STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 6/24/2011

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to develop a care plan for 1 of 1 resident (Resident #51) receiving pallative care services as well as failed to use the admission minimum data set (MDS) results to develop a discharge plan of care for 1 of 3 residents (Resident #146).

The findings include:

1. Resident #51 was admitted to the facility on 12/31/10 with the following cumulative diagnoses: altered mental status, pneumonia, Alzheimer's dementia, pancytopenia, lethargy, hypertension, diverticulitis, history of Reynaud's, seizure disorder, failure to thrive (5/26/11) and seizure disorder.

A review of her record was conducted and revealed on 3/31/11 she received a quarterly Minimum Data Set assessment and was found to have severe cognitive impairments. She required extensive assistance with all of her Activities of Daily Living, except for eating; then needed total assistance from staff.

The chart review also indicated that on 4/8/11, a meeting was held with the family, social worker, nurse supervisor and dietary manager. The family was told that the resident had continual weight loss and may require a peg (feeding tube placed directly into the stomach) tube placement. Strategies were shared by the dietary staff to maintain her weight and nutrition. The family members were not in favor of the peg tube, since it did not represent the resident's wishes, before her health declined. The family rejected IV fluids and wanted the resident to be placed on comfort care measures with pain management. A Do Not Resuscitate order was signed and placed on the chart by the Social Worker, along with the family's wishes.

On 4/8/11 nurse's notes document a meeting held with the family where they expressed a desire to "not hook her up to anything to keep her alive." Family wishes: no code, no feeding tubes, no blood draws, no IV's, and comfort measures only.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND NFs	PROVIDER # 345144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 6/24/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 1

The resident's care plan was developed on 4/13/11. A listed goal included addressing her weight loss; there was no care plan for palliative care.

Interdisciplinary notes dated 4/27/11 included notes from the weight committee which relayed that the resident was on comfort care with end of life issues at hand. Her intake was listed as very poor, with 0-25% meal consumption. Measuring weights will be discontinued as weight loss was expected and avoidable. On 5/25/11, the interdisciplinary notes stated that the resident was on comfort care with weight loss expected. Additional nutrition would be added at lunch.

On 5/26/11, the resident received a diagnosis of failure to thrive.

On 6/24/11 at 8:15am, MDS nurse #2 was interviewed. She stated that residents are care planned when comfort care measures are in place. She was not the author of the care plan, dated 4/13/11 but stated based on chart review, the order on 4/8/11 for comfort care, should have been observed, as well as noted that the date fell within the 7 days look back window for MDS assessment. She concluded that the comfort care measure was probably overlooked in error.

MDS nurse #2 also relayed that normally when a resident becomes failure to thrive, the MDS department gets a pink slip from dietary or nursing, to alert them to review the care plan to adjust any weight loss goals. There was no explanation why the care plan wasn't revised when the resident's status changed. She also acknowledged, that resident's conditions, such as comfort care, are discussed, in the management ' s morning meetings, as another way to communicate between departments.

On 6/24/11 at 12:55pm, the MDS Nurse #1 was interviewed. She was not able to offer an explanation as to why she did not care plan Resident #51 for palliative care.

2. Resident #146 was admitted to the facility on 3/30/11 with the following cumulative diagnoses: Alzheimer's dementia with depression, psychosis, diabetes mellitus type II, hypertension, peripheral vascular disease, Left below knee amputation, generalized weakness, recent falls, congestive heart failure, thyromegaly, pulmonary nodule, abnormal gait, and lack of coordination.

Prior to moving into the facility, the resident was hospitalized due to increased paranoid delusions, mood instability and depression. She had lived with a niece, since there was no immediate family living in the area. At the time of her admission, her niece stated that she was unable to continue to care for her and desired a long term placement.

