12/11/13

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 346144 | A. BUILDING _____ B. WING _____ | 11/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 708 PINEYWOOD RD THOMASVILLE, NC 27360 |

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| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and interviews with staff the facility failed to assist residents to dress in their own clothes to maintain dignity for 2 of 2 residents (Resident #89 and #73) reviewed for dignity.<br><br>Findings included:<br><br>1.Resident #89 was admitted on 11/17/11 with diagnoses that included dementia, altered mental status, generalized muscle weakness and failure to thrive.<br><br>The care plan dated 4/26/13 indicated a progressive decline in intellectual functioning related to dementia. Interventions included: establish a daily routine with the resident.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/18/13 indicated Resident #89 was severely cognitively impaired and did not reject care. She was totally dependent and a two person assist with bed mobility, and was totally dependent and one person assist with dressing.<br><br>On 11/12/13 at 10:12 am and 3:40 pm, Resident #89 was observed in bed, in a semi-fowler's position, wearing a green hospital-style gown. | | 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.<br><br>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 administrativeor legal proceeding.<br><br>F-241:<br><br>Residents #89 and #73 were reviewed for clothing preferences by the DON on 11/15/2013 and dressed in their own clothes according to their preferences. | 12/13/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Hedrick
TITLE: Administrator
(X6) DATE: 12/11/2013

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 241 | Continued From page 1<br>On 11/13/13 at 10:50 am, 12:15 pm, and 2:15 pm, Resident #89 was observed in bed, in a semi-fowler's position, wearing a green hospital-style gown.<br><br>On 11/14/13 at 9:30 am, 11:10 am, 12:07 pm, and 2:20 pm, Resident #89 was observed in bed, in a semi-fowler's position, wearing a blue hospital-style gown.<br><br>During an interview on 11/14/13 at 2:27 pm, Nurse Aide (NA) #1 indicated she was assigned to Resident #89, the resident had clothing to wear, and needed assistance with dressing. She indicated there was no reason the resident was not dressed.<br><br>On 11/14/13 at 2:31pm, Resident #89 was observed no longer wearing a gown. She was dressed in a shirt and pants.<br><br>During an interview on 11/14/13 at 2:37 pm Nurse #1 stated, "I like [Resident #89] up daily and do not know of a reason [she] should not be. [She] should be dressed every day."<br><br>During an interview on 11/14/13 at 3:38 pm, the Director of Nursing (DON) indicated Resident #89 should be dressed unless she requested not to be or her power of attorney requested a hospital gown. She indicated she was not aware of a request for the resident to not be dressed.<br><br>On 11/15/13 at 10:21 am, Resident #89 was observed dressed and sitting in her scoot chair.<br><br>On 11/15/13 at 2:00 pm, Resident #89 was observed dressed, sitting in her room, smiling, and remained in her scoot chair. | F 241 | A 100% audit of residents was completed by the DON, ADON and QI nurse to determine their dressing preferences on 11/22/2013. One resident was identified for wearing personal gowns of choice and had previously been care planned.<br><br>A 100% in-service for nursing staff was conducted by the Staff Facilitator on 11/18/2013 on Resident Dignity, to include residents being dressed appropriately and according to their preferences. A QI tool will be utilized to ensure residents are appropriately dressed according to their preferences with supporting documentation as needed.<br><br>This QI monitoring will be completed by the QI nurse as follows:<br>A random selection of 5 residents (including residents #89 and #73) from each Hall will be monitored for clothing preference three times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, then once weekly for 4 weeks. Any areas of concern will be addressed at the time noted with the administrative nurses. These audit results will be reviewed weekly at the stand-up meeting with additional follow up action taken as noted by the DON & ADON. | |

