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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Pine Ridge Health and Rehabilitation Center Recertification and Complaint investigation 1-28-18 Citation text for tag E001, Fed Regulation E-1.0 C2 Kim Chambers Based on record review and staff interviews the	E 001	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and	3/1/18

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

Electronically Signed | 02/25/2018

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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
E 001	Continued From page 1 facility failed to have an Emergency Preparedness plan (EP). The EP plan did not include facility and community based risk assessments which included missing residents, the facilities resident population and a process that included collaboration with local, regional, state and federal officials. The plan did not have any policy or procedures regarding the emergency plan, the provision of needs for staff and residents, evacuation, sheltering of residents and staff that remain in the facility and the transportation of medical records. The communication plan did not address names or contact information for staff or resident's physicians. The EP plan did not have a way to share information and medical documents of a resident with another facility. The plan failed to have a training program. Findings included: 1A: A record review of the EP manual revealed that the manual did not include a community or facility based risk assessment or strategies. Further review revealed the manual also did not include missing residents in their EP program. B: A further review of the EP manual revealed that the resident population with in the facility was not addressed as well as the residents who needed special care like oxygen and immobility. The plan did not address the type of services the facility was capable of providing to the residents during an emergency situation. The continuity and succession plan was not included in the EP plan and the risk assessment for the facility was not completed. C: The review of the EP manual revealed that	E 001	that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. E001 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to complete and implement the emergency preparedness plan. The facility□s risk assessment was updated on 2/5/18. The resident population information was updated on 2/5/18 to reflect the most current acuity levels. On 2/26/18 the facility will complete a compiled list of criteria for residents/staff in the case that we will be sheltered in the facility. On 3/1/18, the name and contact numbers for all staff will be updated and placed in emergency plan along with the most current contact information for the resident□s physicians. On 2/23/18, a plan was developed that will indicate how resident information and medical documents will be shared with other facilities/health care providers during an emergency situation. On 2/26/18, the facilities residents, family members and/or the resident□s	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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
E 001	Continued From page 2 there was not any criteria listed for residents or staff who would be sheltered in the facility during an emergency. The EP manual also did not have any procedure for sheltering residents, staff and others who needed to remain in the facility in the event evacuation could not occur. D: The EP manual revealed a lack of policies and procedures on how the resident's confidentiality would be maintained, how the resident's medical record information would be protected and how the resident's medical record would be available for continuity of care when evacuated or transferred to another facility during an emergency. E: A record review of the EP manual revealed that the communication plan did not include name and contact information of all the staff working in the facility and the name and contact information of the resident's physicians. F: A review of the communication plan did not include processes or procedures that would indicate how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations during an emergency situation. G: The EP manual revealed that the communication plan did not have any documentation as to how it would share the emergency plan information with the facilities residents, family members and/or the resident's representative. H: A review of the EP manual revealed that there	E 001	representative will be made aware of the emergency plan process. On 2/26/18, all facility staff will receive training and testing related to the emergency plan. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/2/18, the administrator reviewed the emergency plan and identified the areas that needed to be updated, corrected, and implemented. All facility staff will be in-serviced by 3/1/18 by the staff facilitator on the emergency. This in-service will be added to the orientation for all new hires. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The monthly QI committee will review the emergency plan monthly for 3 months for identification of updates, further education needs, facility needs, and completeness of the plan itself. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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
E 001	Continued From page 3 was no training program or testing requirements documented in the plan. An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator chose not to call the maintenance manager to review the EP plan. She stated she did not have any guidance as to how to prepare the plan but that she had a meeting scheduled to review how to prepare the EP plan correctly. The Administrators expectation was that the facility would have an acceptable working EP plan by the next annual survey.	E 001	correction.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Pine Ridge Health and Rehabilitation Center Recertification and Complaint investigation 1-28-18 Citation text for tag F558, Fed Regulation 483.10 D2 Kim Chambers Based on record review, staff interviews and resident interviews the facility failed to accommodate the need of 1 of 1 residents (resident #45) by not providing the resident a shower bench to fit the resident resulting in the	F 558	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 558	Continued From page 4 resident receiving only one shower since admission to the facility. Findings included: Resident #45 was admitted to the facility on 3-24-17 with multiple diagnoses to include heart failure, chronic kidney disease, vascular dementia and diabetes. The Minimum Data Set (MDS) dated 11-15-17 revealed that the resident was cognitively intact. Resident #45 was coded as needing total assistance with 2 people for bed mobility, transfers, dressing and toileting, total assistance with one person for personal hygiene. The care plan dated 11-30-17 revealed that resident #45 had a goal of receiving the necessary physical assistance for ADL's daily. The intervention for this goal was as follows; if resident refuses assistance offer another time to return. Resident #45 was interviewed on 1-29-18 at 3:06pm. The resident stated she has had only 1 shower since she was admitted to the facility. She stated that due to her size she would sweat a lot and did not feel that the bed baths she received were cleaning her properly. An interview with the nurse (nurse #7) occurred on 1-29-18 at 3:12pm. Nurse #7 stated she believed the resident was correct in saying she has had only 1 shower since she was admitted to the facility. She also stated the facility did not have a shower bench that would accommodate resident #45's girth size.	F 558	implementing the acceptable plan of correction. F558 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency of failure to accommodate the need of resident #45 by not providing a shower bench to fit the resident, was a communication deficit. On 2/1/18 a shower bench was ordered to accommodate resident # 45 by the supply clerk. On 2/26/18 the shower bench ordered to accommodate resident # 45 is scheduled to arrive. By 2/27/18 resident # 45 will receive a shower. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant reviewed residents in facility for showers given in the last 7 days to ensure no showers were not given due to equipment needs. With no negative findings noted related to equipment needs to accommodate resident. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on communication of resident equipment	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 558	Continued From page 5 Nurse #7 was interviewed on 2-1-18 at 9:35am. She stated she attempted to place resident #45 on the shower bench that was available at the facility and that the resident complained of pain due to about "4 inches" of the resident's skin was laying over the side of the shower bench. Nurse #7 stated informed the Interim Director of Nursing (IDON). An interview with the Interim Director of Nursing (IDON) occurred on 2-1-18 at 9:45am. She stated she was informed that resident #45 was in need of a larger shower bench but stated she did not know who would order the bench but thought it may be maintenance. Maintenance personal was interviewed on 2-1-18 at 12:30pm. He stated he had ordered the new shower bench for resident #45 and that it would arrive in 10-15 days. The Administrator was interviewed on 2-1-18 at 12:30pm. She stated she had supplied maintenance with the size that was needed and also received an order for Occupational Therapy to evaluate resident #45's safety in receiving a shower. The Administrator stated she expected that staff would inform her when special equipment is needed so the facility can meet the needs of the residents.	F 558	needs, including equipment to accommodate resident□s showers, to maintenance using a work order. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure showers were given and appropriate equipment available to accommodate resident need. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 558	Continued From page 6	F 558	The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: F561 Based on record review, staff interview, resident interview and resident observation the	F 561	An acceptable plan of correction must contain the following elements:	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 7 facility failed to provide 1 of 3 residents (resident #45) the choice of when to be out of bed and failed to provide 2 of 3 residents (Resident #45 and resident #80) showers for two and a half weeks when reviewed for activities of daily living (ADL) and failed to honor a resident's choice to have dinner in the dining room for 1 of 3 residents reviewed for choices (Resident # 124). Findings included: 1. Resident #124 was admitted to the facility on October 10, 2015 with cumulative diagnoses which included dysphagia, oropharyngeal phase, muscle weakness and osteoarthritis. Review of the Minimum Data Set (MDS) dated January 16, 2018 revealed Resident #124 was moderately impaired. Resident #124 needed extensive to total assistance from staff for the completion of all her activities of daily living except for eating. Review of Resident #124 care plan November 14, 2017 revealed no intervention about taking Resident # 124 to dining room for meals or dinner nor was it observed on her care guide. During an interview with Nurse #2 on Sunday January 28, 2018 at 4:30 PM, Nurse # 2 revealed that "we are short staffed and the state is here. Oh my god we got one nursing aide on this hall with 27 residents!" During an observation on Sunday January 28, 2018 between 5:30pm and 7:30 Resident #124 was observed in her room. Also during another observation Resident # 124 received her dinner tray in her room at 6:14pm. Resident #124 was	F 561	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F561 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to allow resident choice of when to be out of bed, shower preferences, and dinning location was knowledge deficit. On 2/1/18 and 2/12/18 resident # 45 was observed out of bed per resident choice by LPN. By 2/27/18 resident # 45 will receive a shower. On 2/6/18 resident # 80 received a shower. On 2/2/18, 2/5/18, 2/8/18, 2/12/18, 2/13/18, 2/14/18, 2/20/18, 2/23/18 resident # 124 was observed by GCAs eating diner in the dining room per	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 8 observed having dinner in her room. During an interview with Resident #124's family on January 29, 2017 at 10:30 am, family revealed that the facility was aware that they liked for Resident #124 to eat in the dining room and it hard for this to happen because during the weekend it's significantly short staffed. Family also revealed that we had been asked to take Resident #124 back to her room because of no staff being in the dining room for meals. During an interview with Nurse # 21 on February 1, 2018 at 2pm revealed that she does not recall being disrespectful to any residents in the facility but she has informed family members to take residents back to their rooms because of inadequate staff in the dining room. During an interview with the Administrator on February 1, 2017 3:30pm, it was revealed that she expected that all halls were adequately staffed to provide the needs and choices of residents on the hall. 2: Resident #45 was admitted to the facility on 3-24-17 with multiple diagnoses to include heart failure, chronic kidney disease, vascular dementia and diabetes. The Minimum Data Set (MDS) dated 11-15-17 revealed that the resident was cognitively intact. Resident #45 was coded as needing total assistance with 2 people for bed mobility,	F 561	resident preference. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/9/18 the facility consultant interviewed all interviewable residents regarding their ability to get up as they choose. No additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of resident choice to get out of bed, or dining location. Five grievances were places regarding resident choice to get out of bed and dining location. All five grievances were resolved. On 2/16/18 the facility consultant reviewed residents in facility for showers given in the last 7 days for showers provided per resident preference. All negative findings will be addressed by facility staff by 3/1/18. On 2/16/18 during the morning meal the facility consultant spoke interviewable residents to ensure they were having meal in location of choice with no negatives noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident choice including resident right to choose when to be out of bed, shower preferences, and dining location. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 9 transfers, dressing and toileting, total assistance with one person for personal hygiene. The care plan dated 11-30-17 revealed that resident #45 had a goal of receiving the necessary physical assistance for ADL's daily. The intervention for this goal was as follows; if resident refuses assistance offer another time to return. An interview with the resident occurred on 1-29-18 at 3:06pm. The resident stated she has not been out of the bed "in at least 4 months". She stated she was told by staff that she was too difficult to get up and that they do not have enough staff to help get her out of the bed. An observation of resident #45 occurred on 1-30-18 at 1:00pm. The resident remained in the bed. An interview with resident #45 occurred on 1-31-18 at 10:05am. The resident stated she was doing ok but that she still had not been able to get out of the bed. She also stated she asked to get up every day but was told there was not enough staff to help get her up. An interview with the nurse (nurse #7) occurred on 2-1-18 at 9:35am. Nurse #7 stated that they have tried in the past to get resident #45 up into the wheelchair but after 15 minutes the resident was "yelling" to get back in the bed. She went on to state that it took 3 people to assist the resident out of the bed and that they "usually" did not have enough staff. An interview with resident #45 occurred on 2-1-18 at 9:50am. The resident stated that when staff	F 561	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, showers were given per resident choice, and resident dining in area of choice. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 10	F 561		

