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 10/13/2021

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PINEHURST HEALTHCARE & REHABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/12/21 through 10/13/21. Event ID# LDM411. 2 of the 8 complaint allegations were substantiated resulting in deficiencies F689 & F686.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments accurately in the area of falls for 2 of 3 sampled residents reviewed for accidents (Residents #1 & #5). Findings included: 1. Resident #1 was admitted to the facility on 9/15/20 with multiple diagnoses including hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non dominant side. The annual Minimum Data Set (MDS) assessment dated 9/10/21 indicated that Resident #1's cognition was intact, and she has no falls since admission or prior assessment. Review of Resident #1's progress notes and incident reports revealed that she had 1 fall with no injury since prior assessment dated 8/15/21.	F 641	F641 Accuracy of Assessments For resident #1 a corrective action was obtained on 10/13/21 by modifying and correcting MDS assessment for assessment reference date of 09/10/21. Section J1800 and J1900 coding was corrected to accurately reflect that resident had a fall without injury during the specified lookback timeframe. Correction was completed by facility MDS nurse on 10/13/21. For resident #5 a corrective action was obtained on 10/13/21 by the facility MDS nurse by modifying and correcting the MDS assessment with assessment reference date of 08/06/21. The assessment was modified and coding for Section J1900 corrected in order to accurately reflect that resident had had one fall without injury and one fall with minor injury during the specified lookback timeframe.	10/26/21

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

Electronically Signed | 10/28/2021

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F 641	Continued From page 1 The MDS Nurse was interviewed on 10/12/21 at 3:45 PM. The MDS Nurse stated that she was trained to look at the incident tracking in the computer when completing the section for falls. She reported that she normally didn't read the progress notes. The MDS Nurse commented that since there was no incident report completed for the 8/15/21 fall, the fall was not entered in the incident tracking and therefore she missed it. She indicated that she would complete a correction MDS to correct the section for falls. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. The DON stated that she expected the MDS assessments to be coded accurately. 2. Resident #5 was admitted to the facility on 11/21/18 with multiple diagnoses including Congestive Heart Failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 8/6/21 indicated that Resident #5's cognition was intact, and he had 2 or more falls with no injury and 1 fall with injury since admission or prior assessment. Resident #5's progress notes and incident reports were reviewed. The resident had 2 falls (1 with injury and 1 with no injury) since prior assessment. The MDS Nurse was interviewed on 10/12/21 at 3:45 PM. The MDS Nurse stated that she was trained to look at the incident tracking in the computer when completing the section for falls. She reported that she normally didn't read the	F 641	Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who have had a fall during the past 90 days was conducted by the Minimum Data Set Consultant. All current residents who have had a fall during the timeframe of 07/25/21 – 10/25/21 were reviewed and their most recent MDS assessment was reviewed to determine if Section J1800 and J1900 had been accurately coded. Audit Results: Total of 34 residents with and a total of 56 falls were reviewed. Note that all of the residents who have had a fall during this timeframe have NOT had an MDS to come due for completion since the fall. • 34 of the 56 falls have not been coded on an MDS yet due to MDS not being due yet. • 16 of the 56 falls were accurately coded on most recent MDS. • 6 of the 56 falls were not accurately coded on most recent MDS. All residents who were identified as having MDS inaccurate coding for Section J1800/1900 for falls were modified and corrected on 10/26/21 by the facility MDS nurse. These corrected assessments were re-submitted to the state database on 10/26/21. Systemic Changes	

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F 641	Continued From page 2 progress notes. The MDS Nurse commented she did not complete the 8/6/21 MDS assessment, however, looking at the incident tracking, Resident #5 had only 2 falls since prior assessment. She verified that the MDS was coded incorrectly and she would complete a correction MDS to correct the inaccuracy. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. The DON stated that she expected the MDS assessments to be coded accurately.	F 641	On 10/15/21, the Regional Minimum Data Set Education and Compliance Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record during the assessment process and before coding the MDS assessment. Special emphasis was highlighted on: • Section J1800 and J1900 – coding of falls and presence or lack of injuries related to falls. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The education emphasized the importance of reviewing the documentation in a resident's electronic medical record including progress notes, assessments, therapy notes, nursing assistant documentation, physician notes incidents, etc. in order to assess whether or not a resident has experienced a fall during the MDS lookback timeframe. The documentation must also be thoroughly reviewed to determine if there were any falls related injuries (including major and/or minor) sustained by the resident. This may also include any hospital documentation if the resident required transfer to the emergency room/hospital. Results from any scans (MRI or CT scan) or x-rays obtained post fall should also be reviewed in order to determine if resident had a major injury as result of fall. Information obtained from these scans may also be used to accurately code for level of injury after the MDS assessment reference date.	

