STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 3/15/21 through 3/19/21. Additional information was obtained on 3/24/21. Therefore, the exit date was changed to 3/24/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 0PO111.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 3/15/21 to conduct a recertification and complaint survey and exited on 3/19/21. Additional information was obtained on 3/24/21. Therefore, the exit date was changed to 3/24/21. A total of 10 allegations were investigated and all of them were unsubstantiated. Event ID# 0PO111.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to	F 563		4/12/21

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

Electronically Signed | 04/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 563	Continued From page 1 the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member, staff and Hospice Representative interviews, the facility failed to promote compassionate care visits for a resident (Resident #255) with overall declining condition for 1 of 3 resident reviewed for falls. The findings included: Resident #255 was admitted to the facility on 06/11/2020 following a hospitalization for repair of left fractured hip after a fall. The resident's admitting diagnoses included dementia, atrial fibrillation, and coronary artery disease. Review of Resident #255's admission Minimum Data Set (MDS) dated 06/25/2020 revealed she was severely cognitively impaired for daily decision making but was able to make her needs known and required extensive assistance of 1 to 2 staff for most activities of daily living (ADL). Review of a fall event report dated 08/30/2020 revealed Resident #255 had an unwitnessed fall in her room around 2:02AM resulting in bilateral hematomas to her head and bruising to her face	F 563	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F563 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #255 discharged from the facility on September 6, 2020. How the facility will identify other residents having the potential to be affected by the same deficient practice. On March 11, 2021, a letter was mailed to all Resident Responsible Parties notifying them of the procedures for visitation. This letter did	

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F 563	Continued From page 2	F 563		

and a skin tear to her left shoulder with bruising. The resident was assessed by Nurse #1 and neurological checks and vital signs showed no abnormalities for the resident.

Review of a Nurse Practitioner progress note dated 08/31/2020 revealed Resident #255 was seen after 2 falls and was described as "lethargic today."

Review of the Nurse progress notes revealed the following:

09/02/2020 at 12:22AM revealed resident had a fall out of bed but was alert and responsive with confusion which has been noted as increased since previous falls on 08/29/2020 and 08/30/2020.

09/02/2020 at 5:36AM revealed Resident #255 was "out of bed in a recliner, restless and throwing her legs over the side of the chair, requiring frequent repositioning and reminders to keep legs on pillows to keep pressure off heels, resident refused AM meds spit them out."

09/02/2020 at 6:39AM revealed Nurse #3 "spoke with family related to fall, resident noted with increased restlessness, confusion, with agitation fighting staff, yelling at staff for positioning her, resident has not slept this shift."

09/03/2020 at 12:48AM revealed Nurse #3 wrote "remains with confusion and agitation when awake."

Interview on 03/16/2021 at 1:52PM with Resident #255's family member revealed the family member had called the Administrator numerous

inform everyone that visitation was open, however an appointment is requested to ensure proper social distancing and infection control procedures occur during the visit.
On March 11, 2021 a call was placed by the administrator to all Resident Responsible Parties notifying them of the procedures for visitation. The call did inform everyone that visitation was open, however an appointment is requested to ensure proper social distancing and infection control procedures occur during the visit. Families were made aware that compassionate care visits were also available for any resident experiencing a need, including/but not limited to a change/decline in condition or end of life care.
On March 12, 2021 all residents received a Daily Newsletter from the Activities Department. This newsletter did inform all residents that visitation was open, however an appointment is requested to ensure proper social distancing and infection control procedures occur during the visit. All nurses were in serviced on 4/12/21 on the visitation updates as well as resident condition changes/situation that may indicate Compassionate Care visitation.
The measures put into place or systemic changes made to ensure that the deficient practice will not recur. On March 11, 2021 the Vice President of Operations in-serviced the administrator with the updated guidelines for visitation including but not limited to, indoor visitation, outdoor visitation, and compassionate care

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F 563	Continued From page 3 times with no response. She stated she finally found a number for their corporate office and talked with someone there and they gave her the Administrator's email address. According to the family member, she emailed the Administrator with no response about visiting Resident #255. The family member stated she later emailed her again about billing concerns and stated the Administrator had responded to her email about her billing concerns. The family member stated she had finally on 09/03/2020 requested Hospice for Resident #255 because she wanted to be able to spend time with her as she continued to decline. According to the family member it was not until 09/02/2020 when she talked with the Nurse Practitioner (NP) that she had been offered the opportunity to visit Resident #255. She stated the NP told her she would be able to visit the resident on 09/03/2020. Interview on 03/17/2021 at 5:20PM with the Administrator revealed she had checked her emails and phone logs and only had one email from Resident #255's family member. She stated in September of 2020 they were in a COVID outbreak and visitation was limited to compassionate care only. The Administrator could not recall any time the family member had made a request to her to visit Resident #255. She stated she was having the corporate office check their phone logs and emails to see if there had been a contact by the family member to them. The Administrator stated even during their outbreak they were still doing compassionate care visits. Review of a Hospice note dated 09/03/2021 revealed a Social Worker (SW) interviewed the family member of Resident #255 and the family	F 563	visitation. This in-service was revised again on April 1 ,2021 to review changes in CMS guidance. On March 12, 2021 the administrator in-serviced all parties involved in visitation including the Wellness Coordinator, Activity Director, Business Office Assistant, Admissions, and Marketing. They were all educated on the correct guidance for visitation including but not limited to indoor visitation, outdoor visitation, and compassionate care visits. How the facility plans to monitor its performance to make sure that solutions are sustained. Beginning April 12, 2021, all visitation requests will be recorded for tracking x 4 weeks. The tracking log will consist of the resident and visitor name, and date and time of visit. The results of the tracking log will be reviewed weekly by the Administrator or Director of Nursing and presented to the QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with the requirements to allow visitation for the residents will be reeducated. Disciplinary action may be used based upon the progressive discipline process. Completion Date: 4/12/2021	