had got her out of bed in the past she would stay up for 2-3 hours. Stated she enjoyed sitting outside when it was warm and attending bingo.

An observation of resident #45 occurred on 2-1-18 at 11:00am. Resident #45 was being assisted by 3 staff members getting out of the bed.

An interview with resident #45 occurred on 2-1-18 at 11:05am. The resident was smiling and stated "I feel strange because I have not been up in such a long time." She also stated she was going to try and stay up for bingo that afternoon at 2:00pm.

An observation of the resident occurred on 2-1-18 at 1:15pm. The resident had finished her lunch and requested to go back to bed. 3 staff were observed returning resident #45 back to the bed.

An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected her staff to respond to residents request and ask for additional help if they need it.

A review of resident #45's care card revealed that the resident was scheduled to have a shower Mondays and Thursdays and that the resident preferred showers.

A review of the shower chart dated 1-17-18 to 2-1-18 revealed that resident #45 had not had a shower from 1-17-18 to 2-1-18 and that the resident did not refuse any offers for a shower.

An interview with resident #45 occurred on 1-29-18 at 3:06pm. The resident stated that she has had only one shower since admission to the

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 11	F 561		

facility. Resident #45 stated she had bed baths but that she would like to have a shower.

An interview with the nurse (nurse #7) occurred on 1-29-18 at 3:30pm. Nurse #7 stated that resident #45 was correct and that it had been almost a year since the resident had a shower. The nurse stated as far as she knew the resident had not refused a shower if one was offered to her.

An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated that she expected the residents to receive their showers as scheduled.

3: Resident #80 was admitted to the facility on 3-2-16 with multiple diagnoses which included chronic kidney disease, muscle weakness, ataxic gait and diabetes.

The Minimum Data Set (MDS) dated 12-19-17 revealed that resident #80 was cognitively intact. The resident was coded as needing extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for dressing and toileting and limited assistance with one person for personal hygiene.

The care plan dated 1-9-18 revealed that resident #80 had a goal of not developing a pressure ulcer with the following interventions; turn and reposition the resident frequently and provide incontinence care after each episode. No further activities of daily living goals were present.

A review of resident #80's care card revealed that she preferred showers and that she was scheduled to receive a shower every Tuesday

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 12	F 561		

and Friday.

A review of resident #80's shower chart dated 1-17-18 to 2-1-18 revealed that she had not had a shower from 1-17-18 to 1-30-18. The chart also revealed that resident #80 had not refused any showers.

An interview with resident #80 occurred on 1-29-18 at 12:39pm. The resident stated she would like to have a shower 2 times a week but that it was often 2-3 weeks before she received a shower.

An interview occurred with resident #80 on 1-30-18 at 2:55pm. The resident stated she still had not had a shower and had not had one for 2-3 weeks. She also stated she was told she could not have one because of the kind of medication she was taking.

An interview with the nurse (nurse #7) occurred on 1-30-18 at 3:00pm. Nurse #7 stated resident #80 did not have a shower last week because she was on antibiotics for "flu like symptoms". She stated the resident finished her medication today so she could have a shower today.

An interview occurred with the nursing assistant (NA #53) on 1-30-18 at 3:10pm. Na #53 stated she is the one who gave the residents their showers. She stated she did try to give the residents a choice on when they receive their shower but "there are so many to do I can't always give them a choice". NA #53 also stated that she missed residents on their shower days because they request a later time and she did not have the time to return to them at their requested time.