A record review was conducted and revealed that on her admission Minimum Data Set (MDS), dated 4/6/11, she was found to have a moderate cognitive impairment and needed limited assistance with most of her Activities of Daily Living. Under Section Q - Participation in Assessment and Goal Setting, the resident was assessed with unknown/unclear goals; however, the MDS indicated that there were no active plans for the resident to return to the community. In addition, the resident was not referred to any contact agency to assist her in discharge planning.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND NFs	PROVIDER # 345144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 6/24/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 2 On 4/15/11, the resident's care plan was developed. A goal was developed for her, which read, "Resident desires to return home upon completion of rehabilitation therapy. Will receive adequate preparation and orientation for discharge to home upon completion of rehab therapy." On 6/23/11 at 3:35pm, Resident #146's aide was interviewed. She stated that she was unaware of any discharge plans. On 6/23/11 at 3:45pm, Social Worker #2 was interviewed. She indicated that as far as she knew, the niece intended for the resident to be long term. She stated that the resident's spouse and daughter lived out of state. She produced a Social Progress Note, dated 3/30/11 that stated that plans were long term due to Dementia. On 6/24/11 at 8:25am, MDS Nurse #2 was interviewed. She stated that she did not assess Resident #146 for discharge planning, but one of the newer staff did. She reviewed the medical chart and stated that an error had been made on the care plan. She speculated that the resident might have been interviewed about her desires to return home, instead of first looking at the Admission or Social Work notes, to determine long term plans. The MDS nurse noted that the goal had since been discontinued, as of 6/23/11. On 6/24/11 at 12:50pm, an interview was conducted with MDS Nurse #1. She stated that she couldn't recall what led her to initiate a care plan goal of community discharge planning.

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	345144	A. BUILDING _____ B. WING _____ AUG 0 2 2011	C 06/24/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 201 SS=B	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to indicate the appropriate reason for the discharge/transfer from skilled nursing facility (SNF) bed to a home for the aged (HA) bed for 4 (Residents # 185, #180 , # 170 & #177) of 4	F 201	Pine Ridge Health & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal Dispute Resolution formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Hedrick — TITLE: Administrator — (X6) DATE: 7/19/11

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

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 201 SS=B	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to indicate the appropriate reason for the discharge/transfer from skilled nursing facility (SNF) bed to a home for the aged (HA) bed for 4 (Residents # 185, #180 , # 170 & #177) of 4	F 201	F201 Resident #185 has received clarification orders for discharge with reason. Resident #170 was discharged home, resident #177 was discharged to the hospital, resident #180 was discharged to skilled nursing, alzheimers unit. All current HFA residents have been audited by Medical Records on 7/19/11 determine transfer from SNF and ensure MD order and reason for transfer are present as necessary. Medical Records and social worker will check future transfers from SNF to HFA to ensure a discharge MD order and reason for transfer are present. Nurses, social worker(s) and admission coordinator have been inserviced to ensure resident transfers from SNF to HFA have an MD order and reason for transfer documented in the medical record. During the daily morning meeting, the social worker will discuss with the other department managers any planned transfer and ensure the order and reason for transfer are present in the chart prior to transfer.	7/22/11

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

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

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F 201	Continued From page 1 sampled residents. The findings include: 1. Resident # 185 was admitted to the facility on 04/13/11 on a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #185 was transferred/discharged to a HA bed on 06/16/11. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident #185. On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for transfer/discharge from a SNF bed to a HA bed for Resident #185.	F 201	The social worker will audit all new transfers from SNF to HA to ensure order and reason for transfer have been obtained, utilizing the QI Tool "Transfer from SNF to HFA Unit" weekly x4 then monthly. Upon identification of any potential concern, the Social Worker and/or DON will follow up as indicated. Medical Records will audit charts following each transfer weekly x4 and monthly thereafter. The results of the audits will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring	

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 201	Continued From page 2 2. Resident # 180 was admitted to the facility on 03/08/11 on a certified SNF bed. The business office records revealed that on 03/24/11, Resident #180 was discharged/transferred to a HA bed. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident #180. On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for the transfer/discharge from a SNF bed to a HA bed for Resident #180. 3. Resident # 170 was admitted to the facility on 03/28/11 on a certified SNF bed. The business office record revealed that Resident #170 was	F 201		

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F 201	Continued From page 3 discharged/transferred to a HA bed on 04/29/11. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident #170. On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for transfer/discharge from a SNF bed to a HA bed for Resident #170.	F 201		

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F 201	Continued From page 4 4. Resident #177 was admitted to the facility on 2/14/11 on a certified skilled nursing facility (snf) bed. She was discharged for hospitalizations but readmitted on 5/5/11 into a snf bed again. The business office records revealed that Resident #177 was transferred/discharged to a HA bed on 6/23/11. Review of the resident's records revealed a Nurse's Note, dated 6/23/11 at 1:30pm that read, "Moved to HFA at this time." An undated doctor's order, written by Administrative Staff #3 stated that Resident #177 "May transfer to HFA unit." On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. On 6/24/11 at 12:20pm, Administrative Staff #3 was interviewed. She acknowledged that she wrote the doctor's order when the social worker told her she needed one to move the resident to a HA bed. She relayed that she contacted the doctor and asker her if she thought the move was appropriate and the doctor said okay, so she wrote the order. No other reason for the move was offered.	F 201		
F 202 SS=B	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be	F 202		