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F 563	Continued From page 4	F 563		

member told her "I just want to be able to visit with Resident #255 and I want to make sure that she is comfortable and not suffering because she has been through so much."

Review of a Hospice note dated 09/04/2021 revealed a Social Worker (SW) had contacted the family member who shared with her Resident #255 had had numerous falls recently and her head was injured. The family member stated the resident had become less responsive each day and declined rapidly since the fall. The SW documented the family member tearfully described the resident's face as severely bruised with knots on her forehead. According to the report the family member had contacted Administration at the facility regarding visiting her mom and was waiting to hear back for approval. The family member stated if she was not allowed to visit Resident #255 at the facility, she would like for the resident to be moved to Inpatient Hospice.

Interview on 03/24/2021 at 1:27PM with the Hospice SW revealed she had talked with Resident #255's family member and had met with her in person. She stated when she talked with the family member on the phone on 09/03/2020 her main concern was she had not been able to visit the resident at the facility. The family member told the SW she was awaiting a call back from the facility to give her permission to see Resident #255. The family member further stated to the SW if she was not going to be able to visit the resident, she wanted her moved to inpatient Hospice where she could spend more time with her. The SW stated they were able to complete the admission process and get the resident transferred on 09/06/2020.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		4/12/21

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F 580	Continued From page 6 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Nurse Practitioner and facility Physician interviews, the facility failed to notify the Physician when a resident's (Resident #255) Computerized Tomography (CT) scan had been cancelled by the facility for 1 of 3 residents reviewed for falls. The findings included: Resident #255 was admitted to the facility on 06/11/2020 following a hospitalization for repair of left fractured hip after a fall. The resident's admitting diagnoses included dementia, atrial fibrillation, and coronary artery disease. Review of Resident #255's admission Minimum Data Set (MDS) dated 06/25/2020 revealed she was severely cognitively impaired for daily decision making but was able to make her needs known and required extensive assistance of 1 to 2 staff for most activities of daily living (ADL). Review of a fall event report dated 08/30/2020 revealed Resident #255 had an unwitnessed fall in her room at around 2:02AM resulting in bilateral hematomas to her head and bruising to her face and skin tear to her left shoulder with	F 580	F580 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Physician/nurse extender was notified of the missed notification on 3/17/2021. Resident #255 discharged from the facility on 9/6/2020. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit for physician notification for resident change in condition, missed appointments or orders for the past two weeks was conducted on 4/12/2021, by the administrator and the Regional Operations Manager. No other issues were noted. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The administrator, DON, staff development coordinator, unit coordinators, and the transportation CNA were in-serviced on 4/12/2021 by the Regional Operations Manager on the	

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F 580	Continued From page 7 bruising. The resident was assessed by Nurse #1 and neurological checks and vital signs showed no abnormalities for the resident. Review of a nursing progress note dated 08/30/2020 at 4:35AM written by Nurse #1 revealed Resident #255 "Noted to have 2 hematomas bilaterally on forehead. Skin tear noted to left shoulder with bruising already present. SBAR (Situation, Background, Assessment and Recommendation) placed in MD (Medical Doctor) book for notification. Neurochecks initiated and within normal limits at this time." Review of a Nurse Practitioner progress note dated 08/31/2020 revealed Resident #255 was being seen related to "Fall, among other concerns. The note stated "seen today after a 2 falls. Staff report that Resident #255 was found on the floor beside her bed. Resident is lethargic today. Obtain CT scan of the head without contrast for possible bleed, post fall, and lethargy." Review of the Transportation Aide's appointment calendar for 2020 revealed the CT scan for Resident #255 had been scheduled to be done on 09/01/2020 at the local hospital. The appointment book also revealed the CT scan had been cancelled by the Administrator due to COVID in the building. Interview on 03/17/2021 at 10:30AM with the NP revealed she recalled Resident #255 and stated she had dementia, heart failure and other diagnoses they were treating her for at the facility. The NP further stated she had ordered a CT scan on 08/31/2020 and stated it had been scheduled	F 580	requirement and process of Physician/nurse practitioner notification for any resident change in condition, including/but not limited to appointments or procedures. How the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 4/12/2021, the daily appointment schedule will be brought to the morning meeting for review and notification as needed and the Director of Nursing or designee will review nursing notes to ensure physician notification occurs. In addition, beginning on 4/12/2021, the Regional Operations Manager will review the appointment calendar and any changes to ensure provider notification if indicated, weekly x 4 weeks. The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with the requirements to notify the physician will be reeducated. Disciplinary action may be used based upon the progressive discipline process. Completion Date: 4/12/2021	

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F 580	Continued From page 8	F 580		

for 09/01/2020. The NP indicated she had not seen the results of the scan and had not been notified the scan was not done on 09/01/2020. The NP stated if the CT scan was cancelled, she would have expected to be notified.

