 was admitted to the hospital and discharged from the facility on 9/20/19. On 9/23/19 Resident #180 was readmitted to the facility.

The quarterly Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #180 ' s cognition was fully intact.

On 1/6/20 at 11:41 AM during an interview with Resident #180 she indicated she had a hospital stay in September 2019 and she had not recalled receiving any written information from the facility staff when he was discharged to the hospital.

On 1/7/20 at 3:55 PM, the facility ' s Social Worker (SW) was interviewed. She indicated she was responsible for notifying the Ombudsman of discharges. The SW reported that she notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 15	F 623		

the Ombudsman of discharges every three months. She believed the last time she notified the Ombudsman was in early September 2019. She reported that she did not have any records that she had notified the Ombudsman of Resident #180's discharge from the facility to the hospital on 9/20/19.

On 1/8/20 at 8:30 AM, the Ombudsman was interviewed by phone. She stated that the facility ' s SW had been sending her the list of discharges at least every three months. She reported she received a list of discharges on 9/6/19 which included the discharges for 4/1/19 through 9/6/19. She stated she also received a list of discharges on 12/9/19 which included discharges for 9/6/19 through 12/8/19.

On 1/8/20 at 10:10 AM, a follow up interview was conducted with the facility ' s SW. She reported that she didn ' t know she had to notify the Ombudsman of discharges at least every 30 days. She also indicated that she could not find any documentation or any information that she had notified the Ombudsman of discharges after 9/6/19.

On 1/8/20 at 11:30 AM, Nurse #1 was interviewed. She stated that when a resident was transferred to the hospital, she had to notify the resident's Responsible Party (RP) by phone and inform them the resident was transferred to the hospital. She reported that she had not provided the resident or the RP a copy of the discharge notice when the resident was transferred to the hospital.

On 1/8/20 at 11:35 AM, Clinical Manager #2 was interviewed. He stated that the nurses had to call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 16	F 623		

the RP to notify them of the reason, date, and time of the transfer to the hospital. He further reported that the resident and/or the RP did not get a copy of the discharge notice.

On 1/8/20 at 1:09 PM, the Director of Nursing (DON) was interviewed. She stated that the nurses were notifying the RP by phone when the resident was discharged to the hospital. The DON indicated that she didn't know that the facility had to notify the resident and/or the RP in writing when a resident was discharged to the hospital.

On 1/9/20 at 12:30 PM, an interview with the Administrator was conducted. He stated that he expected the facility staff to follow the regulations related to written notification of transfers to the hospital for the resident/RP and ombudsman.
4. Resident #2 was admitted to the facility on 3/15/18 with multiple diagnoses that included cerebral vascular accident.

Resident #2's most recent quarterly Minimum Data Set (MDS) dated 9/20/2019 indicated the resident was severely cognitively impaired.

Nursing notes specified Resident #2 was discharged from the facility to the hospital on 9/20/2019, 11/8/2019, and 12/3/2019. Further review of the resident's record revealed the resident was readmitted back to the facility after each of these hospitalizations.

On 1/8/2019 at 12:41PM, an attempt was made to contact the resident's RP and was unsuccessful.

On 1/7/20 at 3:55 PM, the facility's Social Worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 17	F 623		

(SW) was interviewed. She indicated that she was responsible for notifying the Ombudsman of discharges. The SW reported that she had notified the Ombudsman of discharges every three months. She reported that the last time she had notified the Ombudsman was in September 2019. She reported that she did not have any records that she had notified the Ombudsman of Resident #2 transfer from the facility to the hospital on

On 1/8/20 at 8:30 AM, the Ombudsman was interviewed by phone. She stated that the facility ' s SW had been sending her the list of discharges at least every three months. She reported she received a list of discharges on 9/6/19 which included the discharges for 4/1/19 through 9/6/19. She stated she also received a list of discharges on 12/9/19 which included discharges for 9/6/19 through 12/8/19.

On 1/8/20 at 10:10 AM, a follow interview was conducted with the facility's SW. She reported that she didn't know that she had to notify the Ombudsman of discharges at least every 30 days. She also indicated that she could not find any documentation or any information that she had notified the Ombudsman of discharges after 9/6/19.

On 1/7/20 at 11:28 AM, Nurse #3 was interviewed. The Nurse stated when the resident was transferred to the hospital, he notified the resident's RP of the transferred by phone. He reported the facility had not provided the resident's RP a copy of the discharge notice when he was transferred to the hospital.

On 1/8/20 at 11:35 AM, the Clinical Manager #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 18 was interviewed. He stated that the nurses had to call the RP to notify him/her of the reason and the date and time of the transfer. He further reported that the resident or the RP did not get a copy of the discharge notice. On 1/8/20 at 1:09 PM, the Director of Nursing (DON) was interviewed. She stated that the nurses were notifying the RP when the resident was discharged to the hospital by calling them. The DON indicated that she didn't know that the facility had to notify the resident and the RP in writing when a resident was discharged to the hospital. On 1/9/20 at 12:30 PM, interview with the Administrator was conducted. He stated that he expected the SW to notify the Ombudsman of discharges as required.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 19 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident, Responsible Party (RP) and staff interview, the facility failed to provide a copy of the bed hold policy to the resident or the RP when the resident was discharged to the hospital for 5 of 5 sampled residents reviewed for hospitalizations (Residents # 44, # 55, # 180, #2 & #14). Findings included: 1. Resident #55 was originally admitted to the facility on 6/28/18 with multiple diagnoses including Hypertension and history of traumatic brain injury. The quarterly Minimum Data Set (MDS) assessment dated 12/18/19 indicated that Resident #55's cognition was intact. The MDS also indicated that the resident was discharged to the hospital on 11/2/19 and 11/25/19 and was readmitted back to the facility on 11/6/19 and 12/5/19. On 1/7/20 at 2:55 PM, Resident #55 was interviewed. He stated that he was admitted to the hospital twice in November 2019. He indicated that he had not received any information	F 625	F625-C 1. As stated in the statement of deficiencies the staff at Pinehurst health and rehab failed to provide resident's number 44, 55, 180, 2, and 14 with the bed hold notice when they were transferred to the hospital. 2. All residents have the potential to be affected by the deficient practice. On 01/13/2020 the facility administrator in-serviced the facility administrative team regarding residents transferred to the hospital and/or therapeutic leave per Notice of Bed Hold Policy Before/Upon Transfer. The facility administrator and administrative team implemented processes to correspond with Notice of Bed Hold Policy Before/Upon Transfer regarding transfer/discharge to the hospital or therapeutic leave, a nursing facility must provide to the resident and the resident representative a written notice of bed hold/duration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 20 from the facility staff when he was discharged to the hospital. On 1/7/20 at 4:05 PM, the Business Office Manager (BOM) was interviewed. She stated that she started working at the facility 2 years ago. The BOM reported that she was aware of the regulation to offer the bed hold when the resident was transferred to the hospital but she was informed by the corporate office that the facility did not provide a copy of the bed hold policy to the resident or the RP since the facility's census was not full and the facility always had a bed available for the resident. On 1/7/20 at 4:36 PM, the Admission staff member was interviewed. She stated that she started working at the facility in August 2018. She reported that the facility did not offer the bed hold to the resident or the RP since the facility was not full. She added that the bed hold policy was only provided to the resident or the RP when the facility was in need of bed. On 1/9/20 at 12:30 PM, the Administrator was interviewed. He stated that the facility was not offering the bed hold to the resident or the RP since the census was low and the facility had a lot of available beds. 2. Resident #44 was originally admitted to the facility on 10/23/19 with multiple diagnoses including Congestive Heart Failure (CHF). The admission Minimum Data Set (MDS) assessment dated 11/5/19 indicated that Resident #44's cognition was intact. The MDS also indicated that the resident was discharged to the hospital on 11/30/19 and was readmitted back to the	F 625	3. On 01/17 & 01/31/2020 the facility administrator provided an in-service to all department staff regarding the bed hold regulations during scheduled monthly meetings. Audits of bed hold notification will be completed by the business office manager and nursing administrative team daily for one month then monthly for three months. 4. Results of the Notice of Bed Hold Policy Before/Upon Transfer accuracy audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 21	F 625		

facility on 12/3/19.

On 1/7/20 at 2:55 PM, Resident #44 was interviewed. She stated that she was admitted to the hospital in November 2019. She indicated that she had not received any information from the facility staff when she was transferred to the hospital.

On 1/7/20 at 4:05 PM, the Business Office Manager (BOM) was interviewed. She stated that she started working at the facility 2 years ago. The BOM reported that she was aware of the regulation to offer the bed hold when the resident was transferred to the hospital but she was informed by the corporate office that the facility did not provide a copy of the bed hold policy to the resident or the RP since the facility ' s census was not full and the facility always had a bed available for the resident.