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F 641	Continued From page 3	F 641	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS items: J1800 (Falls) and J1900 (Falls related injuries) using the quality assurance audit tool entitled “Accurate Minimum Data Set Coding Audit Tool”-J1800 and J1900 (falls). This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 10/26/21	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		10/28/21

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F 656	Continued From page 4 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff	F 656	F 656 Develop/Implement	

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F 656	Continued From page 5 interview, the facility failed to implement the interventions for falls as care planned 2 of 3 sampled residents reviewed for accidents (Resident #1 & #5). Findings included: 1. Resident #1 was admitted to the facility on 9/15/20 with multiple diagnoses including hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non dominant side. The annual Minimum Data Set (MDS) assessment dated 9/10/21 indicated that Resident #1's cognition was intact, and she needed extensive assistance with toilet use and transfers. The assessment further indicated that she had no falls since admission or prior assessment. The care area assessment (CAA) dated 9/10/21 indicated that Resident #1 was incontinent of bladder and has decreased mobility which puts her at increased risk for falls. Review of Resident #1's progress notes and incident reports revealed that she had 4 falls at the facility (12/14/20, 1/26/21, 6/5/21 and 8/15/21). She had no injury from her falls except for the 6/5/21 fall, she complained that her cheek was a little bit sore. Resident #1's care plan was reviewed. She was care planned for increased risk for falls related to limitations secondary to cerebrovascular accident (CVA) with left hemiparesis (initiated on 9/25/20) and for actual falls (initiated on 12/15/20). The approaches included grip pad to seat of chair (9/25/20), colored call light (6/15/21), and red tape on bathroom call light (10/5/21).	F 656	Comprehensive Care Plan Corrective Actions for Resident #1 A corrective action was taken in order to ensure that falls related interventions on the care plan for Resident #1 were implemented and in place. This was completed by MDS Nurse on 10/13/21. Corrective Actions for Resident #5 A corrective action was taken in order to ensure that falls related interventions on the care plan for Resident #5 were implemented and in place. This was completed by MDS Nurse on 10/13/21. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who have had a fall during the past 90 days were included in the audit. The care plans for these residents were reviewed to ensure that all falls related interventions have been appropriately implemented and are in place. This audit was completed by DON, MDS Nurse, and SDC Nurse on 10/27/21. Results of Audit: " 12 of 35 residents care plans reviewed identified with falls interventions being appropriately in place and implemented. " 23 of 35 residents care plans reviewed identified with falls interventions not being appropriately in place and implemented. All residents who were identified as not having their care planned falls interventions implemented and in place	

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F 656	Continued From page 6 Resident #1's room was observed on 10/12/21 at 9:10 AM and at 3:50 PM. There was no colored call light, red tape on the bathroom call light nor grip pad to her wheelchair. Nurse Aide (NA) #1, assigned to Resident #1 was interviewed on 10/12/21 at 4:30 PM. She stated that she had been working at the facility for 6 months and she had not seen a colored call light, red tape to the bathroom call light nor a grip pad to the resident's wheelchair. The DON was interviewed on 10/13/21 at 11:13 AM. She stated that she expected the interventions to prevent falls to be implemented as care planned. She explained that the resident has recently moved to another room and the colored call light, grip pad and the red tape on the bathroom call light might have been left in her previous room. 2. Resident #5 was admitted to the facility on 11/21/18 with multiple diagnoses including Congestive Heart Failure (CHF). The care area assessment (CAA) dated 1/20/21 indicated that the resident was at risk for falls due to his diagnoses. Resident #5 was assessed as high risk for falls on 6/28/21 and moderate risk on 7/20/21. The quarterly Minimum Data Set (MDS) assessment dated 8/6/21 indicated that Resident #5's cognition was intact, and he had 2 or more falls since admission or prior assessment.	F 656	had corrective action taken with the interventions being put into place as care planned. Systemic Changes On 10/13/21 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on Comprehensive Care Plans and ensuring that interventions are implemented and in place according to care plan direction. The education emphasized that the care plan must communicate the resident□s current condition and needs to the staff. It is important to ensure that interventions listed in the care plan are actually in place and are being carried out. The care plan must have ongoing revisions and updates as the resident□s condition changes. It is important that when residents change rooms that their care plan is reviewed and if there are any special interventions that affect the physical environment of their room such as: colored tape to call light, falls matt, special mattress, etc. that these interventions are placed into their newly assigned room. The educational material included the fact that the care plan is a tool used to communicate resident□s condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents□ needs are met, the care plans must be person-centered and an accurate and current reflection of resident. This information has been integrated into the standard orientation training for new	