Interview on 03/17/2021 at 3:00PM with the Transportation Aide (TA) revealed she was responsible for scheduling appointments and stated she had scheduled an appointment for Resident #255 to have a CT scan at the local hospital to be done on 09/01/2020. The TA further stated the CT scan had been cancelled by the Administrator according to her note but stated she did not remember why but in her note she had documented it was due to COVID in the building.

Interview on 03/17/2021 at 5:08PM with the facility Physician revealed he recalled the resident but did not recall her specific falls. The Physician indicated he was not aware the CT scan had been cancelled for Resident #255 and stated he would have expected the facility to have contacted the NP to let her know the scan had been cancelled.

Interview on 03/17/2020 at 5:20PM with the Administrator revealed she could not recall why she would have cancelled Resident #255's CT scan unless she had been told to do so by the hospital or a physician practice. She stated she did not know why she had cancelled the appointment.

A follow up interview on 03/19/2021 at 9:30AM with the Nurse Practitioner (NP) revealed the normal process at the facility would have been for the NP to have been notified the CT scan had

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F 580	Continued From page 9 been cancelled. She stated if she had been notified, she would have ordered the resident to have been sent out to the local hospital emergency department for the CT scan.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Nurse Practitioner and Physician interviews, the facility failed to ensure a resident who was on antiplatelet therapy, had an unwitnessed fall with head injury resulting in hematomas and bruising received a Computerized Tomography (CT) scan as ordered by the Nurse Practitioner for 1 of 3 residents reviewed for falls (Resident #255). The findings included: Resident #255 was admitted to the facility on 06/11/2020 following a hospitalization for repair of left fractured hip after a fall. The resident's admitting diagnoses included dementia, atrial fibrillation, and coronary artery disease. Review of Resident #255's admission Minimum Data Set (MDS) dated 06/25/2020 revealed she was severely cognitively impaired for daily	F 684	F684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #255 discharged from the facility on 9/6/2020. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was conducted on 4/12/2021, by Administrator and the Regional Operations Manager to ensure all current residents with appointment referrals made within the last two weeks had been carried out as ordered. No other issues were noted. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/12/2021 the	4/12/21

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F 684	Continued From page 10 decision making but was able to make her needs known and required extensive assistance of 1 to 2 staff for most activities of daily living (ADL). Review of Resident #255's physician orders revealed she was on Plavix 75 milligrams (mg) one tablet once a day to be given in the morning. The Plavix was discontinued effective 09/03/2020. Review of a fall event report dated 08/30/2020 revealed Resident #255 had an unwitnessed fall in her room at around 2:02AM resulting in bilateral hematomas to her head and bruising to her face and skin tear to her left shoulder with bruising. The resident was assessed by Nurse #1 and Resident #255's neurological checks and vital signs showed no abnormalities for the resident. Review of a nursing progress note dated 08/30/2020 at 4:35AM written by Nurse #1 revealed Resident #255 "noted to be in floor at bedside. Claims she was trying to get up and fell. ROM (range of motion) x 4 without difficulty. Noted to have 2 hematomas bilaterally on forehead. Skin tear noted to left shoulder with bruising already present. SBAR (Situation, Background, Assessment and Recommendation) placed in MD (Medical Doctor) book for notification. Neurochecks initiated and within normal limits at this time. No acute distress noted. Call light within reach. Will continue to monitor." Review of a Nurse Practitioner progress noted dated 08/31/2020 revealed Resident #255 was being seen related to "Fall, among other concerns. The note stated "seen today after a 2	F 684	Regional Operations Manager in-serviced the administrator, director of nursing, staff development coordinator, all nurses, unit coordinators, and the transportation CNA on the requirements and process of ensuring all appointments are carried out as ordered by the physician and or nurse practitioner. How the facility plans to monitor its performance to make sure that solutions are sustained. Beginning the daily appointment schedule will be brought to the morning meeting for review and notification as needed. Also, the Regional Operations Manager will review all appointments weekly x 4 to ensure all are carried out as ordered. The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with the requirements to notify the physician will be reeducated. Disciplinary action may be used based upon the progressive discipline process. Completion Date: 4/12/2021	

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

(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 684	Continued From page 11	F 684		

falls. Staff report that Resident #255 was found on the floor beside her bed. Resident is lethargic today. Obtain CT scan of the head without contrast for possible bleed, post fall, and lethargy."

Review of the Transportation Aide's appointment calendar for 2020 revealed the CT scan for Resident #255 had been scheduled to be done on 09/01/2020 at the local hospital. The appointment book also revealed the CT scan had been cancelled by the Administrator due to COVID in the building.