On 1/7/20 at 4:36 PM, the Admission staff member was interviewed. She stated that she started working at the facility in August 2018. She reported that the facility did not offer the bed hold to the resident or the RP since the facility was not full. She added that the bed hold policy was only provided to the resident or the RP when the facility was in need of bed.

On 1/9/20 at 12:30 PM, the Administrator was interviewed. He stated that the facility was not offering the bed hold to the resident or the RP since the census was low and the facility had a lot of available beds.

3. Resident #180 was initially admitted to the facility on 3/12/09 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 22	F 625		

Review of the medical record indicated Resident #180 was admitted to the hospital and discharged from the facility on 9/20/19. On 9/23/19 Resident #180 was readmitted to the facility.

The quarterly Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #180 ' s cognition was fully intact.

On 1/6/20 at 11:41 AM during an interview with Resident #180 she indicated she had a hospital stay in September 2019 and she had not recalled receiving any information from the facility staff when he was discharged to the hospital.

On 1/7/20 at 4:05 PM, the Business Office Manager (BOM) was interviewed. She stated that she started working at the facility 2 years ago. The BOM reported that she was aware of the regulation to offer the bed hold when the resident was transferred to the hospital, but she was informed by the corporate office that the facility did not provide a copy of the bed hold policy to the resident and/or the Responsible Party (RP) since the facility's census was not full and the facility always had a bed available for the resident.

On 1/7/20 at 4:36 PM, the Admission staff member was interviewed. She stated that she started working at the facility in August 2018. She reported that the facility did not offer the bed hold to the resident or the RP since the facility was not full. She added that the bed hold policy was only provided to the resident and/or the RP when the facility was in need of bed.

On 1/9/20 at 12:30 PM, the Administrator was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 23	F 625		

interviewed. He stated that the facility was not offering the bed hold to the resident or the RP since the census was low and the facility had a lot of available beds.
4. Resident #2 was admitted to the facility on 3/15/18 with multiple diagnoses that included cerebral vascular accident.

Resident #2's most recent quarterly Minimum Data Set (MDS) indicated the resident was severely cognitively impaired.

Nursing notes specified Resident #2 was discharged from the facility to the hospital on 9/20/2019, 11/8/2019, and 12/3/2019. Further review of the resident's record revealed the resident was readmitted back to the facility after each of these hospitalizations.

On 1/8/2019 at 12:41pm an attempt was made to contact the resident's RP and was unsuccessful.

On 1/7/20 at 4:05 PM, the Business Office Manager (BOM) was interviewed. She stated that she started working at the facility 2 years ago. The BOM reported that she was aware of the regulation to offer the bed hold when the resident was transferred to the hospital but she was informed by the corporate office that the facility did not provide a copy of the bed hold policy to the resident or the RP since the facility's census was not full and the facility always had a bed available for the resident. The BOM confirmed Resident #2's RP was not provided bed hold information when discharged on 9/20/19, 11/08/19 and 12/03/19.

On 1/7/20 at 4:36 PM, the Admission staff member was interviewed. She stated that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 24	F 625		

started working at the facility in August 2018. She reported that the facility did not offer the bed hold to the resident or the RP since the facility was not full. She added that the bed hold policy was only provided to the resident or the RP when the facility was full or when beds were limited.

On 1/9/20 at 12:30 PM, the Administrator was interviewed. He stated that the facility was not offering the bed hold to the resident or the RP since the census was low and the facility had a lot of available beds.

5) Resident #14 was initially admitted to the facility on 3/28/17 with diagnoses that included congestive heart failure (CHF) and atrial fibrillation.

Resident #14's medical record indicated she was discharged from the facility on 12/30/19 and admitted to the hospital. On 1/1/2020 Resident #14 was readmitted to the facility.

An annual Minimum Data Set (MDS) assessment dated 10/2/19 revealed Resident #14 to be cognitively intact.

On 1/6/2020 at 10:45am Resident #14 indicated she had a hospital stay at the end of December 2019 and could not recall receiving any information from the facility regarding a bed hold.

An interview was conducted with the Business Office Manager (BOM) on 1/7/2020 at 4:05pm. She stated she had started working at the facility 2 years ago and reported she was unaware of the regulation to offer a bed hold when a resident was transferred to the hospital. She further stated, she had been informed by the corporate office that the facility did not provide a copy of the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 25 hold policy to the resident and/or Responsible Party (RP) since the facility's census was not full and the facility always had a bed available. On 1/7/2020 at 4:36pm, the admission staff member was interviewed. She stated she had worked at the facility since August 2018 and reported the facility did not offer the bed hold to the resident and/or the RP since the facility was not at full capacity. She added the bed hold policy was only provided to the resident and/or RP when the facility was in need of the bed. During an interview with the Administrator on 1/9/2020 at 12:30pm, he stated the facility was not offering the bed hold to the resident and/or RP since the census was low and the facility had plenty of available beds.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 26	F 636		

(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 27 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a comprehensive admission assessment within 14 days of admission (Resident #231) and failed to comprehensively assess a resident on the Minimum Data Set in the areas of cognition and mood (Resident #36) for 2 of 21 sampled residents. The findings included: 1) Resident #231 was originally admitted to the facility 12/5/19 and a readmission date of 12/23/19. His diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and retention of urine. During a review of Resident #231's most recent Minimum Data Set (MDS) and electronic medical record, revealed an entry MDS completed on 12/5/19, a discharge MDS with return anticipated completed on 12/14/19 and an entry MDS completed on 12/23/19. A comprehensive admission assessment was noted to be in progress with an Assessment Reference Date (ARD) of 1/3/2020. The comprehensive assessment was not complete. On 1/8/2020 at 10:10am, an interview occurred with the Director of Nursing (DON), who indicated there was not a MDS Coordinator and she was doing most of the assessments with the Assistant Director of Nursing (ADON) assisting. The DON further indicated MDS assessments were behind	F 636	F636-D 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident number 231 had the comprehensive admission assessment completed on 1/23/2020, closed on 2/1/2020 and transmitted to the state on 2/1/2020. b. Resident number 36 had the 11/8/19 MDS modified to correct section “C” and section “D” to perform the interviews as per RAI manual instructions on 1/30/2020, and transmitted to the state on 2/1/2020. 2. The regional nurse consultant performed a 100% audit of assessments to ensure assessments are completed per the time frames in the RAI manual on 01/13/2020. No other residents were identified to have any deficient practice. 3. The regional nurse consultant provided the MDS Nurse and the social worker with an in-service on 01/30/2020 regarding time frames for completion of the MDS and how to code section “C” and “D” with regard to interview with the resident or the staff. The regional nurse consultant will perform audits of 5 MDS’s for accuracy in section “C” and Section “D” as well and timeliness of MDS completion per week for one month then Monthly for 3 months. 4. Reports will be presented to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 28 and unfortunately Resident #231's assessment had not been completed 100%. An interview occurred with the Administrator on 1/9/2020 at 12:38pm and indicated the MDS assessments were being completed by the DON and ADON currently as there was not a MDS Coordinator, but expected for the MDS assessments to be completed as per requirement. 2. Resident #36 was admitted to the facility on 4/2/19 with diagnoses that included Alzheimer ' s disease. A nursing note dated 11/5/19 indicated Resident #36 was alert to herself with confusion and was able to respond verbally. The quarterly Minimum Data Set (MDS) assessment dated 11/8/19 indicated Resident #36 had clear speech and was understood by others. Both the Cognitive Pattern and Mood sections indicated Resident #36 was rarely/never understood. During a family interview with Resident #36 ' s family member on 1/6/20 at 11:05 AM he indicated the resident had some speech although it was not always logical and/or understandable. During an interview with the Assistant Director of Nursing (ADON) on 1/9/20 at 10:40 AM she reported that Resident #36 was verbal at times, but her statements were not always logical and/or understandable. The ADON further indicated that the resident cognition and mood interviews were not attempted with the resident. The ADON stated that according to the instructions in the Resident Assessment Instrument (RAI) manual,	F 636	weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Results of the Comprehensive Assessments and Timing audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 29 the interviews should have been attempted with Resident #36. The Administrator was interviewed on 1/9/20 at 12:20 PM. He indicated he expected all sections of the MDS to be comprehensively assessed. He stated that the facility was without an MDS Coordinator and that the DON and ADON were completing MDS assessments.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident was enrolled in hospice program for 1 of 1 sampled resident reviewed for hospice (Resident # 15). Findings included: Resident #15 was originally admitted to the facility on 7/1/16 with multiple diagnoses including	F 637	F 637-D 1. Resident number 15 had a significant change assessment completed on 01/13/2020, closed on 01/13/2020 and transmitted on 02/01/2020. 2. All residents have the potential to be affected by the deficient practice therefore the regional nurse consultant in-serviced the MDS nurse on 01/30/2020 regarding when to perform a significant change assessment when a resident goes on or	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 30 dementia with behaviors. The significant change in status MDS assessment dated 11/4/19 was reviewed. The assessment was incomplete, all sections were not completed except for section A. Resident #15 had a doctor's order dated 11/5/19 for hospice to evaluate and to treat the resident. The hospice note dated 11/7/19 revealed that Resident #15 started to receive hospice services on 11/7/19. On 1/8/20 at 12:14 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She stated that she was the DON and the MDS Nurse at the same time. She reported that she was not aware that Resident #15 was receiving hospice services starting in November 2019 and therefore she didn't complete a significant change in status MDS assessment in November 2019. The DON further reported that it was the corporate MDS Nurse who initiated the significant change in status MDS dated 11/4/19 sometime last week, but she didn't have the time to complete it. On 1/9/20 at 12:30 PM, the Administrator was interviewed. He stated that he expected the MDS assessment to be completed as required.	F 637	off Hospice Services. No other residents were identified to have any deficient practice. 3. The regional nurse consultant completed a 100% audit of all residents who are currently on Hospice services to ensure that a significant change in status assessment was completed per the RAI manual guidelines on 1/27/2020. The regional Nurse consultant will conduct weekly audits for 4 weeks then monthly for 3 months of Residents new to Hospice or have been discharged from Hospice to ensure the significant change in status assessment has been completed per the RAI manual direction. 4. Results of the Comprehensive Assessments After Significant Change audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 638	F638 D □	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 31 facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days after the Assessment Reference Date (ARD) for 1 of 14 sampled residents (Resident #180). The findings included: Resident #180 was initially admitted to the facility on 3/12/09 and most recently readmitted on 9/23/19 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #180' s cognition was fully intact. The most recent quarterly Minimum Data Set (MDS) assessment for Resident #180 indicated an Assessment Reference Date (ARD) of 12/20/19. A review of this quarterly MDS was conducted on 1/8/20 and revealed the following sections were incomplete at the time of the review: Sections A, G, H, I, J, K, M, N, O, and P. An interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 1/8/20 at 10:10 AM. They reported that the facility had no MDS Coordinator and the DON was completing the majority of the MDS assessments with the ADON providing assistance when she had available time. They reported that they previously had a part time MDS Nurse who retired around the end of November and they had not been given permission from management to hire a new employee to fill that position. The DON and ADON added that they have also been without a Staff Development Coordinator (SDC) since the end of summer 2019. The DON revealed they were behind with completing MDS assessments as she and the ADON were trying to	F 638	1. Resident number 180 had her 12/20/19 quarterly MDS completed and closed on 1/8/2020. 2. All residents have the potential to be affected by the deficient practice therefore the regional nurse consultant completed a 100% audit of all active residents as of 1/9/2020 on 1/13/2020. No other residents were identified to have any deficient practice. 3. The regional nurse consultant completed an in-service with the facility assistant director of nursing and MDS Nurse on 01/30/2020 regarding the types and time frames for assessment completion. The regional MDS/ regional nurse consultant will audit 20% of census monthly times 3 months then quarterly for 4 quarters to ensure there are no missed assessments. 4. Results of the Quarterly Assessments at Least Every 3 Months accuracy audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 32 complete the job responsibilities for their positions as well as completing MDS job responsibilities and SDC job responsibilities. The quarterly MDS assessment dated 12/20/19 for Resident #180 that was incomplete was reviewed with the DON. She indicated that this was not a surprise to her that this assessment was not completed as she had not had a chance to finish it. The Administrator was interviewed on 1/9/20 at 12:20 PM. He stated that he expected MDS assessments to be completed within the required timeframe. He confirmed the DON and ADON ' s report that the facility had no MDS Coordinator. He explained that the corporate ownership was presently influx and he hoped to be given direction/permission soon to hire a full time MDS Coordinator. He stated that he felt MDS assessments required a staff person whose sole focus was completing MDS assessments and care planning.	F 638		
F 641 SS=E	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 record review, resident interview, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications (Resident # 55), Preadmission Screening and Resident Review (PASRR) (Resident #3), special treatments (Resident #44), Bowel and Bladder (Residents #55 & #51), dental (Resident #49), nutrition (Resident #66), activities of daily living (ADL)	F 641	F641-E 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident number 55 had their 12/18/19 Quarterly MDS modified on 1/8/2020 to show the accurate coding of	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 33	F 641		