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F 656	Continued From page 7 Resident #5 was care planned for at risk for falls (initiated on 6/3/20) and for actual falls (initiated on 4/4/21). The approaches included crisscrossed grip strips on floor in the room (6/3/20), scooped mattress to define parameters of the bed (6/19/20) and grip strips beside bed (6/15/21). Review of Resident #5's progress notes and incident reports revealed that he had 4 falls with no injury (5/22/21, 7/29/21, 7/30, 21 and 8/16/21) in the last 6 months. Resident #5's room was observed on 10/12/21 at 11:15 AM & 3:40 PM. His mattress was a regular mattress (not scooped mattress) and there were no crisscrossed strips or grip strips on the floor beside his bed. Nurse #1, assigned to Resident #5, was interviewed on 10/12/21 at 3:42 PM. She stated that she had not seen Resident #5 on a scooped mattress and with grip strips on his floor. She reported that he had been on a regular mattress. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. She stated that she expected the interventions to prevent falls to be implemented as care planned. She explained that the resident has been moved to different rooms in the past and so the scooped mattress and the floor grips might have been left in his previous room.	F 656	Minimum Data Set Nurses. 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 Director of Nursing or designee will conduct audits to ensure that current residents□ care planned falls related interventions are in place and are being implemented appropriately. The Quality Assurance tool entitled Implementation of Comprehensive Care Plans QA Tool - Falls will be completed weekly x 4 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Compliance date: 10/28/21	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		10/29/21

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F 657	Continued From page 8 §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, observations and staff interview, the facility to review and revise the care plan interventions for falls for 3 of 3 sampled residents reviewed for accidents (Resident #1, #4, & #5). Findings included: 1. Resident #1 was admitted to the facility on 9/15/20 with multiple diagnoses including hemiplegia and hemiparesis following non	F 657	F657 Care Plan Timing and Revision Corrective Action for Affected Residents. Corrective Action for Resident #1: The care plan for resident #1 was revised in order to remove and resolve the intervention for using a walker. This was completed by the facility Minimum Data Set Nurse on 10/13/21. Corrective Action for Resident #4: The care plan for resident #1 was revised in order to remove and resolve the	

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F 657	Continued From page 9 traumatic intracerebral hemorrhage affecting left non dominant side. The annual Minimum Data Set (MDS) assessment dated 9/10/21 indicated that Resident #1's cognition was intact, and she has no falls since admission or prior assessment. Resident #1's care plan was reviewed (last review date 9/21/21). She was care planned for increased risk for falls related to limitations secondary to cerebrovascular accident (CVA) with left hemiparesis (initiated on 9/25/20) and for actual falls (initiated on 12/15/20). The approaches included encourage me to use my walker when ambulating and to ensure that my walker is in good condition and properly functioning (9/25/20). Nurse Aide (NA) #1, assigned to Resident #1 was interviewed 10/12/21 at 4:30 PM. She stated that she had been working at the facility for 6 months and she had not seen the resident using a walker. The MDS Nurse was interviewed on 10/12/21 at 2:18 PM. She reported that she just started as MDS Nurse at the facility in August 2021. She did not have any experience as MDS Nurse in the past. She had MDS training online and was still learning. The MDS Nurse reviewed the resident's care plan and verified that the care plan was initiated before she started working at the facility, however, she should have reviewed and revised the care plan quarterly. She acknowledged that Resident #1 did not use a walker and she should have resolved the walker when she reviewed the care plan on 9/21/21. The Director of Nursing (DON) was interviewed	F 657	intervention for using a walker. This was completed by the facility Minimum Data Set Nurse on 10/13/21. Corrective Action for Resident #5: The care plan for resident #1 was revised in order to remove and resolve the intervention for using a walker. This was completed by the facility Minimum Data Set Nurse on 10/13/21. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be impacted by the alleged deficient practice. A100% audit was conducted on all current residents who have a fall related care plan to ensure that interventions accurately reflect the resident□s current needs and status. Audit Results: 3 of 14 residents identified as having up to date and accurate interventions. 11 of 14 residents identified as having either outdated or inappropriate interventions for resident□s current status/needs. Audit was completed by the MDS Nurse on 10/28/21. All care plans for residents who were identified as having inaccurate interventions were revised in order to remove/resolve the inappropriate interventions. This was completed by the facility Minimum Data Set Nurse on 10/28/21. Systemic Changes On 10/13/21, the Minimum Data Set Nurse Consultant in-serviced the facility	