Phone interview on 03/16/2021 at 1:52PM with Resident #255's family member revealed when Nurse #1 contacted her on 08/30/2020 early AM (could not remember exact time), Nurse #1 told her Resident #255 had fallen during the night and hit her head and had "two pump knots on her head that looked like devil horns." The family member stated she said to Nurse #1, "I assume you will be sending her out for a CT scan" and stated she told Nurse #1 she wanted Resident #255 sent out for a CT scan. The family member indicated she had spoken with the NP on 08/31/2020 after she had evaluated her mother and the NP told her she had ordered a CT scan of her head without contrast.

Interview on 03/17/2021 at 10:30AM with the NP revealed she recalled Resident #255 and stated she had dementia, heart failure and other diagnoses they were treating her for at the facility. The NP further stated she had ordered a CT scan on 08/31/2020. The NP indicated she had not seen the results of the scan and after looking could not locate the results and stated it must not have been done. The NP further indicated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 684	Continued From page 12	F 684		

had not been notified the scan was not done.

Phone interview on 03/17/2021 at 11:38AM with Nurse #1 revealed she had taken care of Resident #255 when she had fallen and hit her head on 08/30/2020. She stated after the resident fell, she had two large hematomas on her head but stated her neurological checks and vital signs were normal.

Interview on 03/17/2021 at 3:00PM with the Transportation Aide (TA) revealed she was responsible for scheduling appointments and stated she had scheduled an appointment on 08/31/2020 for Resident #255 to have a CT scan at the local hospital to be done on 09/01/2020. The TA further stated the CT scan had been cancelled by the Administrator according to her note but stated she did not remember why except in her note she had documented it was due to COVID in the building.

Interview on 03/17/2021 at 5:08PM with the Physician revealed he recalled the resident but did not recall her specific falls. The Physician indicated he was not aware the CT scan had been cancelled for Resident #255 and stated he would have expected the facility to have contacted the NP to let her know the scan had been cancelled and then she could have sent the resident out to the hospital to have it done.

Interview on 03/17/2020 at 5:20PM with the Administrator revealed she could not recall why she would have cancelled Resident #255's CT scan unless she had been told to do so by the hospital or a physician practice. She stated she did not know why she had cancelled the appointment.

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 684	Continued From page 13 Follow up interview on 03/19/2021 at 9:30AM with the Nurse Practitioner (NP) revealed the normal process at the facility would have been for the NP to have been notified the CT scan had been cancelled but stated she had not been notified the scan was cancelled. She stated if she had been notified, she would have ordered the resident to have been sent out to the local hospital emergency department for the CT scan.	F 684		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/12/21

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F 690	Continued From page 14 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to prevent a latex urinary catheter from being inserted into a resident using latex gloves with a latex allergy and failed to assess the situation for 1 of 3 residents (Resident #76) reviewed for urinary catheters. Resident #76 told a total of 4 staff members before her catheter was changed that she was experiencing symptoms of an allergic reaction. As a result, Resident #76 experienced burning, itching, pain and swelling for a 28-hour period. The findings included: Resident #76 was admitted to the facility on 3/23/20 with diagnoses that included uterine cancer. Review of Resident #76's face sheet revealed her allergies listed were latex and tape. A previous reaction to latex was not included in Resident #76's chart. The annual Minimum Data Set (MDS) assessment dated 1/19/21 indicated Resident #76 was cognitively intact and had an indwelling urinary catheter.	F 690	F690 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The catheter for Resident #76 was changed on 3/12/2021 to a silicone catheter. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed on 3/16/2021 by the Director of Nursing and Staff Development Coordinator to review all active residents with a Latex allergy or a catheter. No other issues were noted. All nurses and CNA II□s were in-serviced on 3/16/2021, on the correct process and procedure of reviewing resident allergies prior to providing care to residents. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. All new hire nurses and CNA II□s will be oriented on correct procedure of reviewing resident allergies in orientation.	

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F 690	Continued From page 15 Resident #76's care plan initiated on 1/27/20 and last revised on 2/12/21 indicated Resident #76 had a urinary catheter related to urinary retention. The goals listed were for Resident #76 to have no harmful impaction, obstruction, or urinary retention through the next review date. The following interventions were listed: monitor for any signs or symptoms, urinary retention, or a urinary tract infection and to assist to the restroom for the highest continence possible. The review revealed Resident #76 did not have a care plan related to her latex allergy. A review of a Physician Order dated 3/11/21 indicated to change the catheter and obtain a urinary specimen due to bladder pressure and pain. An interview conducted on 3/15/21 at 9:42 AM with Resident #76 revealed on 3/11/21 the facility staff had placed a latex indwelling catheter into her instead of using a hypoallergenic catheter which was what she required due to her latex allergy. She stated she did not sleep on the night of 3/11/21 due to this and was experiencing symptoms such as pain, itching, burning, and swelling on 3/11/21 and 3/12/21. The interview revealed the latex catheter was inserted by Nurse Aide (NA) #1 on 3/11/21 around 3:00 PM. She stated she had complained of burning and pain to Nurse #3 who worked the 7:00 to 11:00 PM shift when she was administering the medication Renacidin (an acid solution used to irrigate the bladder). She stated she had received the medication prior to this occurrence and had experienced no symptoms. The interview revealed Nurse #2 came on shift at 11:00 PM and she expressed to her that she was uncomfortable	F 690	How the facility plans to monitor its performance to make sure that solutions are sustained. Resident allergy lists and residents with catheters will be reviewed weekly x 4, then monthly x 3 by the Administrator or the Director of Nursing to ensure compliance. The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed. Completion Date: 4/12/2021	

