STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING ______ B. WING ______	C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHABILITATION CENTER	**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 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite on 2/23/21 and continued offsite through 2/25/21. One of the 9 complaint allegations was substantiated resulting in a federal deficiency. See Event ID# QSN311.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		3/12/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/12/2021

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

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F 585	Continued From page 1 postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;	F 585		

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to thoroughly investigate a grievance and failed to provide the family follow up regarding the grievance investigation for 1 (Resident #3) of 3 residents reviewed for grievances. The findings included: Resident #3 was admitted on 7/23/20 with a diagnosis of a cervical fusion with myelopathy due to a cervical disc herniation. His admission Minimum Data Set dated 7/30/20 indicated he was cognitively intact, exhibited no behaviors, and required supervision to total assistance with his activities of daily activities	F 585	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F585	

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F 585 Continued From page 3
(ADLs).

Review of the facility grievance policy revised 01/2021 read the Grievance Officer will lead the investigation and issue official decisions to the resident.

Review of a grievance dated 8/1/20 read his family called and reported that Nurse #1 told Resident #3 that he did not need to call his family about his care. It read Nurse #1 told Resident #3 she didn't need his family telling her how to do her job. The grievance read follow up was done over the phone on 8/3/21 with his family.

Review of a nursing note dated 8/1/20 read the family called with multiple concerns to include Nurse #1 being rude. After an interview with Resident #3 and his family, the grievance did not rise to the level of abuse. The family requested the Administrator contact them on Monday. The Administrator was notified and the family was given the regional ombudsman's name and phone number. The note read every issue was addressed.

In an interview with the Social Worker (SW) #1 on 2/23/21 at 1047 AM, she stated she did not handle the grievance for Resident #3 but the Administrator was notified. She stated she documented that the follow up was done over the phone with Resident #3's family but she did not call the family. SW #1 stated she was under the impression that the previous Director of Nursing followed up with Resident #3 and his family. She stated the grievance may have been missed because the facility was in a COVID-19 outbreak.

In a telephone interview with the Weekend

F 585

1. Corrective action for resident(s) affected by the alleged deficient practice:
On 08/12/2020 Resident #3 was discharged from the facility, therefore no further corrective action could be completed for this resident.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents who have grievances have the potential to be affected by the alleged deficient practice. On 03/03/2021 a corrective action was initiated by the Administrator and the Social Services Director. On 03/05/2021, the Administrator and the Social Services Director completed a 100 % audit of all grievances for the last 6 months from October 2020 through February 2021 reviewing the grievance log and each grievance to identify any grievances that were not thoroughly investigated and any grievances where the resident or resident representative didn□t receive follow up as part of the grievance investigation. The audit didn□t identify any new issues related to grievances.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

Education:
On 03/10/2021, the Clinical Nurse Consultant initiated education with the Administrator and the Director of Nurses on the process for resolving grievances listed below:

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F 585	Continued From page 4 Supervisor on 2/24/21 at 1:48 PM, she stated she interviewed Resident #3 and Nurse #1. Resident #3 confirmed the allegations made by his family but Nurse #1 denied making the statements to Resident #3. The Weekend Supervisor stated she did not get any statements but rather called the Administrator to let him know about the incident and to see if there was anything else she needed to do. The Weekend Supervisor stated she wrote up the grievance and left a copy for SW #1 and the Administrator. In a telephone interview with the Administrator on 2/24/21 at 1:48 PM, he confirmed he was the facility grievance officer and responsible for ensuring any grievance was thoroughly investigated and follow up was completed with the person making the grievance. He stated there was no evidence of any additional investigation other than what the Weekend Supervisor completed. He stated he did not call the family or speak with Resident #3 regarding the grievance. The Administrator stated it was overlooked and not intentional. He stated it was his expectation that administrative staff complete an investigation for any resident grievance and follow up with the person making the grievance.	F 585	" Resident Rights Summary " Grievance Policy and Procedure Education will be completed with all of the remaining Department Heads including the Social Worker, Business office Manager, Admissions Director, Activities Director, and Nurse Managers. As of 03/12/2021 at 5pm, any Department Manager who has not received the Grievance Process education will not be allowed to work until the training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Social Services Director will complete an audit of all grievances weekly Monday Friday to include grievances from the weekend ensure that the grievance process has been followed. The audit will be completed by using the Grievance Process Audit Tool for compliance. These audits will be completed weekly for a period of 4 weeks and then monthly for a period of 3 months or until resolved by the QA committee. Reports will be presented to the monthly Quality Assurance committee by the Social Services Director to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting.	

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F 585	Continued From page 5	F 585	Date of Compliance: 03/12/2021	