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F 657	Continued From page 10 on 10/13/21 at 11:13 AM. She stated that she expected the care plan to be reviewed and revised if applicable. The DON acknowledged that Resident #1 did not use a walker and it should have been deleted from the care plan. 2. Resident #5 was admitted to the facility on 11/21/18 with multiple diagnoses including Congestive Heart Failure (CHF). Resident #5 was assessed as high risk for falls on 6/28/21 and moderate risk on 7/20/21. The quarterly Minimum Data Set (MDS) assessment dated 8/6/21 indicated that Resident #5's cognition was intact, and he had 2 or more falls since admission or prior assessment. Resident #5 was care planned for risk for falls and for actual falls. The approaches included encourage me to use my walker when ambulating (6/3/20). Nurse #1, assigned to Resident #5, was interviewed on 10/12/21 at 3:42 PM. The nurse indicated that she had not seen Resident #5 using a walker. She added that the resident was using a wheelchair for locomotion. The MDS Nurse was interviewed on 10/12/21 at 2:18 PM. She reported that she just started as MDS Nurse at the facility in August 2021. She did not have any experience as MDS Nurse in the past. She had MDS training online and was still learning. The MDS Nurse reviewed the resident's care plan and verified that the care plan was initiated before she started working at the facility, however, she should have reviewed and revised the care plan quarterly. She acknowledged that	F 657	Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of the resident□s current status and needs. Emphasis was placed on ensuring that fall related care plan interventions are individualized for each resident□s specific needs. This includes ensuring that the care plan accurately reflects any assistive device that the resident may currently use in order to promote a higher level of functioning and safety. It is important that once a resident no longer requires or is unable to use specific assistive devices, the care plan be revised in order to remove/resolve it. Frontline staff who provide direct care to residents rely on the care plan in order to provide safe and effective care. Therefore, it is critical that in addition to the routine quarterly assessment and care plan review and updates that care plans also be updated and revised as resident conditions change. Care plan updates and revisions is an on-going process. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will audit 5 current residents in order to validate whether or not the Fall care plan accurately reflects up to date and current interventions. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing	

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 10/13/2021

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F 657	Continued From page 11 Resident #5 did not use a walker and she should have resolved the walker when she reviewed the care plan on 9/6/21. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. She stated that she expected the care plan to be reviewed and revised if applicable. The DON acknowledged that Resident #5 did not use a walker and it should have been deleted from the care plan. 3. Resident #4 was admitted to the facility on 11/4/20 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side. The quarterly Minimum Data Set (MDS) assessment dated 9/29/21 indicated that Resident #5's cognition was intact, and she had 1 fall with injury since admission or prior assessment. Resident #4 was care planned for at risk for falls related to diagnosis (initiated on 11/5/20). The approaches included to ensure that my walker is in good condition and properly functioning. Nurse Aide (NA) #2, assigned to Resident #4, was interviewed on 10/12/21 at 4:40 PM. NA #2 stated that she had been working at the facility for 1 year and she had not seen Resident #4 using a walker. The MDS Nurse was interviewed on 10/12/21 at 2:18 PM. She reported that she just started as MDS Nurse at the facility in August 2021. She did not have any experience as MDS Nurse in the past. She had MDS training online and was still	F 657	to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 10/29/21	

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	345370	A. BUILDING _____ B. WING _____	C 10/13/2021