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F 690	Continued From page 16	F 690		

and experiencing burning at her catheter insertion site. She stated Nurse #2 came in her room a flushed her catheter with normal saline which helped the burning a little until she woke back up a few hours later urinating on herself. She stated Nurse #2 then came back into the room and resituated her indwelling catheter. The interview revealed on Friday 3/12/21 the latex catheter remained in place when Nurse #4 came on shift from 7:00 AM to 7:00 PM. She stated the catheter was very uncomfortable, even hurting with position change which normally did not happen. She stated Nurse #4 came into her room and she told him she was in pain and burning. Nurse #4 stated he did not want to change her catheter because it had already been changed. Resident #76 stated she had to lay still and try not to change positions so the pain wouldn't be as bad. She stated Nurse #1 came on shift on 3/12/21 at 7:00 PM and Nurse #4 told her she was experiencing trouble with her catheter. The interview revealed Nurse #1 immediately asked if she had a latex catheter inserted or a hypoallergenic catheter. Resident #76 stated Nurse #4 entered her room to check her catheter and said, "it is a latex catheter". She stated Nurse #1 then stated, "get that out of her". The interview revealed Nurse #1 immediately changed the catheter and told her she was so swollen in her vagina that it was hard to place the second catheter. Resident #76 stated the burning and pain she was experiencing decreased significantly when the latex catheter was removed.

An observation conducted on 3/15/21 at 9:42 AM revealed latex free gloves placed in Resident #76's room for facility staff.

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F 690	Continued From page 17	F 690		

On 3/16/21 at 2:55 PM an interview was conducted with Nurse #5. She stated she had taken care of Resident #76 on 3/11/21 from the 7:00 AM to 7:00 PM shift. The interview revealed she had an order to obtain a urine specimen and to change Resident #76's indwelling catheter. She stated she knew Resident #76 had an allergy to latex but had forgotten about it. The interview revealed she had asked NA #1 to change Resident #76's foley catheter and did not tell her the resident had an allergy to latex.

On 3/16/21 at 3:05 PM an interview was conducted with NA #1. She stated she had placed Resident #76's indwelling catheter on 3/11/21 and obtained a urine specimen for Nurse #5. NA #1 stated when she went to the supply room, she had obtained a regular latex catheter with latex gloves and inserted it because she was not told Resident #76 had an allergy. She stated she wouldn't normally look at a resident's chart or allergies prior to inserting a catheter because the nurse would usually let her know if a resident had an allergy. She stated she knew Resident #76 was experiencing pain the next day on 3/12/21 because the resident had stated it to her.

On 3/18/21 at 3:15 PM an interview was conducted with Nurse #3. During the interview she stated she was Resident #76's nurse from 7:00 PM to 11:00 PM on 3/11/21. She stated Resident #76 had complained of burning at her catheter site when she flushed her bladder with the medication Renacidin (an acid solution used to irrigate the bladder), but she felt it was due to trauma with the insertion. The interview revealed she remembered Resident #76 had a latex catheter, brown in color inserted when she was on duty, but she was only there for 4 hours and

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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F 690	Continued From page 18	F 690		

gave report to Nurse #2.

On 3/17/21 at 3:26 PM an interview was conducted with Nurse #2. She stated she was Resident #76's nurse from 11:00 PM to 7:00 AM on 3/11/21. The interview revealed Resident #76 was complaining of cramping and burning at her catheter site, so she deflated the catheter bulb and tried to reinsert the same latex indwelling catheter. She stated she reinserted the catheter, inflated the bulb and flushed it with normal saline. The interview revealed she was not aware Resident #76 had an allergy to latex.

On 3/17/21 at 9:30 AM an interview was conducted with NA #2. She stated she was working on 3/12/21 from 7:00 AM to 7:00 PM. The interview revealed Resident #76 had told her she was having problems with her catheter and complaining of pain. She stated she told Nurse #4 a couple of times during her shift. NA #2 stated the nurses had to eventually change Resident #76's catheter due to it being latex and she had a latex allergy.

On 3/16/21 at 3:47 PM an interview was conducted with Nurse #4. Nurse #4 stated he was responsible for Resident #76 on 3/12/21 for the 7:00 AM to 7:00 PM shift. Nurse #4 stated Resident #76 was complaining of burning and discomfort during his shift, but he felt it could have been caused from trauma having a new catheter inserted and reinserted the night prior. He stated he told Nurse #1 the resident was experiencing issues with her catheter when he gave her report at 7:00 PM. The interview revealed he was unaware Resident #76 had an allergy to latex. Nurse #4 stated Nurse #1 asked him if the resident had a hypoallergenic catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 19	F 690		

in when she received report. He stated he went into the residents room to verify the catheter was latex. Nurse #1 stated to Nurse #4 that she was going to change the catheter.