(Resident #52) and falls (Resident #2) for 8 of 21 sampled residents reviewed.

Findings included:

1a. Resident # 55 was admitted to the facility on 6/28/18 with multiple diagnoses including Atrial fibrillation.

Resident #55 had a doctor's order dated 12/5/19 for Eliquis (an anticoagulant medication) 5 milligrams (mgs) by mouth twice a day for Atrial Fibrillation.

The quarterly Minimum Data Set (MDS) assessment dated 12/18/19 indicated that Resident #55's cognition was intact, and he had not received an anticoagulant medication during the assessment period.

The Medication Administration Records (MARs) for December 2019 revealed that Resident #55 had received Eliquis during the assessment period.

On 1/8/20 at 5:07 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She verified that she had completed the quarterly MDS assessment dated 12/18/19 for Resident #55. She also verified that the resident had received Eliquis during the assessment period. The DON reported that she should have coded the quarterly MDS dated 12/18/19 for the use of anticoagulant medication but she did not.

On 1/9/20 at 12:30 PM. The Administrator was interviewed. He stated that he expected the MDS assessments to be coded accurately.

section “N” and section “H” and transmitted to the state on 1/20/20.
b. Resident number 3 had their Admission MDS modified on to show the accurate coding of section “A” and transmitted to the state on 2/1/2020.
c. Resident number 44 had their Admission MDS modified on to show the accurate coding of section “O” and transmitted to the state on 1/20/20.
d. Resident number 51 had their Quarterly MDS from 7/31/2019 and 10/30/2019 modified on 2/1/2020 to show the accurate coding of section “H” and transmitted to the state on 2/1/2020.
e. Resident number 66 had their 10/8/19 Quarterly MDS modified on to show accurate coding of section “K” on 2/1/2020 and transmitted to the state on 2/1/2020.
f. Resident number 52 had their Quarterly MDS modified on to show accurate coding of section “G” on 1/13/2020and transmitted to the state on 1/20/20.
g. Resident number 49 had their 4/30/19 annual MDS modified on 1/20/20 to show accurate coding of section “L” and transmitted to the state on 2/1/20.
2. All residents have the potential to be affected by the deficient practice therefore the regional nurse consultant conducted and audit of all active residents as of 1/9/2020 to ensure coding was accurate for the following sections of the MDS: N, A, O, H, K, G and J. No other residents were identified to have any deficient practice.
3. Regional Nurse Consultant conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 34 b. Resident # 55 was admitted to the facility on 6/28/18 with multiple diagnoses including Congestive Heart Failure (CHF). Resident #55 had a doctor's order dated 12/6/19 for Lasix (diuretic medication) 20 milligrams (mgs) by mouth daily for CHF. The quarterly Minimum Data Set (MDS) assessment dated 12/18/19 indicated that Resident #55's cognition was intact, and he had not received a diuretic medication during the assessment period. The Medication Administration Records (MARs) for December 2019 revealed that Resident #55 had received Lasix during the assessment period. On 1/8/20 at 5:07 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She verified that she had completed the quarterly MDS assessment dated 12/18/19 for Resident #55. She also verified that the resident had received Lasix during the assessment period. The DON reported that she should have coded the quarterly MDS dated 12/18/19 for the use of Lasix medication but she did not. On 1/9/20 at 12:30 PM. The Administrator was interviewed. He stated that he expected the MDS assessments to be coded accurately. c. Resident #55 was readmitted to the facility on 9/5/19 with multiple diagnoses including hypertension. Resident # 55 had a doctor's order dated 12/5/19	F 641	an in-service with the assistant director of nursing and the MDS Nurse on 01/30/2020 regarding accuracy coding the MDS. The Regional Nurse Consultant will conduct an audit of 20% of MDS completed weekly times one month then monthly for 3 months to ensure accurate coding of Section: N, A, O, H, K, G and J. 4. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Results of the Accuracy of Assessments audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 35	F 641		

for suprapubic catheter - to be changed at the urology clinic.

The nurse's notes dated 12/17/19 at 6:54 PM and on 12/18/19 at 4:49 AM revealed that Resident #55's suprapubic catheter was intact and draining urine.

The quarterly Minimum Data (MDS) assessment dated 12/18/19 indicated that Resident #55 did not have an indwelling urinary catheter.

The care plan dated 12/19/19 revealed that Resident #55 had a suprapubic catheter.

On 1/8/20 at 1:09 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She stated that she had completed the quarterly MDS assessment dated 12/18/19 for Resident #55. She verified that Resident #55 had a suprapubic catheter. When she reviewed the MDS assessment dated 12/18/19, she indicated that it coded wrong, she should have checked the indwelling urinary catheter, but she did not.

On 1/9/20 at 12:30 PM. The Administrator was interviewed. He stated that he expected the MDS assessments to be coded accurately.