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| F 241 | Continued From page 2<br><br>2. Resident #73 was admitted on 12/16/10 with diagnoses that included Alzheimers, lack of coordination, and dementia.<br><br>The quarterly MDS dated 8/22/13 indicated Resident #73 was severely cognitively impaired and did not reject care. She was totally dependent and a two person assist with bed mobility, and was totally dependent and a one person assist with dressing.<br><br>On 11/13/13 at 10:50 am, 12:15 pm, and 2:15 pm, Resident #73 was observed in bed, in a semi-fowler's position, wearing a hospital-style gown.<br><br>On 11/14/13 at 9:30 am, 11:10 am, 12:07 pm, and 2:20 pm, Resident #73 was observed in bed, in a semi-fowler's position, wearing a hospital-style gown.<br><br>During an interview on 11/14/13 at 2:27 pm, Nurse Aide (NA) #1 indicated she was assigned to Resident #73, the resident had clothing to wear, and needed assistance with dressing. She indicated there was no reason the resident was not dressed.<br><br>During an interview on 11/14/13 at 2:37 pm Nurse #1 stated, "I like [Resident #73] up daily and do not know of a reason [she] should not be. [She] should be dressed every day."<br><br>During an interview on 11/14/13 at 3:45 pm, the Director of Nursing (DON) indicated Resident #73 was a total assist with activities of daily living which included dressing and that the resident should be dressed. | F 241 | The results of the audits will be forwarded to the Executive QI Committee monthly X 3 and quarterly thereafter for the identification of potential trends for follow-up as deemed necessary and to determine the need for and/or the frequency for continued monitoring. | |

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| F 241 | Continued From page 3<br><br>On 11/16/13 at 10:21 am, Resident #73 was observed dressed in her own clothes and sitting in her geri chair. | F 241 | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and interviews with staff the facility failed to assist residents, as needed, to get dressed for, be transported to, and participate in desired activities for 2 of 2 residents (Resident #89 and #73) reviewed for activities.<br><br>Findings included:<br><br>1.Resident #89 was admitted on 11/17/11 with diagnoses that included dementia, altered mental status, generalized muscle weakness and failure to thrive.<br><br>The care plan dated 2/7/13 indicated the resident required assistance for all transfers related to debility of chronic disease and cognitive defects. Interventions included: assist of two with all lift transfers.<br>The care plan dated 4/25/13 indicated a progressive decline in intellectual functioning related to dementia. Interventions included: | F 248 | F-248:<br><br>The Activity Director and the hall nurse evaluated resident #89 and #73 activity interests and accommodation needs to attend activities on 11/15/2013 and assisted them to activities.<br><br>A 100% audit of residents was conducted by the Activity Director to determine resident activity interests for group and in-room activities according to their function, ability and/or preference with updating of the Activity Supplemental Assessment as needed.<br><br>A 100% in-service for Activity and Nursing Staff was conducted by the Staff Facilitator on 11/18/2013 to encourage residents to participate in group and/or individual activities, dress residents appropriately and assist residents to and from activities as provided based on their interests and needs. A QI audit tool will be used to monitor resident activity participation in group and individual activities, clothing preferences and assistance to and from activities. | 12/13/13 |

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| F 248 | Continued From page 4<br>encourage group activities and establish a daily routine with the resident.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/18/13 indicated Resident #89 was severely cognitively impaired and did not reject care. She was totally dependent and a two person assist with transfers, was totally dependent and one person assist with dressing, and locomotion on and off the unit.<br><br>The activity progress note dated 9/18/13 indicated Resident #89's group interests were music groups and women's groups. Her independent interests were television and chair rides. The note indicated Resident #89 actively participated in out-of-room activities 2-4 times weekly, that in-room activities were in keeping with her interests, and that her activity needs and goals were being met.<br><br>The Activity Assessment dated 11/11/13 indicated Resident #89's activity interests included gospel music, television and movies.<br><br>A review of the resident's group activities dated 10/14/13-11/14/13 revealed she participated in 1 music program that month and 2 religious programs that month.<br><br>On 11/12/13 at 10:12 am and 3:40 pm Resident #89 was observed in bed, in a semi-fowler's position, wearing a hospital gown. There was no music, television or other activity in the room.<br><br>On 11/13/13 at 10:50 am, 12:15 pm, and 2:15 pm Resident #89 was observed in bed, in a semi-fowler's position, wearing a hospital gown. There was no music, television or other activity in | F 248 | Monitoring will be completed by the QI Nurse as follows: A random selection of 5 residents (including residents #89 and #73) from each Hall will be monitored (3) three times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, then once weekly for 4 weeks. Any areas of concern will be addressed at the time noted by the administrative nurse. Audit results will be reviewed weekly at the stand-up meeting with additional follow up action taken as noted by the DON and ADON.<br><br>The results of the audits will be forwarded to the Executive QI Committee monthly X 3 and quarterly thereafter for the identification of potential trends for follow-up as deemed necessary and to determine the need for and/or the frequency for continued monitoring. | |