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F 202	Continued From page 5 documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document the appropriate reason for the discharge/transfer from skilled nursing facility (SNF) bed to a home for the aged (HA) bed for 3 (Residents # 185, #180 & # 170) of 3 sampled residents. The findings include: 1. Resident # 185 was admitted to the facility on 04/13/11 on a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #185 was transferred/discharged to a HA bed on 06/16/11. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident	F 202	F202 Resident #185 has received a Clarification order for discharge with Reason on 7/19/11. Resident #180 was discharged to Skilled Nursing, Alzheimer's Unit. Resident #170 was discharged home. All current HFA residents have been audited by Medical Records on 7/19/11 determine transfer from SNF and ensure MD order and reason for transfer are present as necessary. Medical Records and social worker will check future transfers from SNF to HFA to ensure a discharge MD order and reason for transfer are present. Nurses, social worker(s) and admission coordinator have been inserviced 7/19/11 to ensure resident transfers from SNF to HFA have an MD order and reason for transfer documented in the medical record. During the daily morning meeting, the social worker will discuss with the other department managers any planned transfer and ensure the order and reason for transfer are present in the chart prior to transfer.	7/22/11

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F 202	Continued From page 6 #185. On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for transfer/discharge from a SNF bed to a HA bed for Resident #185. 2. Resident # 180 was admitted to the facility on 03/08/11 on a certified SNF bed. The business office records revealed that on 03/24/11, Resident #180 was discharged/transferred to a HA bed. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident #180. On 06/24/11 at 10:26 AM, the social worker was	F 202	The social worker will audit all new transfers from SNF to HA to ensure order and reason for transfer have been obtained, utilizing the QI Tool "Transfer from SNF to HFA Unit" weekly x4 then monthly. Upon identification of any potential concern, the Social Worker and/or DON will follow up as indicated. Medical Records will audit charts following each transfer weekly x4 and monthly thereafter. The results of the audits will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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F 202	Continued From page 7 interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for the transfer/discharge from a SNF bed to a HA bed for Resident #180. 3. Resident # 170 was admitted to the facility on 03/28/11 on a certified SNF bed. The business office record revealed that Resident #170 was discharged/transferred to a HA bed on 04/29/11. Review of the resident's records revealed no documentation as to the reason for the transfer/discharge from a SNF bed to HA bed. There was also no doctor's order written for the discharge/transfer. On 06/24/11 at 10:10 AM, Nurse #2 was interviewed. She stated that when a resident was discharged/transferred from a SNF bed to a HA bed, a doctor's order was written. She further stated that she did not have to call the attending physician to get the order because it was a facility protocol. She stated that she did not know why there was no doctor's order written for Resident #170. On 06/24/11 at 10:26 AM, the social worker was interviewed. She stated that before the resident is transferred from a SNF bed to a HA bed, a doctor's order should have been obtained. She agreed that there should have some	F 202		

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F 202	Continued From page 8 documentation in the record regarding the reason for the discharge/transfer. The social worker acknowledged that the facility failed to obtain a doctor's order and to document in the resident's record the reason for transfer/discharge from a SNF bed to a HA bed for Resident #170.	F 202	F226 Resident #160 is no longer in the facility All allegations of misappropriation of Resident property to include missing money in the last 90 days have been reviewed by the Administrator for appropriate and thorough investigation with no issues identified. Administrator will review all concerns for misappropriation of property to include missing money with the Social Worker and/or DON for thorough investigation utilizing a QI Tool, "Misappropriatiojn of Property". Follow up for any potential issue will occur upon identification by the Social Worker and/or DON with the Administrator's oversight as needed. All staff will be inserviced on Abuse, Neglect or Resident Misappropriation of Property to include missing money by the Staff Development Coordinator on 7/19/11. The DON and the Social Workers have been inserviced in regards to conducting a thorough investigation of misappropriation of resident property by the Administrator on 7/14/11.	7/22/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility document review, the facility failed to thoroughly investigate and report an allegation of missing money for 1 of 1 sampled resident (Resident #160). The findings included: A facility policy dated 2/2009 entitled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," read in part: "Allegations of abuse, neglect, or misappropriation of resident property and injuries of unknown origin will be investigated by the facility. The Administrator is responsible to direct the investigation process and to ensure that appropriate agencies are notified, as indicated." Under "Reporting/Response: North Carolina" the policy read: "The facility will thoroughly investigate and document all allegations of resident abuse or neglect, misappropriation of resident or facility property, diversion of drugs belonging to a	F 226		