2. Resident #3 was admitted to the facility on 6/28/19 with multiple diagnoses including Bipolar Disorder.

Review of Resident #3's FL 2 form (a form required prior to admission which contained resident's diagnoses, medications and care needed) dated 6/29/19 revealed a PASRR for 30-day rehabilitation (rehab) services only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 36	F 641		

The admission Minimum Data Set (MDS) assessment dated 7/5/19 indicated that Resident #3 did not have a Level II PASRR.

The PASRR Level II determination notification form dated 8/22/19 revealed a PASRR with no limitation unless change in condition.

On 1/7/20 at 9:58 AM, the Social Worker (SW) was interviewed. She stated that Resident #55 was admitted on PASRR level II for 30-day rehab only and she was reevaluated on 8/22/19 and remained on PASRR Level II. The SW further stated that the PASRR information was placed in the resident's face sheet and a copy of the FL 2 and PASRR determination forms were filed in the resident's chart.

On 1/8/20 at 12:14 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She stated that she had completed the admission MDS dated 7/5/19 for Resident #3. She reported that Resident #3 had a diagnosis of Bipolar Disorder on admission however she didn't know that she was a PASRR Level II. After checking the resident's records, the DON verified that the resident was a Level II PASRR and she verified that she had coded the PASRR section incorrectly.

On 1/9/20 at 12:30 PM. The Administrator was interviewed. He stated that he expected the MDS assessments to be coded accurately.

3. Resident #44 was admitted to the facility on 10/23/19 with multiple diagnoses including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 37	F 641		

Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).

Resident #44 had a doctor's order dated 10/25/19 to apply a continuous positive airway pressure (CPAP) at bedtime for sleep apnea.

The admission Minimum Data Set (MDS) assessment dated 11/5/19 indicated that Resident #44 did not use the CPAP machine during the assessment period.

The Medication Administration Records (MARs) for November 2019 revealed that Resident #44 had used the CPAP machine during the assessment period.

On 1/8/20 at 1:09 PM, the Director of Nursing (DON)/MDS Nurse was interviewed. She verified that she had completed the admission MDS dated 11/5/19 for Resident #44. She reported that she had checked the November 2019 MARs, but she might have missed the page for the CPAP and therefore she did not code the use of the CPAP machine. The DON stated that she would make a correction to the MDS.

On 1/9/20 at 12:30 PM. The Administrator was interviewed. He stated that he expected the MDS assessments to be coded accurately.

4) Resident #51 was originally admitted to the facility on 3/6/18 with a readmission date of 4/17/19. Her diagnoses included cystostomy catheter (a surgically created connection between the bladder and the skin used to drain urine), and vascular dementia.

The resident's nursing progress notes revealed on 5/19/19, Resident #51's suprapubic catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 38	F 641		

was lying on the bed. The resident refused to have the catheter reinserted or to go to the Emergency Room for replacement.

The Voiding Roster for 4/1/19 to 6/30/19 showed the resident noted to have a catheter from 4/1/19 to 5/19/19 and from 5/19/19 to 6/30/19 Resident #51 was marked as incontinent of urine.

The quarterly Minimum Data Set (MDS) dated 7/31/19 indicated Resident #51 had moderately impaired cognition and was coded with an indwelling catheter.

The most recent MDS coded as a quarterly assessment and dated 10/30/19 revealed Resident #51 to have moderately impaired cognition and was coded with an indwelling catheter.

An interview was conducted with Resident #51 on 1/8/2020 at 9:55am, who confirmed she no longer had an indwelling catheter and was incontinent of urine.

On 1/8/2020 at 10:05am interviews were conducted with Nurse Aide #5 and Nurse Aide #6 who both indicated Resident #51 did not have an indwelling catheter and was incontinent of urine.

Nurse #1 was interviewed on 1/8/2020 at 10:15am and stated Resident #51 had an indwelling catheter at one time but refused to have it replaced when it came out "some time before the summer". She verified the resident was incontinent of urine.

During an interview with the Assistant Director of Nursing (ADON)/MDS Nurse #2 on 1/8/2020 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 39	F 641		

12:10pm, she explained Resident #51 returned from the hospital in April 2019 with a suprapubic catheter which was removed by the resident in May 2019 with refusals to have it replaced or be seen in the Emergency Room.

An interview occurred with the Director of Nursing (DON)/MDS Nurse #1 on 1/8/2020 at 4:50pm. She had completed the quarterly MDS assessments dated 7/31/19 and 10/30/19. When she reviewed the MDS assessments, she indicated they were coded wrong and should have been coded as always incontinent of urine instead of the presence of an indwelling catheter.

During an interview with the Administrator on 1/9/2020 at 12:38pm, he indicated it was his expectation for the MDS to be coded accurately and felt the errors were related to the DON having to split her time to complete MDS assessments and not having an employee dedicated to the MDS role.

5) Resident #66 was originally admitted to the facility on 12/27/18. Her diagnoses included cerebrovascular accident (CVA-stroke), severe protein calorie malnutrition and dementia.

A Significant Change in Status Minimum Data Set (MDS) dated 8/26/19 revealed Resident #66 was coded for weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months.

The resident's weight data revealed the following weights during the MDS assessment look back period of Feb 2019 to August 2019, which showed a weight gain and not a weight loss:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 40	F 641		

2/11/19 109.6 pounds (lbs.)
2/21/19 107.8 lbs.
6/24/19 110.6 lbs.
7/29/19 114.6 bs
8/20/19 124.9 lbs.

The most recent MDS coded as a quarterly assessment and dated 10/8/19 indicated Resident #66 was coded for weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months.

Resident #66's weight data revealed the following weights during the MDS assessment look back period of April 2019 to October 2019, which indicated a weight gain and not a weight loss.
4/30/19 108.6 lbs.
9/3/19 114.5 lbs.
9/5/19 114.4 lbs.
9/10/19 114.4 lbs.
10/4/19 120.8 lbs.

An interview occurred with the Director of Nursing (DON)/MDS Nurse #1 on 1/8/2020 at 4:50pm. She had completed the significant change in assessment MDS dated 8/26/19 and the quarterly MDS assessment dated 10/8/19. She reviewed the MDS assessments and the weight data, indicated they were coded wrong and should have been coded as a weight gain instead of a loss.

During an interview with the Administrator on 1/9/2020 at 12:38pm he indicated it was his expectation for the MDS to be coded accurately and felt the errors were related to the DON having to split her time to complete MDS assessments and not having an employee dedicated to the MDS role.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 41	F 641		

6) Resident #52 was admitted to the facility on 11/11/19 with diagnoses that included chronic respiratory failure, malignant neoplasm of the lung and anxiety disorder.

The daily charting for Activities of Daily Living from 11/9/19 to 11/15/19 revealed Resident #52 was dependent on one staff member for dressing.

An Admission Minimum Data Set (MDS) dated 11/15/19 indicated the resident was cognitively intact. The dressing task was coded as activity did not occur for both self-performance and support provided by staff during the seven day look back period.

During an interview with Resident #52 on 1/8/2020 at 1:30pm, she indicated she preferred wearing hospital gowns for now, which were changed daily by staff at the time personal care was rendered and as needed when soiled.

On 1/8/2020 at 1:45pm an interview occurred with Nurse #3 who indicated the staff assisted with the removal and replacing of hospital gowns during daily personal care and as needed when soiled.

On 1/8/2020 at 4:50pm an interview was conducted with the Director of Nursing (DON)/MDS Nurse #1, who completed the MDS dated 11/15/19. She reviewed the MDS and ADL daily charting detail during the look back period and acknowledged the staff documented Resident #52 was dependent on one staff for dressing. She stated it was human error to code the dressing section as activity did not occur during the 7 day look back period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 42	F 641		

During an interview with the Administrator on 1/9/2020 at 12:38pm he indicated it was his expectation for the MDS to be coded accurately and felt the errors were related to the DON having to split her time to complete MDS assessments and not having an employee dedicated to the MDS role.

7. Resident #49 was admitted to the facility on 9/18/17 with diagnoses that included heart disease.

The annual Minimum Data Set (MDS) assessment dated 4/30/19 indicated Resident #49 ' s cognition was fully intact. He was assessed with no dental problems/issues. The dental section of this MDS was completed by the previous part-time MDS Nurse. The assessment was signed as complete by the Assistant Director of Nursing (ADON).

An interview was conducted with Resident #49 on 1/6/20 at 10:47 AM. He reported he wore dentures and he had no natural teeth for over a year.