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| F 248 | Continued From page 5<br>the room.<br><br>On 11/14/13 at 9:30 am, 11:10 am, 12:07 pm, and 2:20 pm Resident #89 was observed in bed, in a semi-fowler's position, wearing a hospital gown. There was no music, television or other activity in the room.<br><br>During an interview with Resident #89 on 11/14/13 at 2:22 pm, when asked if she would like to get out of bed, she stated, "Yes, please."<br><br>During an interview on 11/14/13 at 2:27 pm, Nurse Aide (NA) #1 stated, "[Resident #89] hasn't been up today. She was up yesterday. She is usually up 2-3 hours a day." She indicated there was no reason why the resident had not been out of bed.<br><br>On 11/14/13 at 2:31pm Resident #89 was observed no longer wearing a gown. She was dressed in a shirt and pants. The lift pad was lying underneath her. NA #1 and NA #2 were using the lift to get her out of bed.<br><br>An observation on 11/14/13 at 2:36 pm of the resident care guide, posted on the back of the door to Resident #89's room, indicated she was non-ambulatory and required a lift to get out of bed.<br><br>During an interview on 11/14/13 at 2:37 pm Nurse #1 stated, "I like [Resident #89] up daily and do not know of a reason [she] should not be."<br><br>During an interview on 11/14/13 at 2:55 pm with the Activities Director she stated, "We take [Resident #89] to music and to watch videos. If we can get her out we do that. She doesn't | F 248 | | |

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| F 248 | Continued From page 6<br>actively participate. She has had 3 group activities in the past month. We read to her and rub her hands with lotion. There is no minimum for activities. It depends on her moods." She indicated Resident #89 "is not as active now on the hallway as she was on the locked unit." She further indicated the reason for her decreased activities was that the locked unit has one activity assistant for 29 residents and "the rest of the building, about 120 residents, is handled by myself and one other activity assistant." She indicated residents that require lifts and are not dressed and out of bed at the time of the scheduled activity are not able to participate.<br><br>On 11/15/13 at 10:21 am, Resident #89 was observed dressed and sitting in her scoot chair in the dining room with 6 other residents, watching television. She was interactive, looking around, reaching out to the resident sitting beside her and smiling.<br><br>On 11/15/13 at 10:40 am, Resident #89 was observed in a group activity with 8 other residents. She was sitting in her scoot chair, alert, smiling, interactive and looking around at other residents and staff in the activity. She was reaching out her arms and attempting to catch the balloon being used in the activity when it came close to her. She was holding the balloon and kicking it with her feet when the balloon was passed to her.<br><br>On 11/15/13 at 2:00 pm, Resident #89 was observed sitting in her room, smiling, and remained in her scoot chair.<br><br>2. Resident #73 was admitted on 12/16/10 with diagnoses that included Alzheimers, lack of | F 248 | | |

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| F 248 | Continued From page 8<br>wearing a hospital gown. There was no music, television or other activity in the room.<br><br>During an interview on 11/14/13 at 2:37 pm Nurse #1 stated, "I like [Resident #73] up daily and do not know of a reason [she] should not be. [She] should be dressed every day."<br><br>During an interview on 11/14/13 at 3:45 pm, the Director of Nursing (DON) indicated Resident #73 was a total assist with activities of daily living which included dressing and that the resident should be dressed.<br><br>On 11/15/13 at 10:21 am, Resident #73 was observed dressed and sitting in her geri chair in the dining room with 6 other residents. The television was on and the resident was positioned in front of it. | F 248 | | |
| F 367 SS=D | 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN<br><br>Therapeutic diets must be prescribed by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to provide a modified diet for 1 of 1 sampled resident (resident #136) who had orders by a physician.<br><br>The Findings included:<br><br>Resident #136 was admitted to the facility on 7/11/11 with a diagnosis to include; Dysphagia, abnormal posture, hypothyroidism, | F 367 | F-367 --<br><br>Resident #136 was referred to Speech Therapy for re-evaluation of diet consistency on 11/14/2013. The Dietary Manager and Registered Dietitian re-evaluated the resident's diet for protein and intake on 11/13/2013. Resident #136 receives diet as ordered and continues in restorative dining. | 12/13/13 |