On 3/16/21 at 3:21 PM an interview was conducted with Nurse #1. She stated she had worked on 3/12/21 from 7:00 PM to 7:00 AM on the 100/200 hall in which Resident #76 resided. She stated when she received report from Nurse #4, he stated Resident #76 was experiencing discomfort and pain related to her catheter. The interview revealed she immediately went into Resident #76's room and realized she had a latex catheter in which was causing her discomfort. She stated a lot of the nurses did not realize Resident #76 had a latex allergy, but she did because she was normally the nurse who changed her catheter and knew she needed a hypoallergenic catheter. Nurse #1 stated the facility did not have the correct size catheter Resident #76 had orders for in hypoallergenic catheters, so she had to place a size 18 French hypoallergenic catheter and notified the Director of Nursing. Nurse #1 stated the resident was having symptoms such as burning, swelling, itching and bladder spasms but nobody thought it would be due to the latex catheter prior to her coming on shift. The interview revealed after the changed Resident #76's catheter the resident stated she had some symptom relief. Nurse #1 then amended the Physician order for Resident #76's catheter to include that she had an allergy to latex. Nurse #1 stated the order did not specify resident #76's allergy prior to 3/15/21.

A review of a Physician's Order dated 3/15/21 read in capital letters, "Use a 22 French /5 ml bulb indwelling catheter when catheter needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 690	Continued From page 20	F 690		

be changed. *Latex allergy! Use hypoallergenic silicone coated catheter only*".

On 3/18/21 at 10:59 an interview was conducted with the Director of Nursing (DON). The DON stated she was notified by Nurse #1 on 3/13/21 that a latex catheter was placed into Resident #76. The interview revealed the DON had just conducted a catheter audit on 3/9/21. She stated the facility had two kinds of catheters one being 100% silicone clear in color and the other being latex, brown in color. She stated Nurse #1 told her the catheter was brown in color and Resident #76 had complained of burning. The interview revealed on 3/16/21 the DON completed a medication error on the incident and the order had been amended to include Resident #76 had a latex allergy. She stated she started conducting an in-service with all staff on education of resident allergies which began on 3/16/21. During the interview she stated the resident had latex free gloves placed in her room and was also receiving the medication Renacidin (an acidic solution used to irrigate the bladder) which could have caused some of the burning she experienced. The medication was used as needed prior to 3/11/21 but was changed to twice daily on 3/11/21. Resident #76 received the first dose on the 7:00 AM to 7:00 PM shift and the second dose on the 7:00 PM to 11:00 PM shift when she began complaining of burning. The DON stated Resident #76's allergies were listed on her face sheet in the computer charting system which was visible to all nursing staff. She pulled up the residents Medication Administration Record (MAR) and showed the surveyor at the top right-hand corner of the screen where Resident #76's latex allergy was listed for the nurses to see.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 21	F 690		

Review of an event report dated 3/16/21 revealed on 3/11/21 Resident #76 had stated she started hurting and felt like the wrong catheter was placed and it was not latex free. The type of error was documented as other-latex catheter. The resolution included an evaluation by the Nurse Practitioner.

Review of an in-service log dated 3/16/21 revealed the DON had initiated an in-service regarding education for allergies. The education was provided via in person to those who were working in the facility and via text message to staff who were not in the facility.

On 3/17/21 at 10:42 AM an interview was conducted with the Nurse Practitioner. During the interview she stated Resident #76 had a chronic indwelling catheter in which she refused to have removed due to incontinence. She stated an allergic reaction to latex could cause swelling in the vagina, burning, itching or redness. The interview revealed when she evaluated Resident #76 this week the resident had stated to her that staff had placed a latex catheter instead of a hypoallergenic catheter and she had experienced discomfort as a result. She stated Resident #76 was receiving Renacidin (acid solution used to irrigate the bladder) twice a day starting on 3/11/21 which could have caused some of the burning the resident had experienced due to the trauma of receiving a new indwelling catheter.

On 3/18/21 at 11:48 AM an interview was conducted with the Medical Director. During the interview he stated a reaction to a latex allergy would include swelling, redness, itching and discomfort. He stated he wasn't notified of the