An interview was conducted with the Assistant Director of Nursing (ADON) on 1/9/20 at 10:40 AM. The 4/30/19 MDS that indicated Resident #49 had no dental problems/issues was reviewed with the ADON. The ADON revealed that this MDS was coded inaccurately as Resident #49 had no natural teeth at the time of the MDS assessment. The ADON reported that this section of the MDS was completed by the facility ' s previous part time MDS Nurse who was now retired and was not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 43 The Administrator was interviewed on 1/9/20 at 12:20 PM. He indicated that he expected the MDS to be completed accurately.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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 review and staff interview, the facility failed to review and revise care plans in	F 657	F657D- 1. Address how the corrective action will	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44 the areas of medications (Resident #180), code status (Resident #36), and urinary catheter (Resident #51) for 3 of 21 sampled residents. The findings included: 1. Resident #180 was initially admitted to the facility on 3/12/09 and most recently readmitted on 9/23/19 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 9/30/19 indicated Resident #180 ' s cognition was fully intact. She was noted with no antibiotic use during the MDS review period. Resident #180 ' s active care plan was reviewed on 1/7/20 and revealed a problem/need of chronic antibiotic therapy. This problem/need was initiated on 2/6/19 and most recently reviewed on 9/30/19. A review of Resident #180 ' s active physician ' s orders was conducted on 1/7/20 and revealed no antibiotics were ordered. An interview was conducted with the Director of Nursing (DON) on 1/7/20 at 4:52 PM. She stated that she was responsible for care plan revisions as the facility had no MDS Coordinator. She reported that all new orders were reviewed in the morning clinical meetings Monday through Friday and care plans were revised after this meeting if the orders affected the resident ' s care plan. The care plan for Resident #180 that included a problem/need of chronic antibiotic therapy was reviewed with the DON. The active physician ' s	F 657	be accomplished for those residents found to have been affected by the deficient practice. a. Resident number 180 care plan was revised on 01/13/2020 to show a discontinuation of chronic antibiotic therapy related to UTI's. b. Resident number 36 had her care plan updated on 1/8/2020 to reflect a correct DNR status. c. Resident number 51 care plan has been updated to reflect discontinuation of the Supra pubic catheter on 01/13/2020. 2. All residents have the potential to be affected by the deficient practice therefore 100% of active residents care plans as of 1/9/2020 census listing was completed by 1/13/2020 by the Regional Nurse consultant. 3. The regional nurse consultant provided an in-service to the Minimum Data Set Coordinator and Assistant Director of Nursing, regarding care planning and keeping them current and reflective of resident's status on 1/15/2020. The Nursing administrative team will conduct care plan audits weekly for 20% of the resident census for 4 weeks then monthly for 3 months to ensure care plans are current and reflective. 4. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Results of the Care Plan Timing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45 order for Resident #180 that showed no antibiotic use was reviewed with the DON. The DON reviewed Resident #180 ' s record and revealed she was previously on chronic antibiotic therapy related to Urinary Tract Infection (UTI) risk, but that this medication was discontinued on 7/6/19. She stated that this care plan should have been revised after the 7/6/19 discontinuation order was reviewed in the morning clinical meeting. The Administrator was interviewed on 1/9/20 at 12:20 PM. He confirmed the DON ' s report that the facility had no MDS Coordinator and the DON was completing the majority of the MDS Coordinator ' s job responsibilities with the ADON providing assistance. The Administrator explained that the corporate ownership was presently influx and he hoped to be given direction/permission soon to hire a full time MDS Coordinator. He stated that he felt care planning and MDS assessments required a staff person whose sole focus was on those tasks. 2. Resident #36 was admitted to the facility on 4/2/19 with diagnoses that included Alzheimer ' s disease. The quarterly Minimum Data Set (MDS) assessment dated 11/8/19 indicated Resident #36 had short term and long-term memory problems and severely impaired decision making. Resident #36 ' s active care plan was reviewed on 1/8/20 and revealed the problem/need of a full code status. This problem/need was initiated on 4/9/19 and most recently reviewed on 9/30/19. A review of Resident #36 ' s active physician ' s	F 657	and Revisions accuracy audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 46	F 657		

orders revealed a hard copy physician ' s order dated 6/30/19 for a Do Not Resuscitate code status and an electronic physician ' s order dated 7/1/19 for a DNR code status.

An interview was conducted with the Assistant Director of Nursing (ADON) on 1/9/20 at 10:40 AM. She stated that the Director of Nursing (DON) was unavailable for interview and that she was responsible for answering any questions for the DON. The ADON indicated that the DON was in charge of care plan revisions and she assisted the DON as the facility had no MDS Coordinator. She reported that all new orders were reviewed in the morning clinical meetings Monday through Friday and care plans were expected to be revised after this meeting if the orders affected the resident ' s care plan. The care plan for Resident #36 that included the problem/need of a full code status was reviewed with the ADON. The hard copy physician ' s order dated 6/30/19 and electronic physician ' s order dated 7/1/19 that revealed Resident #36 was a DNR code status was reviewed with the ADON. She stated that she believed Resident #36 was a full code status on admission and the care plan was not revised when the code status changed. The ADON indicated that this care plan should have been revised after the 6/30/19 and 7/1/19 orders for a DNR code status were reviewed in the morning clinical meeting.

The Administrator was interviewed on 1/9/20 at 12:20 PM. He confirmed that the facility had no MDS Coordinator and the DON was completing the majority of the MDS Coordinator's job responsibilities with the ADON providing assistance. The Administrator explained that the corporate ownership was presently influx and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47	F 657		

hoped to be given direction/permission soon to hire a full time MDS Coordinator. He stated that he felt care planning and MDS assessments required a staff person whose sole focus was on those tasks.

3) Resident #51 was originally admitted to the facility on 3/6/18 with a readmission date of 4/17/19. Her diagnoses included cystostomy catheter (a surgically created connection between the bladder and the skin used to drain urine), and vascular dementia.

The resident's nursing progress notes revealed on 5/19/19, Resident #51's suprapubic catheter was lying on the bed. The resident refused to have the catheter reinserted or to go to the Emergency Room for replacement.

The Voiding Roster for 4/1/19 to 6/30/19 showed the resident noted to have a catheter from 4/1/19 to 5/19/19 and from 5/19/19 to 6/30/19 Resident #51 was marked as incontinent of urine.

An interview and observation was conducted with Resident #51 on 1/8/2020 at 9:55am, who confirmed she no longer had an indwelling catheter and was incontinent of urine.

Nurse #1 was interviewed on 1/8/2020 at 10:15am and stated Resident #51 had an indwelling catheter at one time but refused to have it replaced when it came out "some time before the summer". She verified the resident was incontinent of urine.

A review of the resident's active care plan was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48	F 657		

reviewed on 1/9/2020 and revealed a problem area for the use of a suprapubic catheter. This problem area was reviewed and revised by the Director of Nursing/MDS Nurse #1 on 7/29/19, 10/24/19 and 12/5/19.

An interview was conducted with the Assistant Director of Nursing (ADON)/MDS Nurse #2 on 1/9/2020 at 9:30 am. She stated the Director of Nursing (DON) was unavailable for interview and she was responsible for answering any questions for the DON. The ADON indicated the DON was in charge of care plan revisions and she assisted as the facility did not have a MDS Coordinator. She reported all new orders or resident changes were discussed in the morning clinical meetings Monday through Friday and care plans were expected to be revised after the meeting if it affected the resident's care plan. The care plan for Resident #51 which included the problem area for the use of a suprapubic catheter was reviewed by the ADON. She explained Resident #51 returned from the hospital in April 2019 with a suprapubic catheter which was removed by the resident in May 2019 with refusals to have it replaced or be seen in the Emergency Room. She indicated the care plan should have been revised since the resident no longer had a suprapubic catheter but could not state why it was not.