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| F 367 | Continued From page 9<br>gastroesphageal reflux disease, peptic ulcer, and acute renal failure.<br><br>The latest Minimum Data Set (MDS) dated 9/26/13 indicated Resident #136 required extensive assistance with eating. The MDS further indicated Resident #136 had short term and long term memory loss and was severely cognitively impaired for daily decision making.<br><br>Physician Order dated 8/23/13 dictated; change patients diet to no concentrated sugars (NCS), no added salt (NAS) puree with HTL.<br><br>Review of Resident #136's care plan revised on 7/18/13 revealed the resident had the following goals in regards to Resident #136 "state of nourishment"; Will adhere to prescribed diet and will provide protein to meet residents daily requirement. The interventions included; provide prescribed diet, monitor closely during meal times, and provide resident with extensive assist during meals.<br><br>Observation of Restorative dining on 12/12/13 at 12:25 pm revealed Nursing Assistant (NA) #3 providing assistance to Resident #136 with meal set up. Housekeeping Staff #1 intervened prior to NA #3 beginning to feed Resident #136 as evidenced by stating Resident #136 was not to receive meats due to the resident choking yesterday (11/11/13). Housekeeping staff #1 further indicated that a meeting was going to be held to discuss possible consistency changes. NA #3 was observed to remove the meat item from Resident #136's plate. Review of Resident #136 meal card dated 11/12/13 located on the resident ' s tray indicated the resident was to | F 367 | The Clinical Dietary Manager completed an audit of all residents to ensure each resident is receiving his/her diet as prescribed on 12/4/2013. A 1:1 in-service training on "Diets Offered as Prescribed" for housekeeping staff #1 and NA #3 was completed by the Staff Facilitator on 11/18/2013..<br>A 100% in-service of all nursing and trained feeding staff was completed by the DON, ADON and Staff Facilitator on providing diets to residents as prescribed on 11/13/2013. An audit tool will be used to ensure residents receive diets as ordered.<br><br>Monitoring will be completed by the QI Nurse as follows: A random selection of 5 residents (including resident #136) (3) times weekly for (2) weeks, two (2) times weekly for two (2) weeks, then once weekly for 4 weeks. Any areas of concern will be addressed at the time noted by administrative nurses. Audit results will be reviewed weekly at the stand-up meeting with additional follow up action taken as noted by the DON & ADON | |

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| F 367 | Continued From page 10<br>receive pureed double meats. NA #3 was observed to not provide resident with an alternate pureed meat or gain clarification of a change in Resident #136's diet constancy.<br><br>Interview with NA# 3 on 11/12/13 at 12:30 pm revealed she was unaware that the resident was not to have meats or had any episodes of choking. The NA further indicated is she had not been told by Housekeeping Staff #1 she wouldn't have known that resident #136 was not to receive meats. NA#3 stated that changes to resident's meal should be located on the resident's meal card.<br>Continued interview with NA#3 on 11/14/13 at 10:03am revealed she was not aware of Resident 136's diet changes until 11/12/13 when housekeeping staff #1 communicated the resident was not to receive meats due to choking. Due to what was communicated by Housekeeping staff, NA #3 removed the meat from Resident #136's plate. NA #3 stated that she did not locate a nurse to determine whether Resident #136 was not to have meats or to determine if there was a change in the resident's diet. NA #3 did not attempt to locate a substitute food item due to removing the resident's meats. NA#3 stated that she has never observed Resident #136 to choke. NA #3 indicated she discussed Resident #136's diet with the head of the restorative program (NA #4) on 11/14/13 in which she discovered the resident was only having problems swallowing pureed chicken and dumplings and items such as roast beef.<br><br>Interview with Housekeeping staff #1 on 11/14/2013 at 9:42 am revealed Resident #136 did have a choking episode with meats when staff fed resident #136 on 11/11/13. Staff #1 indicated | F 367 | The results of the audits will be forwarded to the Executive QI Committee monthly X 3 and quarterly thereafter for the identification of potential trends for follow-up as deemed necessary and to determine the need for and/or the frequency for continued monitoring. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345144 | A. BUILDING _____ B. WING _____ | 11/15/2013 |