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F 226	Continued From page 9 resident or facility, and fraud against a resident or facility. The Division of Facility Services Health Care Personnel Section is to be notified of all allegations which appear to a reasonable person to be related to abuse, neglect, or misappropriation of property within 24 hours, or as soon as practical. A written report must be sent to Division of Facility Services Health Care Personnel Section, within five (5) working days of the date the facility becomes aware of the alleged incident." Under "Definitions": "Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." Resident #160 was admitted to the facility on 2/10/11. The most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/12/11 which indicated that the resident was cognitively intact, had no behavioral symptoms, required supervision with activities of daily living and was ambulatory. During an interview on 6/22/11 at 9:16 AM, Resident #160 indicated that some money she kept in her cell phone case has been missing. The resident stated she kept the case "in there" (pointing to an open black box on top of her bedside table). The resident stated that after she reported the missing money to staff a social worker talked with her about it. The resident denied any knowledge that a police investigation had been done, and said that the money was still missing. During a second interview on 6/24/11 at 8:10 AM, Resident #160 indicated that she felt disappointed that the money disappeared. She	F 226	Audits of allegations and investigations of misappropriation of resident property to include missing money will be conducted monthly x3 and quarterly thereafter by the nursing consultant or the regional vice president utilizing a QI tool. Follow up for any potential issue will occur upon identification with the Administrator by the Nursing Consultant or regional vice president as appropriate. The audit results will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for the follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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F 226	Continued From page 10	F 226		

could not imagine anyone taking it but did not know what else could have happened. The resident shared that she was absent from the facility for several hours every Monday, Wednesday and Friday and always left the case with the money in the black box atop her bedside table.

A facility "Concern Report" initiated 5/13/11 revealed that on 5/13/11 Resident #160 reported that $55.00 went missing sometime between 5/12/11 at 10:00 PM and 5/13/11 at 4:00 PM. The report indicated that all nursing staff who worked on the 3-11, 11-7 and 7-3 shifts on 5/12/11 and 5/13/11 on the hall where Resident #160 resided were interviewed. The report did not include a written record of these interviews.

During an interview on 6/24/11 at 11:55 AM, administrative staff #1 stated that when Resident #160 reported the missing money, the facility immediately investigated. The investigation included interviews with all the nursing staff on the resident's hall during the period of time when the money went missing. No staff member was suspected of taking the money. The resident's room was searched and $25.00 was found in one of her clothing drawers. Laundry was also notified to look in pockets for the missing money. Administrative staff #1 indicated that because she could not prove that a staff member took the money she did not consider the situation as misappropriation of property. No report was made to the state agency, nor was the resident asked if she wanted a report made to the local law enforcement agency. Administrative staff #1 acknowledged that the facility's investigation "could have been more thorough" and that the

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F 226	Continued From page 11 facility did not document the investigation very well. Administrative staff #1 indicated that her practice was to report to the police only if a probable suspect was identified during the facility investigation. Administrative staff #1 said that the facility did not consider the missing money to fall under the definition of misappropriation of resident property because the facility could not prove a deliberate act was involved.	F 226		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 Target Behaviors for Resident #10, #66 & #117 were identified on the Documentation of Behavior Sheets and the diagnosis for resident #160 was obtained for Haldol on 6/23/11 by the ADON. 100% audit of all Documentation of Behavior Sheets was completed on 6/23/11 by the DON. All residents on psychoactive medications have identified target behaviors for monitoring of the medication(s). All residents on antipsychotic medications have been reviewed by the DON and/or Administrative Nurses (Assistant Director of Nursing, Staff Development Coordinator, Quality Improvement Nurse, MDS Nurses and 7-3 Nurse Supervisor) on 7/19/11 f or target behaviors and supporting diagnosis with follow up occurring as necessary.	7/22/11