During an interview with the Administrator on 1/9/2020 at 12:38pm, he confirmed the facility did not have a MDS Coordinator and the DON was completing the majority of the MDS Coordinator's job responsibilities with the ADON providing assistance. The Administrator stated he felt care planning and MDS assessments required a staff person whose main focus was on those tasks. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 49 indicated it was his expectation for the care plans to be an accurate reflection of the resident.	F 657		
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 observation, record review, resident interview, and staff interview, the facility failed to maintain a hazard free environment as evidenced by a footboard that was not secured to a resident' s bed for 1 of 1 residents (Resident #49) reviewed for accident hazards. The findings included: Resident #49 was admitted to the facility on 9/18/17 with diagnoses that included heart disease. The quarterly Minimum Data Set assessment dated 10/29/19 indicated Resident #49 ' s cognition was fully intact. He had no behaviors and no rejection of care. Resident #49 required the limited assistance of 1 for bed mobility, transfers, locomotion on the unit, and toileting. He required the extensive assistance of 1 for dressing and personal hygiene. Resident #49 was not steady on his feet and he was only able to stabilize with staff assistance.	F 689	F689-D 1. Resident number 49 foot board was repositioned per manufactures recommendations on 01/06/2020 by the wound care nurse. 2. All residents have the potential to be affected by the deficient practice. On 01/13/2020 the maintenance/housekeeping department conducted a 100% audit of all beds to include: crank, semi and fully electric, ensuring the manufactures recommendation per functionality and maintenance. No other residents were identified to have any deficient practice . 3. On 01/17 & 01/31/2020 the facility administrator provided an in-service to all department staff during scheduled monthly meetings regarding the accident free environment(s) to include resident beds and assistive devices. The facility administrator, maintenance and housekeeping departments will audit all	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 Resident #49 ' s care plan included the problem/need of limited to total assistance with all Activities of Daily Living. The interventions included, in part, assistance as needed. This care plan also included the problem/need of the risk for injuries from falls. The interventions included, in part, remind resident to call for assistance with bed mobility and transfers. These problem/needs were both initiated on 2/24/19 and last reviewed on 10/29/19. An interview and observation were conducted with Resident #49 on 1/6/20 at 10:47 AM. Resident #49 was alert and oriented to person, place, time, and situation. He was lying in his bed and his footboard was observed to be crooked with the right end lower than the mattress and the left end higher than the mattress. When the footboard was pressed on it was easily moved. Resident #49 revealed his bed had been in this condition for at least 2 months. He stated he reported this information to the Supply Clerk when she was in his room and she informed him she would tell the Administrator. He reported that he had not verbally spoke to any other staff about this issue as he believed all staff were able to easily see the issue just by looking at his bed. Resident #49 indicated he had no falls during the time that his footboard was in this position, but he indicated that he felt it could cause a fall if needed to use the footboard to hold onto for support to stand up. An observation was conducted of Resident #49 ' s bed on 1/7/20 at 9:40 AM. The footboard of his bed was observed to be in the same condition as on 1/6/20 at 10:47 AM. Medication Aide #1 was interviewed on 1/7/20 at	F 689	beds weekly for 4 weeks then monthly for 4 months to ensure the foot boards are safely on the bed. This in service was completed by 1/13/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Results of the accident free environment(s) to include resident beds and assistive devices audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 51	F 689		

11:20 AM. She reported that today was the first day she had worked at the facility since August or September. She stated that she recalled observing Resident #49 ' s bed with a tilted/crooked footboard the last time she worked. She reported that she was unable to remember if she reported to this issue to anyone. She explained that when there was a maintenance issue the staff were supposed to write this information in the hard copy maintenance log notebook. Medication Technician #1 reviewed the maintenance log from 8/1/19 through 1/7/20 and revealed there was no documentation in the log about Resident #49 ' s footboard.

Nursing Assistant (NA) #1 was interviewed on 1/7/20 at 11:25 AM. She stated that she regularly worked with Resident #49. She reported she had not recalled noticing any issues with the resident ' s bed. Resident #49 ' s bed was observed with NA #1 and she stated, "oh my", and indicated the footboard was tilted/crooked. She revealed that she would let the maintenance staff know verbally and she would also write this information in the maintenance log notebook. NA #1 stated that she had not observed this issue with the footboard before, but she thought maybe this was because the sheets were normally covering the footboard area on Resident #49 ' s bed.

On 1/7/20 at 4:08PM, Nurse #2 was interviewed by phone. She stated that she regularly worked with Resident #49. She reported she had not recalled noticing any issues with the resident ' s bed footboard.

During an interview with the Supply Clerk on 1/8/20 at 11:35 AM she stated that she recalled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 52	F 689		

Resident #49 reporting to her that his mattress was dipped down on the left side and she believed that this was because he always laid more toward the left side of the bed. She indicated she had no recollection of Resident #49 reporting to her an issue with the bed ' s footboard. She stated she had not observed any issues with the footboard nor had she informed the Administrator of any issues.

An interview was conducted with the Maintenance Assistant on 1/8/20 at 8:50 AM. He stated that he was never informed of the issue with Resident #49 ' s improperly secured footboard prior to 1/7/20. He reported that staff were to write any maintenance issues in the maintenance notebook. He indicated he would have repaired the bed and/or replaced the bed as there were extra beds available in facility. The Maintenance Assistant spoke about Resident #49 ' s footboard. He explained there were two poles attached to the footboard and these poles slid into slots that attached to the bedframe. He reported that if the poles were not slid straight into the slots that the footboard would not be fully secured which could cause it to be crooked/tilted and to be easily moved when pressure was applied.

An interview was conducted with the Treatment Nurse on 1/8/20 at 11:43 AM. She revealed that she entered Resident #49 ' s room on the afternoon of 1/7/20 and observed the footboard on his bed to be crooked/tilted. She stated that she removed the footboard from the bed by pulling the footboard and its attached poles up, and then reinserting the footboard ' s poles into the proper slots attached to the bedframe. The Treatment Nurse stated that she had not noticed this issue with Resident #49 ' s bed prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53 1/7/20, but that the resident told her yesterday that it been like that "for awhile". During an interview with the Administrator on 1/9/20 at 12:20 PM he stated that he expected all beds to be in proper working condition and for all parts of the bed to be secured. He indicated that if staff noticed an issue with a bed that they were to write this information in the maintenance log, so the issue could be corrected. He acknowledged than an unsecured footboard could cause an accident if a resident leaned on the footboard for support when transferring.	F 689		
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. §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.	F 756		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54 (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 record review, staff and consultant pharmacist interview, and physician interview, the pharmacist failed to identify and report an irregularity related to the need to obtain a hemoglobin A1C level for 1 of 5 residents (Resident #63) reviewed for unnecessary medications. The findings included: Resident #63 was admitted to the facility on 6/25/2018 with diagnoses including heart failure and type 2 diabetes mellitus. Resident #63's physician orders revealed the resident had orders in place to receive Novolog and Lantus insulin since being admitted to the facility. The resident's medical record revealed the most recent hemoglobin A1C (a lab that measures blood glucose over time) results for Resident #63	F 756	F756D 1. Resident number 63 had a Hemoglobin A1C drawn on 01/09/2020 and reviewed by a pharmacist and physician on 01/13/2020. 2. All residents have the potential to be affect by the deficient practice therefore a 100% audit of all Diabetic resident was conducted on 01/09/2020 to ensure that each resident had a Hemoglobin A1C drawn every 6 months. No other residents were identified to have any deficient practice . 3. The facility assistant director of nursing conducted an in-service with nursing administrative team alerting them to monitor for diagnosis specific lab work to be done timely on 01/09/2020. The pharmacist consultant provided in-service education the facility assistant director of nursing on 01/13/2020. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55 were drawn on 8/15/2018. A comprehensive care plan for Resident #63, dated 11/12/2019, indicated the resident was at risk for labile blood sugars related to diabetes. The resident's quarterly Minimum Data Set (MDS) dated 11/15/2019 revealed the resident received insulin 7 out of 7 days during the assessment period. Resident's #63's January 2020 medication administration record revealed the resident received Novolog insulin before meals and at bedtime and Lantus (long acting insulin) at 38 units subcutaneously daily. Resident #63's monthly pharmacy drug regime reviews revealed from 2/19/2019 to January 2020, the consultant pharmacist did not make a recommendation for a hemoglobin A1C labs to be performed. On 1/08/20 at 4:01 PM an interview with the Assistant Director of Nursing (ADON) was conducted in which she stated the facility policy for monitoring resident's on insulin included monitoring the resident's hemoglobin A1C every 6 months. She acknowledged Resident #63's medical record indicated the last hemoglobin A1C monitoring was done on 8/15/18 and that there was not a pharmacy recommendation for a hemoglobin A1C level to be obtained since that time. In an interview with the pharmacy consultant on 1/09/2020 at 9:15 AM he stated he would recommend a hemoglobin A1C every 6 months for a resident receiving insulin. He further stated	F 756	Nursing administrative team will complete audits for diagnosis specific lab work with regard to Hemoglobin A1C monthly for 3 months then quarterly for 2 quarters Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Results of the accident free environment(s) to include resident beds and assistive devices audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56 he reviewed Resident #63's record for the first time in February of 2019. The consultant pharmacist stated he did not recommend a hemoglobin A1C level at that time and it just got missed when he recommended the labs in August 2019. He further stated a hemoglobin A1C should have been requested in August 2019, and explained it was just an oversight on his part. The facility physician/medical director was interviewed on 1/09/2020 at 10:00 AM. He stated he typically checks hemoglobin A1C on residents receiving insulin every 6 months. He further stated the recommendation for the hemoglobin A1C check usually comes from the consultant pharmacist.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 57 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview, the facility failed to monitor and follow up on labs as ordered by the physician for 1 of 5 residents (# 56) reviewed for unnecessary medications. Findings included: Resident # 56 was admitted to the facility on 9/12/2019 with multiple diagnoses including diabetes mellitus type 2, hypertension, and Alzheimer's disease. Review of the resident's Medication Administration Record (MAR) revealed the resident received Plavix, aspirin, Lasix, Glimiperide, potassium chloride, and sliding scale insulin. A History and Physical (H&P) was completed by the facility medical director on 9/19/2019 in which he recommended running a complete blood count to monitor platelet count (due to Plavix use), renal panel to monitor kidney function, and hemoglobin A1C to monitor how well blood glucose was being controlled over time. He subsequently wrote an order for these labs to be drawn on 9/20/2019. On 1/08/20 at 3:29 PM an interview was conducted with the Assistant Director of Nursing (ADON) in which she stated the labs ordered by the medical director on 9/20/19 were not entered in E-lab and therefore were not run. She further stated, it was her suspicion that the resident's	F 757	F757-E 1. Resident number 56 had labs drawn on 01/09/2020 to include platelet count, renal panel, and Hemoglobin A1C and report to the physician on 01/13/2020. 2. All residents have the potential to be affected by the deficient practice therefore the nursing administrative team conducted a 100% audit of all active resident as of 1/9/2020 for labs ordered and completed. No other residents were identified to have any deficient practice. 3. The nursing administrative team will review all telephone orders daily for one month to include labs ordered to ensure they are entered into the E-lab system. Audits will continue monthly for 3 months. 4. Results of the Unnecessary Drugs to include but not limited to platelet count, renal panel, and Hemoglobin A1C audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 58	F 757		

insurance information was not entered into eLab and therefore samples were not collected from the resident for testing by the laboratory.