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F 690	Continued From page 22 incident occurring it would have been the Nurse Practitioner who would be responsible for evaluating the resident. On 3/19/21 at 2:52 PM an interview was conducted with the Administrator. During the interview she stated her expectation was for the orders on Resident #76's Medication Administration Record (MAR) to reflect a latex allergy and for the nursing staff to correctly follow the order in place.	F 690		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to record the refrigerator temperatures for 1 of 2 nourishment rooms.	F 812	F812 How corrective action will be accomplished for those residents found to	4/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 812	Continued From page 23 Findings included: An observation with nursing staff, was made on 03/18/21 at 12:15 pm of the nourishment room located on the 500 and 600 halls. The temperature record sheet located on the side of the fridge did not have temperatures logged for dates 03/12/21 and 03/15/21. An interview on 03/19/21 at 2:00 pm with the Dietary Aide revealed she oversees nutritional rooms in the facility and was responsible for checking refrigerator temperatures daily. The Dietary Aide revealed that on dates 3/12/21 and 03/15/21 that she was on vacation and the temperatures should have been checked by other kitchen staff. She indicated she did not know who was assigned to check the temperatures the days of 03/12/21 and 03/15/21 and stated the refrigerator temperatures should be checked and logged daily. An interview on 03/19/21 at 11:24 am with the Dietary Manager revealed the Dietary Aide checks nourishment room refrigerator temperatures daily. She stated she was not aware of the temperatures not being recorded for dates 03/12/21 and 03/15/21 and she did not recall who was assigned to cover for those dates. The Dietary Manager revealed she expected the temperatures to be checked and logged daily. An interview on 03/19/21 at 2:51 pm with the Administrator revealed she could not recall why the temperatures were not checked on 3/12/21 and 3/15/21. The Administrator indicated there should have been a replacement to check refrigerator temperatures if the Dietary Aide was	F 812	have been affected by the deficient practice. On 3/19/2021 the Dietary Manager verified correct temperature of the refrigerator in the nourishment room located on the 500 and 600 halls. The log was updated correctly. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/19/2021 the Dietary Manager audited all nourishment room refrigerators to ensure temperature logs were documented appropriately. No other issues were noted. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Dietary Manager in-serviced 100% of dietary staff on the proper temperature monitoring process for nourishment room refrigerators. The in-service was completed on 3/22/2021. How the facility plans to monitor its performance to make sure that solutions are sustained. The Dietary Manager will audit all nourishment room refrigerator temperature logs weekly x 4 weeks to ensure compliance. The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with the requirements will be reeducated. Disciplinary action may be used based upon the progressive discipline process. Completion Date: 4/12/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 812	Continued From page 24 out of the building.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/20/21

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 880	Continued From page 25 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines when they continued to quarantine a previously COVID-19 positive, dialysis resident (Resident #66) after the resident met criteria to come off of isolation and placed a newly-admitted resident (Resident #253) with a	F 880	F880 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #66 was moved to a private room on 3/17/2021. Cook #1 was reeducated by the Dietary Manager on CDC guidelines on how to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 880	Continued From page 26	F 880		

resident (Resident #66) that qualified as general population. The facility also failed to implement the CDC guidelines for the use of Personal Protective Equipment (PPE) when 1 of 3 dietary staff members (Cook #1) was observed wearing a KN95 mask under the chin with the nose and mouth uncovered while handling food. These failures occurred during a COVID-19 pandemic.

The findings included:

1. The Centers for Disease Control and Prevention (CDC) guideline entitled, "Responding to Coronavirus (COVID-19) in Nursing Homes," updated on 4/30/20 indicated the following statements:

* Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.

* New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission).

The facility's COVID-19 policy entitled, "Residents out of facility for medically necessary appointments," dated December 2020 read, in part: Dialysis residents are at increased risk for COVID-19, these residents will be placed on PUI (persons under investigation) unit upon return to the facility due to high risk.

During the entrance conference with the Administrator on 3/15/21 at 9:22 AM, the Administrator indicated that the newly admitted

properly wear a mask, at all times in the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed on 3/17/2021 to ensure no other cohorting issues on the PUI unit were noted. No other issues noted.
An audit on 3/18/2021 was completed with staff and no other staff noted wearing masks improperly.

The measures put into place or systemic changes made to ensure that the deficient practice will not recur. 100% of staff were educated by the Administrator on 4/15/2021 on the CDC guidance for new admissions, readmissions, and dialysis residents related to cohorting.
Administrator or DON will review placement of new admissions daily to ensure proper cohorting compliance.
100% of staff were reeducated, by the Administrator, on wearing a face mask properly on 4/14/2021.

How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator or DON will monitor daily to ensure cohorting compliance x 4 weeks. The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed.
The Administrator, DON, Weekend Supervisor, and Unit Coordinators will audit randomly twice weekly for proper mask placement on all staff. The results

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 880	Continued From page 27 and readmitted residents were placed on 500 hall which was considered as the PUI unit. She also stated that they placed their dialysis resident on the PUI unit per facility policy. A review of the facility census indicated room 507 on the PUI unit and 8 of 9 rooms on 600 hall were empty for 3/15/21. Resident #66 was admitted to the facility on 1/29/21 to room 607 with diagnoses that included acute respiratory failure and end-stage renal disease. She was moved to room 502 on 2/9/21 and then to room 501 on 3/12/21. She had not received any COVID-19 vaccine. Resident #253 was admitted to the facility on 3/11/21 to room 501 with a diagnosis of fracture of right humerus (arm bone between the shoulder and the elbow). She had not received any COVID-19 vaccine. An observation of the PUI unit was made on 3/15/21 at 12:29 PM and revealed Resident #66 and Resident #253 were in room 501 and were separated by a screen. Their room door had a posted enhanced droplet isolation sign and a plastic bin was located outside the door which contained PPE such as gowns and gloves. An interview with the Infection Preventionist (IP) on 3/15/21 at 12:35 PM revealed Resident #66 was in the PUI unit because she went to dialysis three times a week and they treated her like she was positive for COVID-19. The IP stated Resident #66 had just been moved to the room with Resident #253 but had been previously in another room in the PUI unit with another resident. The IP stated that it had not been her	F 880	of the audits will be presented to and reviewed with QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with will be reeducated. Disciplinary action may be used based upon the progressive discipline process. Completion Date: 4/20/2021	

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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F 880	Continued From page 28	F 880		

decision and was not sure why Resident #66 and Resident #253 were in the same room together in the PUI unit.