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F 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility administered antipsychotic medications to 1 of 6 sampled residents (Resident #169) with no diagnosis for antipsychotic use, and to 3 of 3 sampled residents on the 300 hall (Residents #10, #66 and #117) with no specific targeted behaviors on the behavior monitoring forms. The findings included: 1. Resident #160 was admitted to the facility on 2/10/11. The hospital discharge summary dated 2/10/11 did not list any psychiatric diagnoses or behavior problems. The list of discharge medications included Haldol (an antipsychotic) 10 milligrams (mg) at bedtime. Physician orders dated 2/11/11 included Haldol 10 mg every night at bedtime. The admission Minimum Data Set (MDS) dated 2/16/11 and most recent quarterly assessment dated 5/12/11 revealed that Resident #160 was cognitively intact and had no behavior problems. The consultant pharmacist's note dated 3/17/11 indicated a diagnosis was needed to justify Haldol use. A form from the consultant pharmacist entitled "Note To Attending Physician /Prescriber" read in part, Resident #160 "is receiving the antipsychotic agent Haldol 10 mg qd (daily), but lacks an allowable diagnosis to support its use." "Please add supporting indication with an acceptable diagnosis or taper and discontinue drug if no longer required." Handwritten on this form was "will need to contact previous physician	F 329	All residents will continue to be reviewed by the consultant pharmacist for diagnoses and target behaviors during the monthly visit. Upon receipt of the pharmacy consultant report, the DON will distribute the report to the ADON and 7-3 RN Supervisor for prompt intervention. Upon completion of the Pharmacy "Notes To Attending Physicians/Provider" by the physician, the DON or QI Nurse will check all notes to assure appropriate follow up has occurred to include the identification of target behaviors for monitoring and supporting diagnosis for psychoactive medications as present. Licensed Nurses have been inserviced on identifying target behaviors and obtaining diagnoses of antipsychotic medications by the Staff Development Coordinator on 7/19/11. New admissions will be checked by the RN Supervisor for antipsychotic medications, diagnoses and target behaviors weekly utilizing a QI tool, "Antipsychotic Medications". Follow up action will be taken as indicated upon the identification of any concern to include target behaviors for monitoring and/or diagnosis to support the use of antipsychotic medications by the RN Supervisor.	

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F 329	Continued From page 13 to see" followed by an illegible signature. The handwritten note was undated. The consultant pharmacist's note dated 5/19/11 indicated that no diagnosis had been provided for the use of Haldol for Resident #160. Resident #160's monthly Physician Orders for March, April, May and June 2011 revealed orders for Haldol 10 mg at bedtime. During an interview on 6/23/11 at 5:17 PM, administrative staff #2 indicated that responses to consultant pharmacist's notes were written on a physician order form. Administrative staff #2 acknowledged that Resident #160's record did not include a diagnosis for Haldol, and stated she would contact the physician. On 6/23/11 at 5:20 PM, administrative staff #2 revealed a telephone order dated 6/23/11 for Resident #160 for a diagnosis of a schizophrenic disorder. 2. Resident # 10 was admitted to the facility on 09/30/08. Review of the records indicated that Resident #10 was on Risperdal (an anti-psychotic medication) for Bipolar Disorder. Review of the behavior monitoring forms for May and June, 2011 revealed no specific target behaviors listed. On 06/23/11 at 2:18 PM, the QA (Quality Assurance) Nurse was interviewed. She stated that residents on psychotropic medications should have a behavior monitoring form with	F 329	The QI nurse will audit for the presence of supporting diagnosis and target behavior monitoring documentation using the QI Tool "Antipsychotic Medications". These audits will be completed weekly for 4 weeks, then monthly for 3 months and then quarterly. The QI Nurse will follow up on any potential concern upon identification. The audits results will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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F 329	Continued From page 14 specific target behaviors listed on the form. On 06/23/11 at 2:26 PM, Nurse #1 was interviewed. She stated that behavior monitoring forms should have specific target behaviors listed on each form. She further stated that the nurse who checked the MARs (Medication Administration Records) at the end of the month should have listed the specific target behaviors on each forms. 3. Resident # 117 was admitted to the facility on 07/06/09. Review of the resident's records indicated that Resident #117 was on Risperdal for Psychosis. Review of the behavior monitoring forms for May and June, 2011 revealed no specific target behaviors listed. On 06/23/11 at 2:18 PM, the QA (Quality Assurance) Nurse was interviewed. She stated that residents on psychotropic medications should have a behavior monitoring form with specific target behaviors listed on the form. On 06/23/11 at 2:26 PM, Nurse #1 was interviewed. She stated that behavior monitoring forms should have specific target behaviors listed on each form. She further stated that the nurse who checked the MARs (Medication Administration Records) at the end of the month should have listed the specific target behaviors on each forms. 4. Resident # 66 was admitted to the facility on	F 329		