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F 657	Continued From page 12 learning. The MDS Nurse reviewed the resident's care plan and verified that the care plan was initiated before she started working at the facility, however, she should have reviewed and revised the care plan quarterly. She acknowledged that Resident #4 did not use a walker and she should have resolved the walker when she reviewed the care plan on 9/6/21. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. She stated that she expected the care plan to be reviewed and revised if applicable. The DON acknowledged that Resident #4 did not use a walker and it should have been deleted from the care plan.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 3	F 686	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	10/28/21

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F 686	Continued From page 13 sampled residents reviewed for pressure ulcers (Residents #2). The findings included: Resident #2 was admitted to the facility on 2/5/2021 with diagnosis that included congestive heart failure, chronic kidney disease, dementia, and stage 4 sacral pressure ulcer. The resident's most recent quarterly Minimum Data Set (MDS) dated 9/9/2021 indicated the resident had mild cognitive impairment, functional hearing, functional vision, could understand others, and could be understood by others. The MDS also indicated Resident #2 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #2 was coded as having 2 stage 2 pressure ulcers, and 1 unstageable pressure ulcer that were present on readmission to the facility. She had an indwelling urinary catheter and received diuretics 7 out of 7 days during the assessment period. Resident #2's most recent comprehensive care plan dated 8/30/2021 had a focus for impaired skin integrity related to incontinence, diuretic use, antiplatelet therapy, and antibiotic use. The resident's active orders included daily wound care of cleaning wound bed with sodium hypochlorite, packing with gauze soaked in sodium hypochlorite, and covering with superabsorbent dressing. The active orders did not reveal an order for low air loss mattress. On 10/12/2021 at 9:20am an interview was conducted with Resident #2. She was observed	F 686	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 date or dates indicated. F 686 Corrective Action for Affected Residents For resident #2 – On 10/14/21 the Director of nursing ensured the air mattress and settings were as per MD orders and manufacture guidelines. Corrective Action for Potentially Affected Residents On 10/27/21 the Director of Nursing and Wound Nurse ensured that all the orders for air mattresses and the appropriate settings comply with MD orders and manufacture guidelines. This process was completed on 10/27/21. Systemic Changes On 10/21/21 the Director of Nursing began in-servicing all current licensed nurses to include the Wound Nurse. This in-service included the following topics: Pressure Ulcer Prevention and the Importance of ensuring air mattresses have the appropriate settings as per MD orders. The Director of Nursing will ensure that any licensed nurse along with the agency licensed staff that have not received this training by 10/28/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by	

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F 686	Continued From page 14 lying on her right side with the head of the bed slightly elevated. She was observed to be on a low air loss mattress with positioning devices in use. When asked, she stated she thought her wound was getting better and her pain was well controlled. When asked, she stated she got her wound dressing changed every day by staff. On 10/12/2021 at 12:10pm Resident #2 was observed in the bed supine with head of bed elevated approximately 20 degrees while watching television. She was on a low air loss mattress with positioning devices in use. On 10/12/2021 at 2:00pm Resident #2 was observed left side lying with head of the bed elevated slightly. The resident was on a low air loss mattress with positioning devices in use. On 10/12/2021 at 4:45pm Resident #2 was observed right side lying with the head of the bed elevated slightly. She was on a low air loss mattress with position devices in use. During wound care observation on 10/13/2021 at 9:30am, the resident's alternating pressure reducing mattress machine was observed and was set at 80 Kilograms (kg)/160 pounds (lbs.). The machine indicated to set mattress pressure according to occupant's weight. On 10/13/2021 at 10:50am after completing wound care, the alternating pressure mattress machine was observed by the Treatment Nurse who confirmed it was set at 160 lbs/80kg. She revealed the resident's most recent weight according to the electronic medical record was 110.4 lbs. on 10/7/2021. When asked who monitored the function and setting of the low air	F 686	the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Air Mattress settings. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 10/28/21	