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 561	Continued From page 13 An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected residents to receive their showers as scheduled.	F 561		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews, the facility failed to provide 2 out of 2 residents (Resident #118 and Resident #8) with quarterly statements of their personal trust funds managed by the facility. Findings include: 1. Resident #8 was admitted to the facility on 5/17/16 with diagnoses that include Diabetes and Stroke. A review of Resident #8's medical record revealed the resident is his own Power of Attorney. A review of Resident #8's medical record had no documentation of a quarterly statement being given to the resident for the past six months. A review of the Business Office Manager's Resident Trust folders revealed copies	F 568	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 568	Continued From page 14 of Resident #8's monthly trust fund statements. An interview was conducted on 1/29/18 at 10:31am with Resident #8. The resident reported that he has a personal trust fund with the facility. Resident #8 reported he has not received statements from the facility to let him know how much he has in his account. 2. Resident #118 was admitted to the facility on 4/16/15 with diagnoses that include seizure disorder, left side hemiplegia, and depression. A review of Resident #118's medical record revealed the resident has a Power of Attorney who is a friend. A review of Resident #118's most recent MDS (Minimum Data Set) dated 11/20/17 was coded as a quarterly assessment. The MDS coded resident as cognitively intact. A review of Resident #118's medical record had no documentation of a quarterly statement being given to the resident for the past six months. A review of the Business Office Manager's Resident Trust folders revealed copies of Resident #118's monthly trust fund statements. An interview was conducted on 1/29/18 at 3:20pm with Resident #118. Resident #118 reported that she has a personal fund with the facility. She reported she is not given a statement from the facility letting her know how much she has in her account. Resident #118 reported her POA (Power of Attorney) does not receive a statement either. An attempt was made on 1/31/18 at 9:00am to reach Resident #118's POA. A message was left for the POA with no return phone call. An interview was conducted with the (BOM) Business Office Manager on 1/31/18 at 9:34am. The BOM reported that the residents who have a personal trust fund with the facility receive a statement each month. She reported the facility policy states that each resident who has a personal trust fund with the facility receives a	F 568	implementing the acceptable plan of correction. F568 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to provide residents with quarterly statements of their personal trust funds managed by the facility- was knowledge deficit. On 2/20/18 resident #118 was provided a statement of their personal trust funds by the social worker. On 2/19/18 resident # 8 was provided a statement of their personal trust funds by the social worker. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/19/18 the social worker spoke with all residents, or resident power of attorneys, whose trust funds are managed by the facility, to ensure they have received a statement of the president□s personal trust fund in the last 90 days, with no additional negative findings noted. The social worker was in-serviced by the administrator on 2/19/18 regarding delivery of quarterly trust fund statements to residents, when the facility manages their trust funds, and documentation of this delivery. Any new social worker hired	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 568	Continued From page 15 copy of the statement and if the resident has a POA, the POA is mailed a copy of the statement. The BOM reported the facility's policy is that the SW (social worker) hands out the statements monthly to the residents and documents that the statements are given to the residents in the social worker progress note in the medical record. An interview with the SW was conducted on 1/31/18 at 9:45am. The SW reported she has only been employed with the facility for two weeks. She reported she "thinks the Business Office deals with giving out resident statements." An interview was conducted with the Administrator on 1/31/18 at 10:27am. The Administrator reported some residents get personal funds statements and others are mailed to the POA. The administrator reported the Activities Director delivers the personal fund account statements to the residents. The administrator reported she is not aware whether there is documentation that the statements are given to the residents. An interview with the Activities Director was conducted on 1/31/18 at 10:37am. The Activities Director reported she is not sure whether she delivers the monthly personal funds statements to the residents. She reported she delivers whatever is put in her box with the mail to be handed out. An attempt was made to reach the former SW who was employed at the facility until December 2017 on 1/31/18 at 11:35am. A voice mail message was left for the SW with no return call received. An interview was conducted with the Administrator on 2/1/18 at 4:25pm. The Administrator reported it is her expectation that each resident who has a personal trust fund with the facility receive a statement at least quarterly.	F 568	will receive this in-service during orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, or business office manager will audit 10% of residents whose trust funds are managed by the facility to ensure delivery of their trust fund statements has occurred within the last quarter weekly x 12 weeks. This audit will be documented on the trust fund audit tool. The monthly QI committee will review the results of the trust fund audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 16	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 17 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to provide an odor free environment and repair of walls, floors, and windows for 4 out of 5 halls (the 100 hall, 200 hall, 300 hall, and 400 hall) Findings include: a. An observation on 1/29/18 at 10:35am in room 200 revealed paint peeling on the wall next to the bed closest to the door. There were sticky light brown spots scattered throughout the floor. There was a strong ammonia like smell in the bathroom. The plaster was peeling on the wall across from the toilet. An observation on 1/30/18 at 4:15pm in room 200 revealed peeling paint on the wall next to the bed closest to the door. The floor in the room had sticky, light brown spots on the floor. The bathroom had a strong ammonia like odor. There was plaster peeling on the wall across from the toilet. An observation on 2/1/18 at 1:30pm in room 200 revealed peeling paint on the wall next to the bed closest to the door. The bathroom revealed a strong ammonia like odor. An observation revealed plaster peeling from the wall across from the toilet in the bathroom. b. An observation on 1/29/18 at 10:55am in room 308 revealed scratch marks and peeling paint on the wall next to the bed closest to the door. The bathroom floor revealed loose brown/grey dirt like material all over the floor. An observation on 1/30/18 at 4:50pm in room 308 revealed peeling paint on the wall next to the bed	F 584	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F584 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to provide an odor free environment and repair of walls, floors, and windows- was communication failure. On 2/19/18 room 200s wall by the bed was repainted repairing the peeling paint, and plaster repaired to correct the peeling	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 18 closest to the door. The bathroom floor had loose brown/grey dirt like material on it. The bathroom door going into room 308 had scuff marks at the lower quarter of the door. An observation on 2/1/18 at 1:45pm in room 308 revealed peeling paint on the wall next to the bed closest to the door. The bathroom floor had loose brown/grey dirt like material on it. The bathroom door going into room 308 had scuff marks at the lower quarter of the door. c. An observation on 1/29/18 at 11:05am in room 405 revealed peeling paint to the wall at the bed closest to the door. An observation on 1/30/18 at 3:15pm in room 405 revealed paint peeling on the wall behind both beds in the room. An observation on 2/1/18 at 1:47pm in room 405 revealed paint peeling on the wall behind both beds in the room. d. An observation on 1/29/18 at 11:36am in room 208's bathroom revealed a black colored streak across the wall approximately 6 inches from the floor on the wall directly across from the toilet. An observation on 1/30/18 at 4:28pm in room 208's bathroom revealed scuff marks on both bathroom doors at the bottom and a black colored streak on the wall opposite of the toilet. An observation on 2/1/18 at 1:40pm in room 208's bathroom revealed scuff marks on both bathroom doors at the bottom and a black colored streak on the wall opposite of the toilet. e. An observation on 1/29/18 at 11:51am in room 210 revealed paint peeling off the wall next to the bed closest to the door. There was a web like material outside of the right side of the window. An observation on 1/30/18 at 4:22pm in room 210 revealed peeling paint on the wall next to the bed	F 584	by the toilet by maintenance assistant. The floors are cleaned daily by the housekeeping staff. On 2/2/18 the bathroom in room 200 was cleaned which removed the sticky light brown spots scattered on the floor, and ammonia like smell by housekeeping. On 2/24/18 room 308s wall next to the bed was painted by the maintenance director repairing the scratch marks and peeling paint. The bathroom floor in room 308 was cleaned by housekeeping on 2/2/18 removing brown/grey dirt like material from floor. The bathroom door going into room 308 was repaired and scuff marks were removed by the maintenance director on 2/24/18. On 2/24/18 room 405s wall at the both beds were repainted to repair the peeling paint by maintenance director. On 2/19/18 room 208s bathroom was repainted by the maintenance assistant which removed the black colored streak across the wall directly across from the toilet. On 2/19/18 both bathroom doors were repaired which removed the scuff marks at the bottom of the doors. On 2/25/18 room 210s wall next to the bed closest to the door was repainted by the maintenance director this corrected the peeling paint. On 2/25/18 the housekeeping supervisor cleaned the window outside of room 210 and the web like material was removed from the outside right side of the window. On 2/2/18 the floors in room 210 was cleaned	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 19 closest to the