In an interview with Clinical Supervisor #1 on 01/09/20 at 10:20 AM, she stated the facility physician would make a list of residents he had seen on rounds and any orders he would like added or changed. He would include labs on that list. Clinical Supervisor #1 stated she would go in eLab and order the labs. She further explained what happened with Resident #56's blood lab order. She stated Resident #56 was a new resident at the time the labs were ordered and he was not in the eLab system. Clinical Supervisor # 1 stated that she has to fax the face sheet with all the new resident's insurance information to the lab and then wait for them to enter the resident in their system before she can order any labs. She stated once the lab enters the resident's information, she can enter labs. Clinical Supervisor #1 stated she just keeps checking the eLab system until the resident is entered in the system by the lab and then she enters the labs ordered by the medical director. She explained that Resident #56's labs were ordered on a Friday and he was not in the system. She recalled faxing the resident's information but she stated she forgot to follow up on Monday.

On 1/09/20 at 10:07 AM an interview was conducted with the medical director. He stated he writes the order for labs then hands those orders off to the clinical nurse supervisors when he completes rounds for the day. When he comes in for rounds, he meets with the nursing supervisors and reviews previously ordered labs. He stated to his knowledge, there is not a system in place to catch a situation such as this one where the labs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 59 were ordered but never collected or processed. He stated he does expect ordered labs to be completed.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 60 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, Pharmacy Consultant, and physician, the facility failed to identify targeted behavioral symptoms and monitor those behavioral symptoms to support the clinical rationale for the use of antianxiety medication, and also failed to monitor for potential side effects of psychotropic medication for 1 of 5 residents (Resident #74) reviewed for unnecessary medications. The findings included: Resident #74 was admitted to the facility on 11/19/14 and most recently readmitted on 12/16/19 with diagnoses that included dementia with behavioral disturbance, anxiety, and depression. A physician ' s order for Resident #74 dated 10/18/19 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) twice daily for anxiety. A review of the electronic medical record and the	F 758	F 758 D 1. Resident number 74 had monitoring for side effects and behaviors added to the MAR on 1/8/2020 ensuring nursing staff and nursing administrative team can monitor. 2. All residents have the potential to be affect by the deficient practice therefore a 100% audit of all residents receiving psychotropic to ensure monitoring for behaviors and side effects are documented on the MAR on 1/13/2020. No other residents were identified to have any deficient practice and no other residents were identified to have any new target behaviors. Each nursing measure included in the MAR that requires monitoring of behaviors has a drop down box that includes the following list of targeted behaviors for nurses to assess: cursing, disrobing in public, disruptive sounds, hitting, hitting self, biting, biting self, kicking, pacing, public sexual acts,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 61 hard copy record revealed no corresponding documentation to indicate what targeted behavioral symptoms were identified that required the initiation of Ativan for Resident #74. A Psychiatric Nurse Practitioner (PNP) note dated 11/1/19 indicated Resident #74 ' s attending physician managed her Ativan use. The PNP assessed Resident #74 ' s condition as stable, no mood issues, and no symptoms of anxiety. The quarterly Minimum Data Set (MDS) assessment dated 12/4/19 indicated Resident #74 ' s cognition was moderately impaired. She was assessed with no behavioral symptoms and no rejection of care. She received antianxiety medication daily during the MDS review period. Resident ' s #74 ' s active care plan included the problem/need of antianxiety medication utilization. This problem/need was last reviewed on 12/9/19. The interventions included, in part, record/monitor resident for patterns of target behaviors. Resident #74 was admitted to the hospital on 12/10/19 and was readmitted to the facility on 12/16/19. Resident #74 ' s hospital discharge summary date 12/16/19 indicated her Ativan 0.5 mg twice daily was discontinued during her hospital stay. The hospital discharge medication orders included an order to discontinue her Ativan 0.5 mg twice daily that was in place prior to her hospitalization. A physician ' s progress note dated 12/17/19 indicated Resident #74 was alert and oriented times three. There was no mention in this note of anxiety, behavioral symptoms, or the use of Ativan.	F 758	pushing, rummaging, scratching, screaming, smearing bodily waste, smearing foods, threatening, throwing food, sexually abusing. 3. The consultant pharmacist provided the nursing department with an in-service regarding monitoring for side effects from psychoactive medication and monitoring for behaviors on 01/10 & 01/13/2020. Audits will be conducted weekly for 4 weeks to ensure documentation is in place to monitor for side effects and behaviors then monthly for 4 months by the nursing administrative team. This in service was completed by 1/13/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Results of the Free from Unnecessary Psychotropic Meds/PRN Use audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 62	F 758		

A nursing note completed by Clinical Manager (CM) #2 on 12/17/19 indicated the physician met with this resident and new orders were received.

A physician ' s order entered into the electronic medical record by CM #2 for Resident #74 dated 12/17/19 indicated Ativan 0.5 mg twice daily for anxiety.

A Social Work (SW) note dated 12/20/19 indicated Resident #74 had no identified behavioral symptoms.

An observation was conducted of Resident #74 on 1/6/20 at 12:15 PM. She was seated on her bed listening to an audiobook. No behavioral issues or medication side effects were observed.

A review of Resident #74 ' s active physician ' s orders was conducted on 1/7/20. Resident #74 continued to receive Ativan 0.5 mg twice daily for anxiety.

A review of the Medication Administration Records (MARs) from 10/18/19 through 1/7/20 revealed no targeted behavioral symptoms were identified related to the use of Ativan for Resident #74 and no behavior monitoring or side effect monitoring was in place.

An observation was conducted of Resident #74 on 1/8/20 at 11:30 AM. She was laying on her bed listening to an audiobook. No behavioral issues or medication side effects were observed.

An observation was conducted of Resident #74 on 1/9/20 at 9:45 AM. She was laying on her bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 63	F 758		

with her eyes closed. No behavioral issues or medication side effects were observed.

Nurse #4 was interviewed on 1/9/20 at 9:50 AM. He reported that he was familiar with Resident #74 and that she had no behavioral issues. He indicated that the resident spent the majority of the day in her room listening to her audiobooks. Nurse #4 was asked what the facility ' s protocol was for behavior monitoring and side effect monitoring documentation for residents on psychotropic medications. He stated that behavior monitoring and side effect monitoring documentation was on the MAR. Nurse #4 was unable to explain what behaviors Resident #74 had that related to the use of Ativan.

An interview was conducted with CM #2 on 1/8/20 at 3:30 PM. He reported that behavior monitoring, and side effect monitoring were documented on the MAR for residents on psychotropic medications. He indicated that targeted behavior identification and behavior monitoring allowed the facility to track what the medication was being used for, if behaviors were ongoing or were stable, and if the medication was needed or was able to be decreased and/or discontinued. CM #2 further indicated that psychotropic medication use presented the risk of potential side effects which required the staff to monitor the residents closely to ensure no side effects occurred.

This interview with CM #2 continued. Resident #74 ' s orders for Ativan 0.5 mg twice daily and the MARs that indicated no targeted behavioral symptoms were identified and no behavior monitoring, or side effect monitoring was in place since the Ativan ' s initiation on 10/18/19 were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64	F 758		

reviewed with CM #2. He confirmed that Resident #74 had no targeted behavioral symptoms identified and no behavior monitoring, or side effect monitoring related to the use of Ativan since its initiation on 10/18/19. CM #2 stated that when a psychotropic medication order was input into the electronic medical record that behavior monitoring, and side effect monitoring was also supposed to be input into the electronic medical record so that it would populate onto the MAR for the nurses to fill out when that psychotropic medication was administered. The 12/17/19 physician ' s order to restart Resident #74 ' s Ativan 0.5 mg twice daily that was discontinued during her hospitalization was reviewed with CM #2. CM #2 stated he received the verbal order from the physician to restart Resident #74 ' s Ativan on 12/17/19, but he was unable to explain what behavioral symptoms required the Ativan to be restarted. He added that he failed to input the behavior monitoring and side effect monitoring into the electronic medical record when he input the 12/17/19 Ativan order.