| 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 |
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| F 367 | Continued From page 11<br>the resident would occasionally choke on stringy meats that were pureed but recently had been choking on everything. Staff #1 indicated that while feeding resident on Friday (11/11/13), Resident #136 choked. Staff #1 further indicated that she communicated the choking incident to nurse #2 who informed the housekeeping staff not to provide the resident with any meat. Staff #1 revealed she'd communicated to NA #3 that Resident #136 was not to have meats until the facility had a meeting to determine consistency changes. The Housekeeping staff indicated changes to the resident ' s diet would be documented on the resident's meal card.<br><br>Review of nursing notes from 11/8/13 through 11/12/13 revealed no documentation in regards to Resident #136 having difficulty consuming or choking on meat items.<br><br>Review of the facility incident log for 11/8/13 through 11/12/13 did not reveal any incidents involving Resident #136.<br><br>Interview with the head of Restorative NA #4 on 10/14/13 at 10:40 am revealed Resident #136 was having only having issues swallowing pureed food items that are stringy such as chicken and dumplings and roast beef. NA #4 revealed Housekeeping staff do not feed residents. Staff #1 is in restorative dining to act as an assistant as evidenced by retrieving items that may be needed by the NA. NA #4 indicated no other staff had communicated any choking problems in regards to Resident #136. NA #4 stated that Housekeeping Staff #1 was trained to feed residents although she was not to feed any resident with swallowing difficulty or on a thickened liquid. Staff are made aware of | F 367 | | |

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|---|---|---|---|
| | 345144 | A. BUILDING _____ B. WING _____ | 11/15/2013 |

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

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| F 367 | Continued From page 12<br>changes to residents diets as they are to be located on the residents meal cards. NA #4 stated it was her expectation that NA's follow the order on the resident ' s meal card. In the instance there is a question or an entry is not located on the diet sheet, the NA should consultant with the nurse, speech therapy or dietary to confirm the resident ' s diet prior to removing an item from the resident's plate.<br><br>Interview with the DON on 11/14/13 at 1:34 pm revealed the facility does not have paid feeding assistants and Housekeeping staff do not feed residents. The DON further indicated that Housekeeping staff do not feed residents who have specialized diets. The DON revealed it was her expectation that staff review what is transcribed on resident meal cards. The DON further indicated staff should gain clarification prior to removing an item from a resident's meal. | F 367 | | |

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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<br>B. WING _____ | 12/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 705 PINEYWOOD RD<br>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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III (211) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system. LIC # NH0187 and the census for the facility at the survey was 138. | K 000 | K012<br><br>The identified radiation dampers on the 300/400 hall shower room, soiled sorting room off service hallway, and Linen storage room on the service hallway was cleaned on 12/5/2013.<br><br>All other radiation dampers in the facility were checked and cleaned on 12/11/2013 by the house-keeping supervisor. | 1/19/14 |
| K 012 SS=D | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 12/5/2013 the following Life Safety item was observed as noncompliant, specific findings include: The radiation dampers in the return air registers of the following areas were not well maintained and had dust and lint on the heat sensitive elements of the radiation dampers.<br><br>1. The 300/400 hallway shower room.<br>2. The soiled sorting room as you enter the laundry room from the service hallway.<br>3. Linen storage room on the service hallway | K 012 | Using a QI Tool, the housekeeping supervisor and/or maintenance director monitor all dampers weekly to ensure they are clean and free of dust and lint.<br><br>The results of the weekly monitoring 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 to determine the need for and/or the frequency of continued monitoring. | |
| K 025 | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD | K 025 | K025<br>The identified unsealed penetration at the 400 hallway cross corridor was repaired by the maintenance director on 12/12/2013. | 1/19/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Hedrick — TITLE: Administrator — (X6) DATE: 12/19/2013