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F 329	Continued From page 15 11/14/08. Review of the resident's records indicated that Resident #66 was on Seroquel (an anti-psychotic medication) for Delusion, Hallucination and Aggression. Review of the behavior monitoring forms for May and June, 2011 revealed no specific target behaviors listed. On 06/23/11 at 2:18 PM, the QA (Quality Assurance) Nurse was interviewed. She stated that residents on psychotropic medications should have a behavior monitoring form with specific target behaviors listed on the form. On 06/23/11 at 2:26 PM, Nurse #1 was interviewed. She stated that behavior monitoring forms should have specific target behaviors listed on each form. She further stated that the nurse who checked the MARs (Medication Administration Records) at the end of the month should have listed the specific target behaviors on each forms.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	F334 Resident #37 is no longer in the facility. Resident #154 received educational materials to include the risks and benefits for the pneumococcal and influenza vaccines on 6/21/11 with acknowledgement. 100% audit of all current residents was completed on 6/24/11 by DON and administrative nurses to ensure education was provided for pneumococcal and influenza immunizations with no issues identified.	7/22/11

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F 334	Continued From page 16 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 334	Social Workers, Admission Coordinator and nurses have been inserviced by the Staff Development Coordinator on July 15, 2011on Resident/Family Education for Pneumococcal and Flu Immunization to include risk and benefits. Upon admission, the admission coordinator and/or social worker provides education for immunizations to the resident/family with a signed "Receipt of Information Acknowledgement". During each influenza season annually, education of influenza immunization will be provided and documented by the hall nurse on the "Immunization Record" as appropriate. The Social Worker and/or SDC will audit results and report to the QI nurse weekly x4 then monthly thereafter. The QI nurse will report results to the Executive QI Committee for monthly review x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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F 334	Continued From page 17 the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide education regarding the benefits and potential side effects of influenza vaccine prior to offering the vaccine to 2 (Residents # 154 & #37) of 5 sampled residents. The findings include: The facility's policy on Infection Control for Residents dated 3/12/06 was reviewed. The policy read in part "Education about infection control and prevention should be provided to residents and families as appropriate. The risks and benefits of vaccines (influenza, pneumococcal, etc) should be discussed with residents and/or residents' representatives upon admission to the facility. Documentation of this discussion may occur through the utilization of Receipt of Acknowledgement form (BN 3008)". 1. Resident # 37 was admitted to the facility on 11/5/02. Review of the resident's immunization record revealed that on 10/6/10, an influenza	F 334		

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F 334	Continued From page 18 vaccine was administered to the resident. There was no documentation in the record that education regarding the benefits and potential side effects of influenza vaccine was provided to the resident and/or resident's representative prior to the administration of the influenza vaccine. On 06/23/11 at 11:45 AM, the infection control nurse was interviewed. He stated that he was new to his position and the previous infection control nurse who administered the vaccine was no longer at the facility. He acknowledged that there was no documentation in the record to show that education was provided prior to the administration of the influenza vaccine on 10/6/10. 2. Resident # 154 was originally admitted to the facility on 8/29/08. Review of the resident's immunization record revealed that on 10/6/10, education material for influenza vaccine was mailed to the resident's responsible party (RP). The record further indicated that on 10/6/10, the resident and/or the RP refused the influenza vaccine. On 03/25/11, the immunization record revealed that influenza vaccine was administered to the resident. There was no documentation in the record to show that education regarding the benefits and potential side effects of the vaccine was provided to the resident and/or RP prior to the administration of the vaccine on 03/25/11. On 06/23/11 at 11:45 AM, the infection control nurse was interviewed. He stated that he was new to his position and acknowledged that he was the one who administered the influenza vaccine to the resident on 03/25/11. He indicated	F 334		

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(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 334	Continued From page 19 that he did not provide the education material to the resident and/or the RP prior to the administration of the vaccine because it was already provided in October, 2010.	F 334		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to promptly refer 1 of 3 sampled residents (Resident #160) for dental services. The findings included: Resident #160 was admitted to the facility on 2/10/11. During an interview on 6/28/11 at 2:30 PM, administrative staff #1 confirmed that Resident #160 was covered by Medicare from 2/10/11 -	F 411	F411 Resident #160 is no longer in the facility. All residents have been reviewed by the DON and/or Administrative Nurses on 7/19/11 for proper dental services to include referrals to the dentist with follow up occurring as necessary. Residents will continue to be reviewed for appropriate dental services to include referral on admission, quarterly and annually with the RAI process. Edentulous residents/responsible party will be contacted to determine desire for dental consult for dentures by the social worker. (Tool attached, "Edentulous Residents"). The Social Worker will maintain a list of edentulous residents and update with new admissions and current residents for follow-up care. Inservices were provided for the social Worker(s) regarding inhouse dental visits and follow up care by the staff development coordinator on 7/19/11.	7/22/11