During a phone interview with the Pharmacy Consultant on 1/9/20 at 9:15 AM he indicated that targeted behaviors were expected to be identified for psychotropic medications, so the facility was able to track what the medication was being used for, if behaviors were ongoing or were stable, and if the medication was needed or was able to be decreased and/or discontinued. He explained that identification of targeted behaviors provided a rationale for what the medication was being used to control. The Pharmacy Consultant additionally explained that psychotropic medication use presented the risk of potential adverse side effects which required the staff to monitor the residents closely to ensure no side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 65 effects occurred. He stated that the facility ' s behavior monitoring, and side effect monitoring were documented on the MARs. An interview was conducted with Resident #74 ' s physician on 1/9/20 at 10:00 AM. The physician indicated that he expected staff to identify targeted behaviors and monitor those behaviors for residents on psychotropic medications. He explained that this documentation should show what behavioral symptoms were occurring that made the use of the psychotropic medication necessary. The physician stated that due to the risk of potential adverse side effects of psychotropic medications that he expected staff to monitor residents closely to ensure no side effects occurred. The physician was asked what behavioral symptoms Resident #74 had that required the use of Ativan. He indicated he believed Resident #74 suffered from hypochondriasis as her baseline was always being worried that something was wrong with her or complaining about something or another. An interview was conducted with the Administrator on 1/9/20 at 12:20 PM. The Administrator stated that targeted behaviors were expected to be identified for psychotropic medication use to justify the need for the medication. He stated that staff were expected to document behavior monitoring and side effect monitoring on the MAR.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 66 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date multi-dose medications including insulin, inhaler and Purified Protein Derivative (PPD) when opened on 2 of 2 medication carts (200 hall and 400/600 hall medication carts) and 1 of 1 medication room (400/500/600 hall medication room) observed. Findings included: 1. On 1/8/20 at 4:33 PM, the 200-hall medication cart was observed. The following were observed: A used Basaglar (insulin used to treat Diabetes Mellitus (DM)) kwikpen that was undated. The	F 761	F761 E 1. As stated in the statement of deficiency the nursing department failed to date multiuse medications, on 01/08/2020 the open multiuse medications were discarded. New multiuse medications were obtained and when opened they were dated as per manufactures recommendations. 2. All residents have the potential to be affected by the deficient practice. On 01/22/2020 the nursing administration team conducted a 100% audit of all medication carts to remove any multiuse medications that were found not to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 67 instruction on the pen read "discard 28 days after opening". A used Advair (used to treat Chronic Obstructive Pulmonary Disease (COPD) 100-50 diskus that was undated. The instruction on the box read "discard 1 month after removed from the foil pouch or after all inhalation powder has been used or it read 0". On 1/8/20 at 4:40 PM, Nurse #1 was interviewed. She observed the used Basaglar kwikpen and the used Advair inhaler and stated that she could not find the date when they were opened. She indicated that the Basaglar and the Advair should have been dated when opened but they were not. On 1/9/20 at 10:10 AM, the Clinical Manager #2 was interviewed. He stated that he was assigned on the east wing (100, 200, & 300 halls) and was responsible for checking the medication carts and medication room for expired and undated medications once a week. He reported that he had checked the carts and the medication room, but he might have missed the Basaglar and the Advair. On 1/9/20 at 12:35 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she expected all multi-dose medications including insulin, inhaler and PPD to be dated when opened and to follow the manufacturer's specification for expiration guidelines. 2. On 1/8/20 at 4:50 PM, the 400/600 hall medication cart was observed. The following were observed:	F 761	dated and replaced with new multiuse medications and dated when opened per manufactures recommendations. No other residents were identified to have any deficient practice . 3. The nursing administration team conducted an in-service with the nursing department regarding dating multiuse medications on 01/23-24/2020. The nursing administration team will conduct weekly audits of all medications carts and medication rooms to ensure all multiuse medications are dated when open as appropriate. Audit will continue monthly for 3 months. This in service was completed by 1/13/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Results of the Label/Storage Drugs and Biologicals in medications carts and medication rooms audits will be reviewed by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 68	F 761		

A used Lantus (insulin used to treat DM) pen that was undated. Instruction on the pen "discard 28 days after opening".

A used Wixela or Advair 250-50 diskus that was undated. The instruction on the box read "discard 1 month after removed from the foil pouch or after all inhalation powder has been used or it read 0".

A used Breo Ellipta (used to treat COPD) 100-25 inhaler that was undated. The instruction on the box read "discard 6 weeks after opening the moisture protection foil tray or when counter read 0 or whichever comes first".

On 1/8/20 at 5:05 PM, the Medication Technician (Med Tech) #2 was interviewed. She stated that she was assigned to pass the medications on 400/600 hall. She observed the used Lantus, Breo Ellipta and the Advair and verified that they were not dated when opened. The Med Tech indicated that the multi-dose medications should have been dated when opened.

On 1/9/20 at 11:10 AM, the Clinical Manager #1 was interviewed. She stated that she was assigned on the west wing (400, 500 & 600 halls) and was responsible for checking the medication carts and medication room for expired and undated medications. She reported that she checked the medication carts and the medication room once a week and she might have missed these undated medications.

On 1/9/20 at 12:35 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she expected all multi-dose medications including insulin, inhaler and PPD to be dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 69 when opened and to follow the manufacturer's specification for expiration guidelines. 3. On 1/9/20 at 10:50 AM, the medication room on 400/500/600 hall was observed. There was a used bottle of PPD that was undated. On 1/9/20 at 11:10 AM, the Clinical Manager #1 was interviewed. She stated that she was assigned on the west wing (400, 500 & 600 halls) and was responsible for checking the medication carts and medication room for expired and undated medications. She reported that she checked the medication carts and the medication room once a week and she might have missed the undated PPD. On 1/9/20 at 12:35 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she expected all multi-dose medications including insulin, inhaler and PPD to be dated when opened and to follow the manufacturer's specification for expiration guidelines.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews and physician interview, the facility's Quality Assessment and Assurance (QAA)	F 867	F867 E 1. The original Plan of Correction from 12/20/2018 will be reviewed and revised	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 70 Committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the annual recertification survey dated 12/20/2018. This was for two recited deficiencies in the areas of Accuracy of Minimum Data Set (MDS) Assessments and Labeling and Storage of Drugs and Biologicals that were previously cited on 12/20/2018. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This citation is cross referenced to: F641-Based on record review, resident interview, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications (Resident # 55), Preadmission Screening and Resident Review (PASRR) (Resident #3), special treatments (Resident #44), Bowel and Bladder (Residents #55 & #51), dental (Resident #49), nutrition (Resident #66), activities of daily living (ADL) (Resident #52) and falls (Resident #2) for 8 of 21 sampled residents reviewed. During the facility's recertification survey on 12/20/2018 the facility was cited for failure to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses (Residents #31 and #73), bladder and bowel (Residents #40 and #73), medications (Residents #67 and #40), prognosis (Resident #40), hospice (Resident #86), activities of daily living assistance (Resident #42), skin conditions (Resident #63), and therapies (Resident #54) for 8 of 17 residents	F 867	by the QA team and will correspond with the current 02/06/2020 Plan of Correction and will be implemented upon completion of the review. 2. The QA&A Committee will complete the review of the 12/20/2018 plan of correction to identify any past deficiencies and ensure compliance going forward citing regulations F641 and 761. 3. The facility administrator, director of nursing, assistant director of nursing, and MDS coordinator(s) will review the Plan of Correction to ensure all measures and recommendations are being followed. This review will continue weekly for 4 weeks then monthly for 12 months. 4. Results of the QAPI/QA&A revisions will be implemented and maintained by the QA&A committee to include the facility administrator, director of nursing, unit managers, MDS coordinator, medical records, and admissions coordinator, social services director, maintenance and housekeeping supervisor during the monthly QA &A meetings to ensure substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 71	F 867		

reviewed.

F761-Based on record review, observation and staff interview, the facility failed to date multi-dose medications including insulin, inhaler and Purified Protein Derivative (PPD) when opened on 2 of 2 medication carts (200 hall and 400/600 hall medication carts) and 1 of 1 medication room (400/500/600 hall medication room) observed.

During the facility's recertification survey of 12/20/18 the facility was cited for failure to discard two expired insulin pens and failed to date when opened three insulin pens (400 even/600 hall cart) for 1 of 2 medication carts reviewed for medication storage.

An interview was completed on 1/09/2020 at 11:55 AM with the Administrator and the Assistant Director of Nursing (ADON). The ADON stated the repeat citation in MDS accuracy was likely due to human error that occurs then she and the Director of Nursing (DON) are constantly interrupted while trying to complete the MDS. The ADON further stated she felt the use of agency nurses accounted for the inconsistencies found with labeling and dating medications on the medication carts.