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<br>B. WING | 12/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINE RIDGE HEALTH AND REHABILITATION CENTER | 706 PINEYWOOD RD<br>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 |
|---|---|---|---|---|
| K 025 SS=D | Continued From page 1<br><br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 12/5/2013 the following Life Safety item was observed as noncompliant, specific findings include: There was unsealed penetrations in the smoke wall above the cross corridor doors leading from the center core to the 400 hallway. | K 025 Cont. | All smoke walls in the facility were checked by the maintenance director on 12/12/2013to ensure there are no other unsealed penetration areas.<br><br>The maintenance director will monitor smoke/fire walls monthly to ensure continued compliance.<br><br>The results of the monthly monitoring will be forwarded to the next monthly Executive QI Committee meeting and quarterly thereafter for the identification of potential trends and follow-up as deemed necessary to determine the need for and/or frequency of continued monitoring. | |
| K 029 SS=E | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed | K 029 | K029<br><br>The combustion chamber of the identified dryers were cleaned by the housekeeping supervisor on 12/6/2013.<br><br>All dryers were cleaned thoroughly by the housekeeping supervisor on 12/6/2013. | 1/19/14 |

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|---|---|---|---|
| | 345144 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/05/2013 |

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

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| K 029 | Continued From page 2<br>48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interview during the tour on 12/5/2013 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry.<br><br>CFR#: 42 CFR 483.70 (a) | K 029 | An inservice of all laundry staff on "Fire Prevention - Monitoring and Cleaning Dryer Combustion Chambers" was completed by the housekeeping-laundry supervisor. Using a QI Tool, the housekeeping/laundry supervisor will monitor all dryer combustion chambers weekly to ensure they are clean and free of dust and lint.<br><br>The results of the weekly monitoring 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 the frequency of continued monitoring. | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345144 | A. BUILDING 02 - BUILDING 02<br>B. WING _____ | 12/05/2013 |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III (211) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system. LIC # NH0187 and the census for the facility at the survey was 138. | K 000 | 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.<br><br>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 administrativeor legal proceeding. | |
| K 012 SS=D | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 12/5/2013 the following Life Safety item was observed as noncompliant, specific findings include: The radiation dampers in the return air registers of the following area was not well maintained and had dust and lint on the heat sensitive elements of the radiation dampers.<br><br>1. The shower room just across the hallway from room 503. | K 012 | K012 BUILDING 02<br><br>The identified radiation damper at the shower room across from room #503 was cleaned by the housekeeping supervisor on 12/5/2013.<br><br>All other radiation dampers in the facility were checked and cleaning completed on 12/11/2013 by the housekeeping supervisor. | 1/19/14 |
| K 056 SS=D | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is | K 056 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jadie Hedrick — TITLE: Administrator — (X6) DATE: 12/19/20

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|---|---|---|---|
| | 345144 | A. BUILDING 02 - BUILDING 02<br>B. WING _____ | 12/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 708 PINEYWOOD RD<br>THOMASVILLE, NC 27360 |

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| K 056 | Continued From page 1<br>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interview during the tour on 12/5/2013 the following item was observed as noncompliant, specific findings include: The facility could not verify that the standard head sprinkler head in the 500 hallway activities office was an active sprinkler head.<br><br>1. The standard head sprinkler head in this office was the only standard sprinkler head noted in the facility.<br><br>2. The facility did not have extra standard sprinkler heads in the sprinkler riser room.<br><br>CFR#: 42 CFR 483.70 (a) | | K012 Cont.<br><br>Using a QI Tool, the housekeeping supervisor and/or maintenance director will check and monitor all dampers weekly to ensure they are clean, and free of dust and lint.<br><br>The results of the weekly monitoring 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 the frequency for continued monitoring.<br><br>K056<br><br>The identified standard sprinkler head was verified as an active sprinkler. An extra standard sprinkler head was received from the sprinkler company and is now in the sprinkler riser room. | 1/19/14 |

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

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|---|---|---|---|
| | 345144 | A. BUILDING 02 - BUILDING 02<br>B. WING | 12/05/2013 |

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

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| K 056 | Continued | K 056 | Sunland Fire Protection, Inc. evaluated the identified sprinkler head for replacement on 12/17/2013. The sprinkler head has been ordered to be consistent with the sprinkler system on the 500 hall unit and will be installed upon receipt.<br>All other sprinkler heads in the facility were checked by the maintenance director to ensure they comply with the current system.<br><br>The Sprinkler Company, Sunland Fire Protection, Inc will provide an inspection of the sprinkler system quarterly and annually to ensure compliance. This will be monitored by the Maintenance Director.<br><br>The inspection results will be forwarded to the Executive QI Committee by the maintenance director at the next monthly meeting and quarterly thereafter for follow-up as deemed necessary for continued compliance. | |

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Building 02