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F 686	Continued From page 15 loss mattress, she stated she was not sure. She further stated she had only been working in the facility for two months as the treatment nurse. An interview was conducted with the Director of Nursing (DON) on 10/14/2021 at 10:07am. When asked who placed low air loss mattresses for residents, she stated maintenance director did but he was not responsible for the mattress settings. She stated the Treatment Nurse was responsible for monitoring the function and settings of the low air loss mattress. She further stated she expected the low air loss mattress to be set according to the resident weight and monitored by the Treatment Nurse.	F 686		
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 record review, observation, resident and staff interview, the facility failed to implement the care plan interventions for falls (Residents #1 & #5) and failed to modify the interventions after each fall to prevent further falls (Resident #1) for 2 of 3 sampled residents reviewed for accidents (Residents #1 & #5). Findings included:	F 689	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	10/29/21

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F 689	Continued From page 16 1 a. Resident #1 was admitted to the facility on 9/15/20 with multiple diagnoses including hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non dominant side. The annual Minimum Data Set (MDS) assessment dated 9/10/21 indicated that Resident #1's cognition was intact, and she needed extensive assistance with toilet use and transfers. The care area assessment (CAA) dated 9/10/21 indicated that Resident #1 was incontinent of bladder and has decreased mobility which puts her at increased risk for falls. Review of Resident #1's progress notes and incident reports revealed that she had 4 falls at the facility (12/12/20, 1/26/21, 6/5/21 & 8/15/210. She had no injury from her falls except for the 6/5/21 fall, she complained that her cheek was a little bit sore. Resident #1's care plan was reviewed. She was care planned for increased risk for falls related to limitations secondary to cerebrovascular accident (CVA) with left hemiparesis (initiated on 9/25/20) and for actual falls (initiated on 12/15/20). The approaches included grip pad to seat of chair, colored call light, and red tape on bathroom call light. Resident #1 was observed on 10/12/21 at 9:10 AM & 3:50 PM. She was in bed and she didn't have a colored call light. There was no red tape on the bathroom call light and no grip pad on her wheelchair when observed. Nurse Aide (NA) #1, assigned to Resident #1 was interviewed on 10/12/21 at 4:30 PM. She stated	F 689	deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: a. For resident #1, Therapy referral was filled out on 10/26/21 by DON. MDS Nurse care planned and created tasks for staff to offer toileting assistance before breakfast, after breakfast, before lunch, after lunch, before dinner, after dinner, and before bed. b. For resident #5, Therapy referral was filled out on 10/26/21 by the Director of Nursing. On 10/26/21 the Director of Nursing implemented grip strips on the floor in the residents room and provided a scooped mattress on residents bed to define the parameters. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 10/26/21 the Director of Nursing, MDS Nurse, and SDC (Interdisciplinary Team or IDT) audited all current residents with falls in the past 90 days to ensure interventions documented on the incident report were entered into the care plan and carried out. This will be completed by 10/29/21. On 10/27/21 The Interdisciplinary Team began filling out new therapy screening/referral forms for each resident that has had a fall in the past 90 days to ensure appropriate interventions are in place. This was completed on 10/28/21. 3. Measures /Systemic changes to	

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F 689	Continued From page 17 that she had been working at the facility for 6 months and she had not seen a colored call light, red tape to the bathroom call light nor a grip pad to the resident's wheelchair. The DON was interviewed on 10/13/21 at 11:13 AM. The DON indicated that she expected the interventions to prevent falls to be implemented as care planned. She explained that the resident has recently moved to another room and the colored call light, grip pad and the red tape on the bathroom call light might have been left in her previous room. 1 b. Resident #1 was admitted to the facility on 9/15/20 with multiple diagnoses including hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non dominant side. The annual Minimum Data Set (MDS) assessment dated 9/10/21 indicated that Resident #1's cognition was intact, and she needed extensive assistance with toilet use and transfers. The assessment further indicated that she was occasionally incontinent of bowel and bladder. The care area assessment (CAA) dated 9/10/21 indicated that Resident #1 was incontinent of bladder and has decreased mobility which puts her at increased risk for falls. Review of Resident #1's progress notes and incident reports revealed that she had 4 falls at the facility. The report dated 12/14/20 at 5:55 PM revealed that the resident was observed on the floor in front of the toilet. When interviewed, the resident stated that she was going to use the bathroom and she slipped when turning to sit on	F 689	prevent reoccurrence of alleged deficient practice: On 10/26/21, the Quality Assurance Nurse Consultant educated the interdisciplinary team (Director of Nursing, MDS Nurse, Therapy Director, and Staff Development Coordinator) on the following topics: " Identifying Root cause analysis and implementing timely fall interventions. " On 10/26/21 a new therapy screen request form was initiated by DON for all resident falls going forward. Specific measures taken to prevent recurrence are as follows: The DON or designated representative reviews all incident reports for previous 24 hour period with the IDT at the daily clinical meeting held at 9:30 each am. Each fall is discussed and root causes are identified(i.e. lack of grip strips on floor). Interventions are identified and implemented and new therapy screens are completed if appropriate. The intervention decided upon is added to the assisted devices audit form utilized by IDT/Ambassadors and the IDT Member or Ambassador is assigned the task of monitoring the resident based on the assignment matrix. Care plan is modified to add intervention. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not	