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	345144	A. BUILDING _____ B. WING _____	C 06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 411	Continued From page 20 4/23/11; Medicaid coverage began on 4/24/11. A "nutritional line note" dated 2/11/11 indicated that Resident #160 told the clinical dietary manager (CDM) that she had no chewing or swallowing problem. The CDM noted that the resident was edentulous. The admission MDS, dated 2/16/11, indicated that Resident #160 was cognitively intact, understood others and was understood by others, and was edentulous. The Care Area Assessment (CAA) for dental care, dated 2/21/11, read "risk for dental problems r/t (related to) no teeth: Care plan factors: provide diet as needed." "No need to care plan." There was no documentation that Resident #160 had been asked about ever having had dentures. During an interview on 6/24/11 at 12:44 PM, MDS nurse #1 indicated that she had performed the dental aspect of Resident #160's admission MDS and the dental CAA. MDS nurse #1 indicated that she should have asked the resident about dentures during the assessment but did not. During an interview on 6/22/11 at 9:25 AM, Resident #160 stated that she had worn dentures in the past but they were lost shortly before her admission to the facility. The resident said she would like to get another set of dentures and had discussed this with the social worker, but had not yet seen a dentist since her admission to the facility. The resident added that she now received a mechanical soft diet and had no difficulty eating. During an interview on 6/23/11 at 2:56 PM, the	F 411	The QI nurse will audit the Edentulous Residents Tool weekly x 4 then monthly for appropriate dental services to include timeliness of referrals. Follow up will occur upon the identification of any potential issue as appropriate by QI Nurse. The results of the audits will be forwarded to the Executive QI Committee for review monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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F 411	Continued From page 21 social worker (SW#1) indicated that she was unaware that Resident #160 had worn dentures until she was notified on 5/12/11 by an outside clinic the resident regularly visited. SW#1 indicated that she immediately added Resident #160 to the list of residents to be seen by the dentist during his visit to the facility on 5/17/11. Nurses Notes dated 5/17/11 indicated that Resident #160 had visited an outside clinic on 5/17/11, and from the clinic was sent to the hospital. The resident did not see the dentist on 5/17/11. A "lab report card" from an outside clinic revealed that on 6/1/11 Resident #160's albumin level had dropped from 3.4 on 5/4/11 to 3.1. The lab report card indicated that the minimal acceptable albumin level is 3.5, and one of the recommendations was to increase meat consumption. Nutritional line notes dated 6/10/11 indicated that Resident #160 told the CDM that she was having difficulty chewing meats. Physician orders dated 6/10/11 revealed that the CDM received a physician order to down grade Resident #160's diet to a regular diet with ground meat. During an interview on 6/23/11 at 2:56 PM, SW#1 indicated that she was not aware that Resident #160 had missed the dental appointment on 5/17/11. SW#1 indicated that she would follow up with the resident and set up an appointment with an outside dentist who accepts Medicaid.	F 411		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428 SS=D	Continued From page 22 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to act on the consultant pharmacist's recommendation to obtain a diagnosis for the use of Haldol (an antipsychotic drug) for 1 of 6 sampled residents (Resident #160). The findings included: 1. Resident #160 was admitted to the facility on 2/10/11. The hospital discharge summary dated 2/10/11 did not list any psychiatric diagnoses or behavior problems. The list of discharge medications included Haldol (an antipsychotic) 10 milligrams (mg) at bedtime. Physician orders dated 2/11/11 included Haldol 10 mg every night at bedtime. The consultant pharmacist's note dated 3/17/11 indicated a diagnosis was needed to justify Haldol use. A form from the consultant pharmacist entitled "Note To Attending Physician /Prescriber" read in part, Resident #160 "is receiving the	F 428	F428 Diagnosis was obtained for Resident #160 from the physician and placed in the medical record on 6/23/11 by the ADON. All residents on antipsychotic medications have been reviewed by the DON and/or Administrative Nurses on 7/14/11 for target behaviors and supporting diagnosis with follow-up occurring as necessary. All residents will continue to be reviewed by the consulting pharmacist for the presence of a diagosis for any psychoactive medication. The consulting pharmacist will inform the DON during the monthly visit of any psychotrophic medication requiring a diagnosis for prompt response. Upon completion of the Pharmacy "Notes to Attending Physicians/Provider" by the physician, the DON or designee will check all notes to assure appropriate response. In the event a diagnosis has not been provided, the DON/ADON will follow up with the primary physician. The 7-3 RN Supervisor/ADON will audit the pharmacy consults for completion and follow-up using the QI Tool "Antipsychotic Medications". These audits will be completed monthly .	7/22/11