An interview with the Director of Nursing (DON) on 3/15/21 at 12:43 PM indicated that she did not have a clue why Resident #66 did not get moved to a private room except for the facility not having a private room available. The DON revealed a resident who had been in room 507 had recently died which was why it was currently empty. They had two semi-private rooms in the PUI unit and had always placed two residents in the semi-private rooms. The DON stated she thought this practice was acceptable. She also explained they considered Resident #66 as presumptive positive for COVID-19 because she went to dialysis three times a week and had decided to place her in the PUI unit.

Another observation of the PUI unit on 3/16/21 at 8:35 AM revealed Resident #66 and Resident #253 were still in room 501.

An interview was conducted on 3/16/21 at 9:06 AM with the Administrator who stated that Resident #66 had previously tested positive for COVID-19 last December and Resident #253 had never tested positive for COVID-19. The Administrator explained that they did not move one of them out of the room the day before because they did not have a room available due to 600 hall still having one COVID-19 positive resident. She added that they wanted to sanitize the whole hall first before moving either Resident #66 or Resident #253 to 600 hall.

An observation on the 600 hall on 3/17/21 at 8:24 AM revealed a plastic barrier was set up

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	345446	A. BUILDING _____ B. WING _____	C 03/24/2021

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F 880	Continued From page 29	F 880		

separating the last four rooms from the rest of the hall while a resident still occupied room 605 which was behind the plastic barrier. Further observation of the 600 hall on 3/17/21 at 1:58 PM revealed Resident #66 had been moved to room 601.

2. The Centers for Disease Control and Prevention (CDC) guideline entitled, "Preparing for COVID-19 in Nursing Homes," which was last updated on 11/20/20 indicated that HCP (healthcare personnel) should wear a facemask at all times while they are in the facility.

The CDC guideline entitled, "How to Wear Masks," last updated on 1/30/21 indicated:
* Wear a mask over your nose and mouth to help prevent getting and spreading COVID-19.
* Wear a mask correctly for maximum protection.
* Don't put the mask around your neck or up on your forehead.

A review of the facility's COVID-19 policy entitled, "Masks," dated October 2020 read, in part:
Masks must be worn in/around the facility at all times. The mask must cover your mouth and your nose.

During an observation of the facility's kitchen on 3/18/21 at 1:15 PM, Cook #1 was seen with her mask pulled down underneath her chin. Cook #1's nose and mouth were both exposed. She was observed turning from the sink to the prep table where she was noted to be preparing a sandwich. Nurse Aide (NA) #1 was observed waiting by the open door to the kitchen.

An interview with NA #1 on 3/18/21 at 1:15 PM indicated she had been waiting by the kitchen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 880	Continued From page 30	F 880		

door because Cook #1 was making one of her residents a sandwich. NA #1 stated she had been waiting about five minutes, but she did not notice whether Cook #1 had her mask down below her chin while fixing the sandwich because Cook #1 had her back turned to her.

An interview with Cook #1 on 3/18/21 at 1:20 PM revealed she knew that she was supposed to wear her mask over her nose and mouth but she had been having such a hard time breathing with a KN95 mask on and that she couldn't wear it over her nose and mouth for a long time. Cook #1 stated that she had tried wearing a surgical mask, but she couldn't breathe through it either. Cook #1 admitted that she had to pull her mask down several times while working in the kitchen and that she had just been preparing a sandwich with her mask down and her mouth and nose exposed. Cook #1 further stated that she had told the Director of Nursing (DON) and the Administrator that she had a problem about not being able to breathe with a mask on but she was told that she should wear a mask anyway. She added that she tried to get her doctor to write her a note that she couldn't wear a mask but her doctor refused to do so and told her that a mask was supposed to protect her from COVID-19.

An interview with the Infection Preventionist (IP) on 3/18/21 at 1:45 PM indicated she expected Cook #1 to wear a mask properly to cover both her nose and mouth while in the kitchen and while handling food for the residents. The IP stated everyone had a hard time breathing through a mask, but it was not an excuse to pull her mask down below her chin.

An interview with the Director of Nursing (DON)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

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F 880	Continued From page 31 on 3/18/21 at 1:47 PM revealed Cook #1 had been educated on how to wear a mask properly and she should have worn her mask to cover both her nose and mouth. The DON stated she had been aware that Cook #1 had been having issues with wearing a mask and her difficulty with breathing through it but she should still have worn her mask properly especially while working in the kitchen and preparing a resident's food. An interview was conducted on 3/18/21 at 3:00 PM with the Administrator who stated that there was no excuse for Cook #1 to not wear her mask properly and that she had been educated several times previously. The Administrator revealed that this had not been the first time Cook #1 had pulled her mask down while working in the kitchen. She added that Cook #1 should have worn her mask to cover both nose and mouth the whole time while she was in the facility unless she was on break.	F 880		