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F 689	Continued From page 18 the toilet. When assessed, there was no injury noted. The report further revealed that the interdisciplinary team (IDT) has reviewed the report to determine the root cause. The call light was not activated, and the resident was reminded to call for assistance prior to transfer. The report dated 1/26/21 at 5:00 AM revealed that Resident # 1 was found on the floor beside her bed. The resident was sent to the emergency room for evaluation per protocol and came back with no new orders. When interviewed, she stated that she was trying to get up to use the bathroom, fell and hit her head. The report further revealed that the interdisciplinary team (IDT) has reviewed the report to determine the root cause. The resident attempted to transfer unassisted, and the resident was reminded to call for assistance prior to transfer. The report dated 6/5/21 at 12:34 PM revealed that Resident #1 was found on the floor. When interviewed, the resident stated that she slipped from the toilet and hit the left side of her face. The resident complained that her cheek was a little bit sore. Ice pack was applied, and the resident was sent to the emergency room for evaluation. The resident came back to the facility with no new orders. The report further revealed that the interdisciplinary team (IDT) has reviewed the report to determine the root cause. The resident attempted to transfer unassisted, and the resident was reminded to call for assistance prior to transfer. The progress note dated 8/15/21 at 4:45 AM revealed that Resident #1 was found on the floor. When assessed, there was no injury noted. When interviewed, the resident stated that she	F 689	receive scheduled in-service training will not be allowed to work until training has been completed by 10/28/21. 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 Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure fall interventions are carried out timely. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/29/21	

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 689	Continued From page 19	F 689		

was trying to get up to use the bathroom. There was no incident report completed for this incident and therefore there was no root cause analysis and intervention put in place.

Resident #1 was observed and interviewed on 10/12/21 at 9:10 AM. The resident was alert and oriented and was able to answer to questions appropriately. She stated that she was aware that she had been falling. She could not walk and could not get out of bed by herself. She needed the assistance from the staff. Most of her falls were from trying to use the bathroom. She could not wait that long, and she didn't want to wet or soiled herself. The resident indicated that assisting her to the bathroom at least every 2-3 hours might help.

The Director of Nursing (DON) was interviewed on 10/12/21 at 1:50 PM. The DON stated that she just started as DON in August 2021. She reported that the facility did not have a falls committee at present. The incident reports were reviewed on the daily meeting with just 3 staff members (DON, MDS Nurse and the Therapist). The facility did not have a social worker and clinical managers. She commented that the resident's falls (12/14/20. 1/26/21 and 6/5/21) were investigated and interventions put in place by the previous DON. The incident on 8/15/21 was not investigated since there was no incident report completed. She added that Resident #1 was alert and oriented with confusion.

Nurse Aide (NA) #1, assigned to Resident #1 was interviewed on 10/12/21 at 4:30 PM. She stated that Resident #1 was alert but confused. She needed help to use the bathroom. She was instructed to call for assistance when she needs

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F 689	Continued From page 20	F 689		

to use the bathroom but she thought she was at home and could not remember to call.

The DON was again interviewed on 10/13/21 at 11:13 AM. She stated that she had reviewed the incident reports and verified that the interventions after each fall was to remind the resident to call for assistance prior to transfer. She commented that the fall interventions should have been modified if not effective. She acknowledged that all her falls were trying to use the bathroom, so she would try to put the resident on a toileting program.

2. Resident #5 was admitted to the facility on 11/21/18 with multiple diagnoses including Congestive Heart Failure (CHF).
The care area assessment (CAA) dated 1/20/21 indicated that the resident was at risk for falls due to his diagnoses.