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F 428	Continued From page 23 antipsychotic agent Haldol 10 mg qd (daily), but lacks an allowable diagnosis to support its use." "Please add supporting indication with an acceptable diagnosis or taper and discontinue drug if no longer required." Handwritten on this form was "will need to contact previous physician to see" followed by an illegible signature. The handwritten note was undated. The consultant pharmacist's note dated 5/19/11 indicated that no diagnosis had been provided for the use of Haldol for Resident #160. Resident #160's monthly Physician Orders for March, April, May and June 2011 revealed orders for Haldol 10 mg at bedtime. During an interview on 6/23/11 at 5:17 PM, administrative staff #2 indicated that responses to consultant pharmacist's notes were written on a physician order form. Administrative staff #2 acknowledged that Resident #160's record did not include a diagnosis for Haldol, and stated she would contact the physician. On 6/23/11 at 5:20 PM, administrative staff #2 revealed a telephone order dated 6/23/11 for Resident #160 for a diagnosis of a schizophrenic disorder.	F 428	The DON and/ADON will review the completed pharmacy consult audits and report to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/09/2011

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K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, on August 9, 2011 at approximately 11:30am onward, there is no baffle between fat fryer and range; with fat fryer closer than sixteen inches from range. 42 CFR 483.70(a)	K 069	Pine Ridge Health & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal Dispute Resolution formal appeal procedure and/or any other administrative or legal proceeding.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, on August 9, 2011 at approximately 11:30am onward, there are impediments stored in the 100 corridor area. 42 CFR 483.70(a)	K 072	K069 A stainless shield was installed on the fryer between the fryer & range on 8/10/10.There is no other fyer in facility. The Dietary Manager will check the fryer to ensure the shield remains in place. The Dietary Manger will report to The Executive QI Committee at the next monthly meeting and quarterly thereafter for follow-up as deems necessary to determine the need for and/or frequency of continued QI monitoring.	9/15/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janice Hedrick	Administrator	8/25/11

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

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	345144	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2011

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K 147	Continued From page 1 Based on observation, on August 9, 2011 at approximately 11:30am onward, the receptacle cover is missing from the receptacle located in the laundry area - receptacle is located in front of telephone equipment board. 42 CFR 483.70(a)	K 147	K072 Items were removed from the 100 Hall /Corridor. Other halls/corridors were check for items in hall not in use and removed. All Staff will be inserviced on "Maintaining Halls/Corridors free of obstruction or impediments" Through QI rounds, halls will be checked by nursing, housekeeping and/or maintenance staff daily. Results will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring. K147 Promptly installed new receptacle cover on outlet on 8/9/11. Other receptacles throughout the facility were checked by maintenance to ensure no missing receptacle covers. Using a QI tool, maintenance will check receptacles weekly throughout the facility.	9/15/11 9/15/11

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			Additional page Insert Cont. from pg 2 of 2 K147 Cont. Results will be forwarded to the Executive QI Committee monthly x3 then quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	

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	345144	A. BUILDING 02 - BUILDING 02 B. WING _____	08/09/2011

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K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, on August 9, 2011 at approximately 11:30am onward, there are carts stored in the alcove and corridor area near the cross corridor entrance doors to the Alzheimer unit - located near resident room 117. 42 CFR 483.70(a)	K 072	BUILDING 02 K072 The Linen cart was removed from the HFA hall.. Other halls were checked for items in hall not in use and removed if indicated. All staff will be inserviced on Maintaining Halls/Corridors free of obstructions or impediments". Through QI rounds, halls will be checked by nursing, housekeeping and/or maintenance daily. Results will be forwarded to the Executive QI Committee monthly x3 and quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	9/15/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation, on August 9, 2011 at approximately 11:30am onward, the receptacle in resident room 120 is not secured to the structure - exposed raceway and outlet box are hanging from inside exterior wall. 42 CFR 483.70(a)	K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Hedrick — TITLE: Administrator — (X6) DATE: 8/29/11

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			Additional page insert Page #2 Cont from page 1 of 1 K147 Outlet box secured to wall using toggle bolts on 8/10/11. Maintenance checked throughout facility to ensure all receptacles and/or outlet boxes are secure to the structure. Using a QI tool, maintenance will check receptacles and outlet boxes weekly throughout the facility Results will be forwarded to the Executive QI Committee monthly x3 the quarterly thereafter for the identification of potential trends, for follow-up as deemed necessary and to determine the need for and/or frequency of continued QI monitoring.	9/15/11