door. There was a web like material outside of the right side of the window. The observation also revealed loose brown material on the floor behind the door. An observation on 2/1/18 at 1:41pm in room 210 revealed paint peeling off the wall next to the bed closest to the door. There was a web like material outside of the right side of the window. The observation also revealed loose brown material on the floor behind the door. f. An observation on 1/29/18 at 1:02pm in room 412 revealed a wheelchair for Resident #78 with grime and dirt like material in the wheels and on the metal pieces for the leg rests. It was also revealed the bolt to hold the left side of the seat to the side was missing. There was brown material behind the door and a grey streak on the floor behind the door. Resident #78 reported the bolt to her wheelchair has been missing for several weeks. She reported the administrator has been told about the bolt. She has the old bolt laying on the shelf at the sink. An observation on 1/30/18 at 3:22pm in room 412 revealed a wheelchair for Resident #78 with grime and dirt like material in the wheels and on the metal pieces for the leg rests. It was also revealed the bolt to hold the left side of the seat to the side was missing. There was brown material behind the door and a grey streak on the floor behind the door. An observation on 1/31/18 at 2:13pm in room 412 revealed the bolt missing to the left side of the seat of Resident #78's wheelchair. The wheelchair was observed to have grime and dirt like material in the wheels and on the metal pieces to hold the leg rests in place. The floor behind the door had brown loose material on it along with a grey streak on the floor behind the door. An interview was conducted with Resident	F 584	by housekeeping which removed the loose brown material on the floor behind the door. On 1/31/18 resident # 78□s wheelchair was repaired by the maintenance director to replace the missing bolt and thoroughly cleaned. On 2/2/18 housekeeping cleaned the floor in room 412 which removed the brown material from behind the door and the grey streak on the floor. On 2/24/18 the maintenance director repaired the plaster at the bed closest to the door in room 309 which corrected the peeling plaster. On 2/2/18 housekeeping cleaned the bathroom floor in room 309 which removed the loose brown dirt like material. On 2/2/18 the maintenance assistant repaired the bathroom door in room 206 which removed the black colored streak. On 2/2/18 the maintenance assistant repaired the wall behind the first bed and repainted the wall which repaired the rough wood and peeling paint. On 2/19/18 the maintenance director repaired the plaster and repainted the wall at the head of the both beds window in room 110. This corrected the peeling plaster and paint. On 2/24/18 the housekeeping supervisor cleaned the windowsill in room 110 which removed the dust like material.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 20 #78. She reported the bolt is still missing from her wheelchair. She reported no one has come in and looked at the wheelchair since she reported it broken due to bolt out. An observation on 2/1/18 at 1:50pm in room 412 revealed the bolt missing to the left side of the seat of Resident #78's wheelchair. The wheelchair was observed to have grime and dirt like material in the wheels and on the metal pieces to hold the leg rests in place. The floor behind the door had brown loose material on it along with a grey streak on the floor behind the door. g. An observation on 1/29/18 at 2:29pm in room 309 revealed plaster peeling on the wall at the bed closest to the door. An observation on 1/30/18 at 4:52pm in room 309 revealed peeling plaster on the wall at the bed closest to the door. The bathroom floor had loose brown dirt like material on it. An observation on 2/1/18 at 1:46pm in room 309 revealed peeling plaster on the wall at the bed closest to the door. h. An observation on 1/29/18 at 2:39pm in room 206 revealed a black colored streak on the bathroom door approximately 6 inches from the floor going all the way across the door and peeling paint behind the first bed with rough wood exposed. An observation on 1/30/18 at 4:17pm in room 206 revealed a black colored streak on the bathroom door approximately six inches from the floor going all the way across the door. There was also peeling paint behind the bed closest to the door with rough wood exposed. An observation on 2/1/18 at 1:35pm in room 206 revealed a black colored streak on the bathroom door approximately six inches from the floor going all the way across the door. There was also	F 584	On 2/24/18 the maintenance director replaced the nightstand and bedside table at the bed closest to the window in room 213 which removed the rough, wood exposed at the edges. On 2/2/18 housekeeping cleaned the floor in room 213 which removed the loose brown material behind the door. On 2/2/18 the maintenance repaired the sink counter in room 205 which removed the rough jagged edge across the front of the sink counter. On 2/25/18 the maintenance director repainted the wall behind the head of the bed closet to the window in room 406, which corrected the peeling paint. On 2/2/18 housekeeping cleaned the floor in room 406 which removed the black spots on the floor between the bed and window. On 2/25/18 the maintenance director removed the plastic coating on the door facing on the right in room 409 which repaired the jagged plastic coating. On 2/25/18 the maintenance director repaired the plastic coating on the bottom left door facing in room 411 which repaired the jagged plastic coating. On 2/2/18 the maintenance director repaired the front piece of plastic on the sink counter in room 201 which corrected the rough, jagged edge. On 2/24/18 the housekeeping supervisor cleaned the window in room 101 which	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 21 peeling paint behind the bed closest to the door with rough wood exposed. i. An observation on 1/29/18 at 3:03pm in room 110 revealed paint and plaster peeling off the wall at the head of the bed closest to the window. An observation on 1/30/18 at 4:42pm in room 110 revealed plaster peeling on the walls at the head of both beds. There was also a dust like material on the windowsill. An observation on 2/1/18 at 1:22pm in room 110 revealed plaster peeling on the walls at the head of both beds along with a dust like material on the windowsill. j. An observation on 1/29/18 at 3:53pm in room 213 revealed the nightstand at the bed closest to the window had a rough edge with uneven wood exposed. An observation on 1/30/18 at 4:25pm in room 213 revealed the nightstand and overbed table at the bed closest to the window had rough, wood exposed at the edges. There was a loose brown material behind the door. An observation on 2/1/18 at 1:43pm in room 213 revealed the nightstand and overbed table at the bed closest to the window had rough, wood exposed at the edges. There was a loose brown material behind the door. k. An observation on 1/30/18 at 9:29am in room 205 revealed a rough and jagged edge across the front piece on the sink counter. An observation on 1/30/18 at 4:30pm in room 205 revealed a rough and jagged edge on the piece of plastic on the front of the sink counter. An observation on 2/1/18 at 1:33pm in room 205 revealed a rough and jagged edge on the piece of plastic on the front of the sink counter. l. An observation on 1/30/18 at 3:20pm in room 406 revealed paint peeling behind the head of the bed closest to the window. There were black	F 584	removed the web like material in the right corner and upper left corner of the window. On 2/25/18 the maintenance director repainted the wall between the sink and window in room 209 which corrected the brown spots and peeling paint. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the maintenance assistant completed a 100% audit of the facility to ensure 1. Any areas of scuffed, peeling, or scratched paint were repaired or work orders filled out, 2. No areas of plaster peeling, or if areas peeling work areas filled out, 3. No bedside table or nightstand has exposed wood or sharp edges, 4. No doors have scuff marks, or peeling plastic coating, 5.No bathroom sink cabinets have sharp edges, 6. The floors are clean including behind doors and in bathrooms, 7. Windows are clean with no web like material. Insert findings. On 2/2/18 the administrator in-serviced the maintenance director on expectations regarding 1.painting, including walls be free of chipped or peeling paint and no scuff marks, 2. Plaster will be free of peeling, 3. No sharp edges, or exposed wood can be present on bedside tables, nightstands, or sink cabinet, 4.wheelchairs must be repaired when notified. Any new maintenance directors will be in-serviced during orientation.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 22 spots on the floor between the bed and the window. An observation on 2/1/18 at 1:48pm in room 406 revealed paint peeling behind the head of the bed closest to the window. There were black spots on the floor between the bed and the window. m. An observation on 1/30/18 at 3:21pm revealed the door facing on the right at the bottom with an area of jagged plastic coating noted on room 409 and and an area of jagged plastic coating missing on the bottom of the left door facing on room 411. n. An observation on 1/30/18 at 4:19 pm in room 201 revealed a rough, jagged edge to the front piece of plastic on the sink counter. An observation on 2/1/18 at 1:31pm in room 201 revealed a rough, jagged edge all the way across the front piece of plastic on the sink counter. o. An observation on 1/30/18 at 4:41 pm in room 101 revealed web like material in the right corner of the window and upper left corner of the window. An observation on 2/1/18 at 1:21pm in room 101 revealed web like material in the right corner of the window and in the upper left corner of the window. p. An observation on 1/31/18 at 2:31pm in room 209 revealed brown spots and peeling paint on the wall between the sink and the window. An observation on 2/1/18 at 1:38pm in room 209 revealed brown spots on the wall between the sink and the window. There was also peeling paint on the same wall. q. During a tour of the facility on 2/1/18 at 2:14pm with the Housekeeping Supervisor, the above issues with housekeeping were confirmed with the supervisor. r. During a tour of the facility on 2/1/18 at 2:36pm with the Maintenance Supervisor, the	F 584	On 2/2/18 the administrator in-serviced the housekeeping director on expectations related to facility cleanliness including clean floors free of debris, spots, windows free of web like material, and room□s odor free. Any new housekeeping directors will be in-serviced during orientation. On 2/2/18 the housekeeping staff were in-serviced by the staff facilitator on expectations related to