Resident #5 was assessed as high risk for falls on 6/28/21 and moderate risk on 7/20/21.

The quarterly Minimum Data Set (MDS) assessment dated 8/6/21 indicated that Resident #5's cognition was intact, and he had 2 or more falls since admission or prior assessment.

Resident #5 was care planned for at risk for falls (initiated on 6/3/20) and for actual falls (initiated on 4/4/21). The approaches included crisscrossed grip strips on floor in the room (6/3/20), scooped mattress to define parameters of the bed (6/19/20) and grip strips beside bed (6/15/21).

Review of Resident #5's progress notes and

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	345370	A. BUILDING _____ B. WING _____	C 10/13/2021

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 689	Continued From page 21 incident reports revealed that he had 4 falls with no injury (5/22/21, 7/29/21, 7/30, 21 and 8/16/21) in the last 6 months. Resident #5's room was observed on 10/12/21 at 11:15 AM & 3:40 PM. His mattress was a regular mattress (not scooped mattress) and there were no crisscrossed strips or grip strips on the floor beside his bed. Nurse #1, assigned to Resident #5, was interviewed on 10/12/21 at 3:42 PM. She stated that she had not seen Resident #5 on a scooped mattress or grip strips on his floor. She reported that the resident had been on a regular mattress. The Director of Nursing (DON) was interviewed on 10/13/21 at 11:13 AM. She stated that she expected the interventions to prevent falls to be implemented as care planned. She explained that the resident has been moved to different rooms in the past and the scooped mattress and the floor grips might have been left in his previous room.	F 689		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		10/25/21

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F 727	Continued From page 22 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours per day 7 days a week for 9 of 30 days reviewed. The findings included: A review of the posted daily Nurse Staffing forms from 9/12/2021 through 10/12/2021 revealed the facility had not had the required Registered Nurse (RN) coverage (at least 8 consecutive hours per day 7 days a week) on the following dates: 9/12/2021, 9/21/2021, 9/24/2021, 9/25/2021, 9/26/2021, 10/01/2021, 10/05/2021, 10/08/2021, and 10/10/2021. On each of these dates the census was between 91 and 100 residents. During an interview with the Director Nursing (DON) on 10/12/2021 at she revealed that the previous DON left without working a notice and due to this the facility had been having difficulty ensuring RN coverage was met. She further stated that the facility was utilizing agency staff, but that agency RNs were also difficult to find. The DON indicated that she recently interviewed a qualified applicant and was waiting for background check to be completed. She expected to have RN coverage in accordance with the regulations soon.	F 727	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 date or dates indicated. F 727 Corrective Action for Affected Residents No specific resident was mentioned. Director of Nursing reviewed Licensed Nursing Schedule to ensure 8hrs of continuous consecutive RN coverage was in place on 10/13/21. Corrective Action for Potentially Affected Residents The daily staffing records and time cards were reviewed for the last 30 days on 10/14/21. The findings revealed three days 9/21/21, 9/24/21, and 10/1/21 the facility failed to have 8 consecutive hours of RN Coverage. This review was performed on 10/14/21 by the Quality Assurance Nurse Consultant and Director of Nursing.	

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F 727	Continued From page 23	F 727		

The Director of Nursing and QA Nurse Consultant then reviewed the next 30 days to ensure RN Coverage was schedule ahead of time, going forward.

This was completed on 10/14/21.

Systemic Changes

On 10/21/21 the Quality Assurance Nurse Consultant began in servicing the Director of Nursing, Nurse Managers, and Facility Scheduler.

Topics included:

The daily nursing staffing data and the importance of ensuring RN consecutive 8hrs of coverage. Education also included posting daily at the beginning of each shift. The staffing data must include the following components:

- Facility name
- Current Date
- Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

1. Registered Nurses at least 8 hrs consecutive coverage. (If this criteria is not met please alert the Director of Nursing and the Administrator immediately)
2. Licensed Nurses
3. Certified Nursing Assistants

- Resident Census

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F 727	Continued From page 24	F 727	The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. Any in-house staff member who did not receive in-service training by 10/25/21 will not be allowed to work until training has been 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. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Survey Quality Assurance Tool for Monitoring RN Coverage. The monitoring will include reviewing Monthly Schedule and Daily Staffing sheets. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 727	Continued From page 25	F 727	Date of compliance: 10/25/21	