cleaning of windows, completion of work order when issues with paint are noted or broken equipment noted. This in-service will be completed by 3/1/18. All new housekeeping employees will receive in-service during orientation. On 2/2/18 the nursing staff were in-serviced by the staff facilitator on completing a work order when rooms in need of paint or broken equipment, and rooms must be clean including floors and free of web like material. This in-service will be completed by 3/1/18 and new nursing employees will receive in-service in orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, director of nursing, housekeeping director, or maintenance director will observe 50% of rooms weekly x 4 weeks then 25% of rooms weekly x 8	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 23 maintenance issues stated above were confirmed by the supervisor. An interview was conducted with NA (Nursing Assistant) #52 on 2/1/18 at 10:32am. NA#52 reported if the staff sees a maintenance issue, they fill out a maintenance request and put it on the bulletin board at the nursing station. An interview with Nurse #3 was conducted on 2/1/18 at 2:00pm. Nurse #3 reported that if she sees something maintenance needs to fix, she will put in a maintenance request and put the request on the bulletin board at the nursing station. An interview was conducted on 2/1/18 at 2:14pm with the Housekeeping Supervisor. He reported all rooms are expected to be mopped and cleaned daily including cleaning furniture and bathrooms. He reported the floors are polished weekly by the floor technicians. The Housekeeping Supervisor reported floor technicians are expected to clean 2-3 wheelchairs nightly. He reported if the staff lets him know of a dirty wheelchair, he will make sure that chair is done immediately. An interview was conducted on 2/1/18 at 2:36pm with the Maintenance Supervisor. He reported the staff fills out work requests and post them on the bulletin board at the nursing stations. He reported when he receives the work requests, he prioritizes the needs and then completes the work. The Maintenance Supervisor revealed he has one part time employee that performs monthly room assessments on each room and completes any maintenance issues. He reported the work is documented on a monthly maintenance log. When questioned about Resident #78's broken wheelchair, the Maintenance Supervisor reported he was aware of the brakes needing repair in January and the	F 584	weeks for peeling, scuffed, or missing paint; peeling plaster; exposed wood or rough edges on bedside tables, bathroom skinks, or nightstands; cleanliness of floors (no debris, no spots); no odor; no web like material in windows. This audit will be documented on the homelike environment audit tool The monthly QI committee will review the results of the homelike environment audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 584	Continued From page 24 brakes were repaired. He reported he was not aware of the bolt until 1/29/18 but had not been able to repair because the resident had been up in her wheelchair when he checked. He reported "with all the other stuff going on I just haven't gotten to it." A review of the monthly maintenance reports from September 2017 through January 2018 showed no repairs had been made to rooms 110, 200, 201, 205, 206, 208, 209, 210, 213, 308, 309, 405, 406, 409, and 411. An interview with the Administrator was conducted on 2/1/18 at 4:25pm. The Administrator reported it is her expectation that the facility will be kept clean and in good repair.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, resident observation and record review the facility failed to provide incontinence care for 1 of 5 sampled residents (Resident #71) who required	F 600	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 600	Continued From page 25 extensive assistance and who requested incontinence care on 2 different occasions because she had soiled herself. Findings included: Resident #71 was admitted to the facility on 6-21-16 with multiple diagnoses to include cerebral infarction, muscle weakness, abnormality of gait and vascular dementia. The Minimum Data Set (MDS) dated 12-7-17 revealed that the resident was moderately cognitively impaired. Resident #71 was coded as needing limited assistance with one person for bed mobility, transfers, locomotion on and off the unit, dressing and personal hygiene and extensive assistance with toileting. A review of the care plan dated 12-28-17 revealed that resident #71 did not have any goals or interventions related to activities of daily living (ADL). A review of the nursing Kardex revealed that there was no instructions for ADL care but resident #71 was listed as using "pull-ups" under the toileting program section of the Kardex. An interview with resident #71 occurred on 1-29-18 at 11:43am. The resident stated she had been waiting since 7:30am to have her pull-up changed because she had urinated. She stated she knew what time it was because she looked at the clock on her wall. The resident also stated she told the nursing assistant that she needed changed when she brought her breakfast tray. Resident #71 interviewed on 1-30-18 at 12:00pm.	F 600	processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F600 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to provide requested incontinence care was failure to follow established facility policy. On 2/16/18 the facility consultant observed resident # 71 at 730am, 815am, and 9am. Resident denied being soiled and no visible or olfactory signs of incontinence noted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant observed all non-interviewable residents for visible or olfactory signs of	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 600	Continued From page 26 The resident stated she did not have any issues today because staff took her for a shower. An interview with resident #71 occurred on 1-31-18 at 9:10am. The resident stated she had been waiting since 8:00am to have her pull-up changed. She stated she told the male nursing assistant who came and picked up her breakfast tray but that he had not returned to render care. An observation of resident #71 occurred on 1-31-18 at 9:40am. ADL care for this resident had not been completed. The observation of resident #71 occurred on 1-31-18 at 10:45am. The nursing assistant was noted to be in the resident's room gathering supplies to render ADL care. An interview with the nurse (nurse #7) occurred on 1-31-18 at 1:08pm. The nurse stated that resident #71 will let staff know when she needs assistance in changing her pull-up. Resident #71 was interviewed on 2-1-18 at 9:55am. She stated she had a bowel movement "during breakfast" and that she told the nurse when the nurse brought her medication. The resident stated the nurse told her she would inform the nursing assistant but that no one had been in to "clean me up". Resident #71 was noted to be on her way to the shower on 2-1-18 at 10:15am. An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected incontinence care to be provided in a timely fashion "within 10-15 minutes".	F 600	incontinence at 830am with 3 residents noted soiled. At 845am affected residents were being provided incontinent care by facility staff. On 2/16/18 the facility consultant observed and interviewed all unreviewable residents regarding incontinence with no negative findings noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident providing incontinent care promptly. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident is clean and dry. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 600	Continued From page 27	F 600	monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 636	Continued From page 28 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a physical assessment for 1 of 1 resident (resident #38) following an unwitnessed fall out of his wheelchair. The facility aditionally failed to complete a comprehensive	F 636	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 636	Continued From page 29 assessment within the required timeframes for 3 of 7 residents reviewed for resident assessment (Resident #6, Resident #2 and Resident #5.) Findings included: Resident #38 was admitted to the facility on a readmit 11-22-17 with multiple diagnoses which included urinary tract infection, cerebral vascular accident, dementia and neurogenic bladder. The Minimum Data Set (MDS) dated 11-8-17 revealed that resident #38 had memory issues and was severely cognitively impaired. The resident was coded as needing extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene. He was coded as needing extensive assistance with 2 people for transfers. Resident #38 was not coded for falls or restraints. A review of the incident report dated 11-19-17 revealed only a nursing note. The rest of the report was blank. The nursing note revealed that resident #38 was in his wheelchair at 3:30am by the staff breakroom. The nursing assistant (NA) found the resident sitting on his buttocks on the floor in front of his wheelchair. The NA informed the nurse working that evening of the fall and assisted the resident back into his wheelchair. The note also revealed that the resident did not complain of pain or communicated how he fell. An interview with resident #38's representative occurred on 1-30-18 at 8:36am. The representative stated she found out a day later that the resident had fallen but that the nurse who	F 636	cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F636 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to complete physical assessment on resident after an unwitnessed fall and complete comprehensive assessment within required timeframe- was staff failure to follow established policy and procedure. Resident #38 was sent to emergency room on 1/31/18 where was assessed by medical physician. Resident #6□s comprehensive assessment was completed on 2/2/18 and submitted to the national repository on 2/6/18 by the MDS nurse. Resident #2□s comprehensive assessment was completed on 2/12/18 and locked by the minimum data set nurse (MDS).	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 636	Continued From page 30 called her could not give her any details as to how he fell or what time of day he fell. The resident's representative stated resident #38 was on a "blood thinner" at the time of his fall. The representative added that resident #38 had not spoken since his last stroke "a few years ago". A review of resident #38's medication revealed that the resident was on Plavix 75mg daily. The nursing assistant who worked with resident #38 the night he fell was unavailable for an interview. An interview with the Interim Director of Nursing (IDON) occurred on 1-31-18 at 11:40am. The IDON stated "I don't handle things out there on the floor I am the MDS nurse". She did state that she had the title of IDON and was able to state that the nurse on shift should have done an assessment on resident #38 when she was informed that he fell and completed neurological checks since no one knew if the resident had hit his head. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:30pm. Nurse #6 stated she was filling in for a nurse that called off that night. She stated she was told of resident #38's fall and that she saw him sitting on his buttocks on the floor. Nurse #6 stated she did not do any type of physical assessment to check for injuries and she did not do any neurological checks because she was not told he had hit his head. She went on to state that resident #38 was "always up in the middle of the night in his wheelchair wheeling himself around and it kept him from falling out of bed". An interview with the Administrator occurred on	F 636	Resident #5□s comprehensive assessment was exported and accepted by the natation repository on 2/6/18 by the MDS nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed a review of all falls in the past 30 days to ensure a physical assessment had been completed and documented after all unwitnessed falls with no negative findings. On 2/20/18 the MDS consultant audited all current residents to ensure comprehensive assessments have been completed as scheduled for the past 30 days. No outstanding missing assessments were found. All licensed nurses will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion of an assessment after each fall and documenting in the medical record. No licensed nurse will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hires licensed nurses. On 2/2/18 the MDS coordinator was in-serviced on completing assessments timely based on the resident assessment instrument (RAI) manual. Any newly hired MDS coordinator will be in-serviced. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 636	Continued From page 31 2-1-18 at 3:30pm. The Administrator stated that if a resident fell or had a change in condition that her staff complete a physical/neurological assessment. 2. A review of Resident #6"s last annual comprehensive assessment identified it was completed on 12/27/16. As of 2/1/18 the annual MDS with an assessment reference date (ARD) of 12/27/17 had not been completed. Sections I, V and O were still in progress. An interview with the MDS nurse on 2/1/18 at 4:31 pm revealed the annual MDS with an ARD date of 12/27/17 for Resident #6 was close to being completed, but it was late. Resident #2 was admitted to the facility on 1/10/18. As of 2/1/18 the initial comprehensive admission assessment with an ARD of 1/23/18 had not been completed. Sections A, B, C, D, E, G, H, I, J, L, M, N, O, P and Q were still in progress. An interview with the MDS nurse on 2/1/18 at 4:35 pm revealed the admission MDS with an ARD date of 1/23/18 for Resident #2 was in progress and had not been completed yet. A review of Resident #5 ' s last annual comprehensive assessment was dated 12/28/16. As of 2/1/18 the annual MDS with an ARD of 12/27/17 had been completed, but had not been exported. An interview with the MDS nurse on 2/1/18 at 4:38 pm revealed Resident #5 ' s annual MDS was late and had not been fully completed until 1/30/18. She added that she had gotten behind	F 636	requirements The director of nursing, or staff facilitator will audit 100% of unwitnessed falls x 4 weeks then 50% of unwitnessed falls for 8 weeks to ensure a licensed nurse completed a physical assessment which is documented in the medical record. This audit will be documented on the fall audit tool. The administrator, or director of nursing will audit 100% of MDS assessments complete and submitted to the national repository weekly x 4 weeks then 50% weekly x 8 weeks to ensure assessments were submitted timely based on the RAI manual. This audit will be documented on the MDS audit tool. The monthly QI committee will review the results of the fall and MDS audit tools monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 636	Continued From page 32 completing some MDS ' s because she was working as the interim Director of Nursing (DON) in addition to her MDS position. The MDS nurse stated the facility had recently hired another MDS nurse. An interview with the Administrator on 2/1/18 at 4:45 pm revealed it was her expectation that MDS assessments were completed within the required timeframes.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for hospice services involving 1 of 1 residents (resident #120) reviewed for hospice care. Findings included: Resident #120 was admitted to the facility on 10-27-2008 with multiple diagnoses which included dementia, pressure ulcers of the left and right heels, dysphagia and schizophrenia. The Minimum Data Set (MDS) dated 1-4-2018 revealed that resident #120 had memory issues and was coded as severely cognitively impaired. Resident #120 was also coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, total assistance with one person for	F 641	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F641 Accuracy of Assessments The plan of correcting the specific	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 641	Continued From page 33 dressing, eating and personal hygiene, extensive assistance with 2 people for toileting. The resident was not coded for any special treatments such as hospice. The care plan dated 1-23-18 revealed a goal that resident #120 will not experience pain without appropriate nursing interventions. The interventions for this goal were as follows; consult hospice regarding pain management, encourage family involvement, provide supportive private environment for the resident and her family. A review of the physician's orders revealed that resident #120 was placed on hospice 3-31-17 and the resident remained on hospice as of 2-1-18. An interview with the Minimum Data Set (MDS) nurse occurred on 2-1-18 at 8:05am. The MDS nurse stated she had a "consultant" helping her score the MDS assessments and that she "must have just made a mistake". She could not remember which consultant was helping her at that time "I have had so many in and out of here". The MDS nurse did state that resident #120 should have been coded for hospice services. An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected the Minimum Data Set (MDS) be coded accurately and reflect the resident's current health condition.	F 641	deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately coding resident receiving hospice services to reflect life expectancy of 6 months or less. On 2/6/18 resident # 120□s MDS dated 1/4/18 was modified by the minimum data set nurse (MDS). The modified assessment was submitted and accepted by the national repository on 2/6/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant audited all MDS assessments completed and transmitted in the past 30 days to ensure hospice coding was correct with no additional negative findings. On 2/2/18 the MDS Coordinator was in-serviced by the facility Consultant on correctly coding residents receiving hospice services to be coded as having a life expectancy of 6 months or less based on the resident assessment instrument (RAI) manual. Any newly hired MDS coordinators will be in-serviced. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator or director of nursing will audit completed MDS assessments	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 641	Continued From page 34	F 641	for correct coding of residents receiving hospice services MDS Audit Tool. 100% of completed assessments will be audited weekly x 4 weeks, then 50% of completed assessments weekly x8 weeks. The monthly QI committee will review the results of the MDS Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 656	Continued From page 35 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan to address activities of daily living (ADL) care, specifically toileting with no goals, measureable objectives or time frames for a dependent resident in 1 of 1 residents (resident #71). Findings included:	F 656	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 656	Continued From page 36 Resident #71 was admitted to the facility on 6-21-16 with multiple diagnoses to include cerebral infarction, muscle weakness, abnormality of gait and vascular dementia. The Minimum Data Set (MDS) dated 12-7-17 revealed that the resident was moderately cognitively impaired. Resident #71 was coded as needing limited assistance with one person for bed mobility, transfers, locomotion on and off the unit, dressing and personal hygiene and extensive assistance with toileting. A review of the care plan dated 12-28-17 revealed that resident #71 did not have any goals or interventions related to activities of daily living (ADL). A review of the nursing Kardex revealed that there was no instructions for ADL care but resident #71 was listed as using "pull-ups" under the toileting program section of the Kardex. An interview with the nursing assistant (NA #52) occurred on 1-31-18 at 1:15pm. NA #52 stated that he did have to change resident #71's pull-up "throughout" the day because it was wet. He also stated that resident #71 could not change her pull-up by herself and needed assistance in proper cleaning of her genital area. An interview with the Interim Director of Nursing (IDON) occurred on 1-31-18 at 1:28pm. The IDON stated she was the person who creates and updates resident's care plans. She reviewed resident #71's care plan and stated she did not know why resident #71 was not care planned for ADL care and that she should have been.	F 656	specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F656 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately developing a care plan to address activities of daily living (ADL) care, specifically toileting with goals, measurable objectives, and time frame for dependent resident. On 1/31/18 resident # 71□s care plan was updated by the minimum data set coordinator to accurately reflect residents□ dependence in ADL care, specifically toileting, including a goal, measureable objective, and time frame. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/22/18 the MDS consultant completed an audit of all residents ADL care plan for toileting to ensure it was accurate and included a goal, measurable objective, and time frame. 43 care plans	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 656	Continued From page 37 An interview with the Administrator occurred on 2-1-18 at 3:30pm. The Administrator stated she expected the residents care plan to reflect the needs of the resident and accurately reflect MDS coding.	F 656	were altered to accurately reflect the residents current ADL levels, goals, objectives, and time frames. On 2/2/18 the MDS Coordinator was in-serviced by the facility Consultant on developing a care plan based on the residents most recent assessment. Any newly hired MDS coordinators will be in-serviced. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, or director of nursing will audit residents with completed MDS assessments for care plan accuracy in ADL care specifically toileting using the MDS Audit Tool. 100% of residents with completed assessments will be audited weekly x 4 weeks, then 50% of residents with completed assessments weekly x8 weeks. The monthly QI committee will review the results of the MDS Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 656	Continued From page 38	F 656	The director of nursing is responsible for implementing the acceptable plan of correction.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident observation, resident representative interview and staff interview the facility failed to provide Activities of Daily Living (ADL) care, incontinence care for 1 of 1 residents (resident #51). Findings included: Resident #51 was admitted to the facility on 12-08-17 with multiple diagnoses which included dementia, dysphagia, peripheral vascular disease and aphasia. The Minimum Data Set (MDS) dated 11-22-17 revealed that resident #51 had memory problems and was moderately cognitively impaired. The resident was coded as not rejecting care when care was offered. Resident #51 was coded as needing extensive assistance with 2 people for bed mobility, total assistance with 2 people for transfers, extensive assistance with one for dressing and toileting and extensive assistance with 2 people for personal hygiene. A review of the care plan dated 12-12-17 revealed that resident #51 had a goal that the resident	F 677	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F677 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 677	Continued From page 39 would not develop a pressure ulcer. The interventions for this goal was as follows; assess skin daily, encourage or assist resident to change positions frequently, provide incontinence care after each incontinent episode or toileting. Resident #51's representative approached the survey team on 2-1-18 at 5:00pm. She stated that for the past 3 days she had come to see the resident and he had been in a soiled brief. The representative stated she could "smell he had a bowel movement". She stated she did not know how long he had been in a soiled brief. An observation of resident #51's Activities of Daily Living (ADL) care occurred on 2-1-18 at 5:05pm. The nursing assistant (NA #55) removed the residents brief and dried feces was noted in the resident's crotch area as well as down his left leg. NA #55 was interviewed on 2-1-18 at 5:15pm. She stated she was the only nursing assistant working resident #55's hall that evening and that she attended to his needs as soon as she could. NA #55 stated she did not know how long the resident had been sitting in a soiled brief but that "it must have been a while since his feces was dry and stuck to his skin". An interview with the Administrator occurred on 2-1-18 at 5:30pm. The Administrator stated her expectations were the same as earlier, that her staff provide incontinence care in a timely fashion "within 15-20 minutes".	F 677	to provide requested incontinence care was staff failure to follow established procedure. On 2/16/18 the facility consultant observed resident # 51 at 730am, 815am, and 9am. Resident was not soiled and had no visible or olfactory signs of incontinence noted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant observed all non-interviewable residents for visible or olfactory signs of incontinence at 830am with 3 residents noted soiled. At 845am affected residents were being provided incontinent care by facility staff. On 2/16/18 the facility consultant observed and interviewed all unreviewable residents regarding incontinence with no negative findings noted. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident providing incontinent care promptly. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 677	Continued From page 40	F 677	The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks resident is clean and dry. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 684	Continued From page 41 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident observation, and resident representative interview and staff interviews the facility failed to have the resident up daily in his wheelchair for 2 months and not providing the resident with activities resulting in the resident sleeping all day for 1 of 1 residents (resident #38). Findings included: Resident #38 was admitted to the facility on a readmit 11-22-17 with multiple diagnoses which included urinary tract infection, cerebral vascular accident, dementia and neurogenic bladder. The Minimum Data Set (MDS) dated 11-8-17 revealed that resident #38 had memory issues and was severely cognitively impaired. The resident was coded as needing extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene. He was coded as needing extensive assistance with 2 people for transfers. Locomotion on and off the unit was coded as total assist with one person. Resident #38 was not coded for falls or restraints. The MDS revealed that the resident was discharged from physical therapy and occupational therapy on 1-24-17. The care plan addressed that the resident was needing total care. An attempted interview with resident #38 occurred on 1-28-18 at 2:00pm. The resident was laying in the bed with his eyes closed but easily aroused when his name was called. The resident was unable to speak however he was able to	F 684	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F684 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to have resident up in wheelchair, and not providing activities was knowledge deficit. Resident #38 was not observed up in wheelchair per resident representative choice. Resident #38 was referred to therapy on 1/31/18 by the director of nursing for decreased transfer ability. Resident representative discontinued therapy	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 684	Continued From page 42 wave and reached for the surveyor's hand. Resident #38 was observed on 1-29-18 at 12:30pm laying in his bed with his eyes closed resting comfortably. It was noted that the resident did not have a lunch tray. An interview with the nursing assistant (NA #56) occurred on 1-29-18 at 12:35pm. The NA stated that resident #38's wife brings him his meals so he does not get a lunch tray. During this interview the NA stated that the resident will sleep till his wife returns in the evenings for the supper meal and that staff allowed him to sleep but that they did "check" on him throughout the shift. Resident #38 was observed on 1-30-18 at 10:30am laying in his bed with his eyes closed. The TV in the resident's room was on but the resident was not watching the TV. An observation of resident #38 occurred on 1-30-18 at 3:00pm. The resident remained in the bed with his eyes closed. The nurse (nurse #1) stated on 1-30-18 at 3:20pm that resident #38 "pretty much sleeps all day" and that she has not had the resident up in his wheelchair but that she did "check" on him throughout the day and that he was not receiving any type of therapy. She also stated that the resident used to get into his wheelchair regularly prior to his fall. The resident representative was interviewed on 1-30-18 at 4:40pm. During this interview the representative stated that resident #38 was more independent prior to his fall on 11-19-17 and that he used to get up in his wheelchair every day and	F 684	services. Resident #38 was added to in room activity list by the activity director on 2/9/16. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed an interview with interviewable residents to ensure residents are getting out of bed per preference with no negative findings not already addressed. On 2/23/18 the Activity Director audited the list of resident□s receiving in rom activities to ensure residents who choose to stay in bed are present unless they choose otherwise. No negative findings were noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of resident choice to get out of bed, and activities. Five grievances were placed regarding resident choice to get out of bed and activities. All five grievances were resolved. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion residents should be out of bed daily unless they choose differently, residents should be provided with activity to provide stimulation, and a change in resident mobility must be communicated. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hired licensed	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 684	Continued From page 43 was able to wheel himself around the halls. She also stated staff had not attempted to place the resident back into his wheelchair since he returned from the hospital. The representative also stated she was able to assist the resident into his wheelchair by herself and was able to take him home for 2-3 days at a time prior to his fall in November but now she cannot get him up and can no longer take him home because "he has declined so much I can't handle him on my own anymore". The wife stated she felt that the residents decline was "normal disease progression". The resident was noted to be awake during the interview with his representative and waving at the surveyor smiling. An interview with the nurse (nurse #6) occurred on 1-31-18 at 2:50pm who stated the resident was "always" in his wheelchair "he liked wheeling himself around the halls". During the interview she stated she has not seen the resident in his wheelchair since he returned from the hospital in November. The Administrator stated on 2-1-18 at 3:30pm that she expected staff to assist residents in maintaining or improving their level of functioning.	F 684	nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, or staff facilitator will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, activity provided if resident in room, and if change in mobility it is communicated. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 689	Free of Accident Hazards/Supervision/Devices	F 689		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 689 SS=D	Continued From page 44 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, family and staff interviews the facility failed to provide supervision to prevent falls for 1 of 3 residents (Resident #54) reviewed for accidents. Findings include: Resident #54 was admitted to the facility on 9/19/2016 then re-admitted on 10/28/20176. Resident #54 was admitted with multiple diagnoses including Malignant Neoplasm of the left Kidney and Renal Pelvis, Alzheimer's, Chronic Kidney Disease stage 3. Resident # 54 was under hospice care. Review of the Minimum Data Set (MDS) dated 11/25/2017 revealed that the resident was severely impaired. The areas of bed mobility and transfers were scored extensive with a two person assist. The areas of toileting and hygiene were scored extensive with two person assist while bathing was total dependence with one person assist. During an interview with a Family Member (FM) on 01/29/2018 at 4pm FM revealed that on Saturday Resident #54 had a fall from his	F 689	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F689 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to provide supervision to prevent fall was	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 689	Continued From page 45 wheelchair and hit the right side of his eye, resulting in a black eye. FM indicated that it was one nursing aide and one nurse for all 28 residents. FM indicated this is all the time during the weekend and sometime during the week. Observation was made on 01/29/2018 at 4:45pm on Resident #54 he was observed in his room sitting his wheelchair with a black eye on the right side. Resident #54 appeared to be asleep. Review of incident dated 1/27/2018 indicated "Observed resident sitting in wheel chair leaning forward with eyes closed. Resident bumped right eye brow lid on the corner of the bed side table during his fall. Repositioned resident three separate occasion prior fall." Review of Resident #54's care plan dated 11/09/2017 resident risk for falls characterized by history of falls related to impaired mobility, poor safety awareness, unaware of safety needs, and use of psychotropic medications. During an interview with another Family Member from the hall on January 30, 2018 at 11:30 am "revealed that one reason for so many issues and concerns on this hall was because not having enough staff on the hall to meet the needs of the resident. FM indicated that we are here and know for a fact that one nursing assistant during the day and now that the state was here we got two but next week come back we will be down to one." During an interview with Nursing Assistant (NA) #50 on January 31, 2018 at 1pm, she indicated that she worked on the unit but was not assigned to Resident #54. NA #50 had no knowledge of	F 689	communication. Resident #54 was assessed by nurse on 1/27/18 after fall with superficial laceration noted. Resident # 54 was referred to therapy on 2/19/18 by facility consultant for seating. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed a review of all falls in the past 30 days for any trends with none noted. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on providing supervision to prevent falls. No licensed nurse will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hires licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, facility consultant, or staff facilitator will audit 100% of falls x 4 weeks then 50% of falls for 8 weeks to observe any trends related to lack of supervision. This audit will be documented on the fall audit tool. The monthly QI committee will review the results of the fall audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 689	Continued From page 46 Resident #54 fall on Saturday. During an interview with NA #53 on January 31, 2018at 1:15pm. Indicated she was not assigned to any resident because she was in orientation and following the other NAs. NA #53 revealed she did not observed Resident #54 on Saturday. During a phone interview with Nursing Assistant (NA) # 51 on January 31, 2018 at 1:30pm revealed that she was not assigned to Resident #54 on Saturday. NA #51 revealed that she assisted the Nurse after his incident. During an interview with Nurse # 5 on January 31, 2018at 3:30 pm Nurse indicated that she recalled a visitor on the unit calling her to Resident #54 room, the visitor observed Resident# 54 falling from his wheelchair. Nurse #5 revealed she assessed Resident #54 after his fall. Called the medical doctor and notified his family. Nurse #5 indicated the NAs that worked on the hall but could not recalled who was assigned to Resident #54. During an interview with the Director of Nursing (DON) on February 1, 2018 at 11am revealed she only knew his MDS information, had just got this position two weeks ago. DON indicated she was not aware of Resident #54 fall during the weekend of January 27, 2018. During an interview with the Administrator on February 1, 2018 at 4:30 pm revealed that this facility has had issues with staffing since her first day. Administrator staff had been identified as an issues and we are working on that. However her expectation was that the facility had enough staff on duty to prevent accidents for residents with	F 689	and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 689	Continued From page 47 repeat falls and to meet all the resident's needs.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, family and resident interview the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide	F 725	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 48 incontinence care, toileting, get residents up and snack for residents who required assistance. This affected 10 of 32 residents. (Resident #33, Resident #38, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, Resident #124 and Resident #403). Findings included: F561 Based on record review, staff interviews, resident interviews and resident observations the facility failed to provide 1 of 3 residents (resident #45) the choice of when to be out of bed and failed to provide 2 of 3 residents (Resident #45 and resident #80) showers for two and a half weeks when reviewed for activities of daily living (ADL) and failed to honor a resident's choice to have dinner in the dining room for 1 of 3 residents reviewed for choices (Resident # 124). F600 Based on resident interview, staff interviews, resident observation and record review the facility failed to provide incontinence care for 1 of 5 sampled residents (Resident #71) who required extensive assistance and who requested incontinence care on 2 different occasions because she had soiled herself. F677 Based on resident observation, resident representative interview and staff interview the facility failed to provide Activities of Daily Living (ADL) care, incontinence care for 1 of 1 residents (resident #51). F684 Based on record review, resident observation, and resident representative interview and staff interviews the facility failed to have the resident up daily in his wheelchair for 2 months	F 725	cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F725 The plan of correcting the specific deficiency The position of Pine Ridge center regarding the process that lead to this deficiency-failed to provide nursing staff of sufficient quantity to provide staffing of sufficient quantity and quality to honor resident choices, provide supervision to prevent accidents, provide incontinent care, toileting, get residents up, and snack for residents who require assistance was failure to communicate. Resident #54 was assessed by nurse on 1/27/18 after fall with superficial laceration noted. Resident #38 was not observed up in wheelchair per resident representatives choice. Resident # 54 was referred to therapy on 2/19/18 by the facility consultant for seating. On 2/16/18 the facility consultant	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 49 and not providing the resident with activities resulting in the resident sleeping all day for 1 of 1 residents (resident #38). F689 Based on observation, record reviews, family and staff interviews the facility failed to provide supervision to prevent falls for 1 of 3 residents (Resident #54) reviewed for accidents. F809 Based on observations, record reviews, family, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 3 of 3 residents (Resident # 403, Resident # 124, and Resident #73). An observation of the facility on 1/28/2018 at 4pm revealed there were was 1 nursing assistant (NA) present to care for 24 residents residing on the 100 hall. There was 1 NA present to care for 27 residents on the 200 hall. There was 1 NA present to care for 26 residents on the 300 hall and 1 NA present to care for 27 residents on the 400 hall. There also 1 NA on the 500 hall with 27 residents. An interview on 1/28/2018 Nurse #41 at 4:10 pm revealed "oh my god we are short staff and the state is here." Nurse #41 indicated the NA on this 400 hall has 27 residents by herself. The Nurse #41 stated that there just was not enough staff to take care of the residents the way they should. We just do what we can around here. An interview on 1/28/2018 at 4:15pm with NA #4 who worked on the 400 hall indicated that she just does the best she can when she is the only NA on the hall. She indicated that she had been working like this for six months. NA #4 indicated that it is like this during the week as well.	F 725	observed resident # 71 at 730am, 815am, and 9am. Resident was not soiled and had no visible or olfactory signs of incontinence noted. On 2/16/18 the facility consultant observed resident # 51 at 730am, 815am, and 9am. Resident was not soiled and had no visible or olfactory signs of incontinence noted. By 2/27/18 resident # 45 will receive a shower. On 2/1/18 and 2/12/18 resident # 45 was observed out of bed per resident choice by LPN. On 2/6/18 resident # 80 received a shower. On 2/2/18, 2/5/18, 2/8/18, 2/12/18, 2/13/18, 2/14/18, 2/20/18, 2/23/18 resident # 124 was observed by GCAs eating diner in the dining room per resident preference. Resident #430 was offered a bedtime snack and accepted on 2/2/18. Resident #124 was offered a bedtime snack in the dining room and accepted on 2/2/18. Resident #74 was offered a bedtime snack but refused on 2/2/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed a review of all falls in the past 30 days for any trends with none noted. On 2/16/18 the facility consultant completed an interview with interviewable residents to ensure residents are getting	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 50 An interview occurred with the nursing assistant (NA #53) on 1-30-18 at 3:10pm. NA #53 stated she is the one who gave the residents their showers. She stated she did try to give the residents a choice on when they receive their shower but "there are so many to do I can't always give them a choice". NA #53 indicated we are short staff here and need more help to address the needs of the residents. On January 31, 2018 at 8:55 am an observation of 500 hall; family member had reported that there was only 1 NA on the floor to serve and feed all of the resident breakfast. Family member stated that when she got her this morning around 8:15 there was only 1 NA on the 500 hall; stated when the breakfast trays came out she went and complained that there weren't enough staff to help feed all the residents. She told them she was going to have us (the state) look at this and once she told them that they started sending all kinds of staff to the unit to help with breakfast. Stated that this happens all the time. Added that they will often have a RCA on the hall, but they can't feed any resident on thickened liquids, which a lot of the residents on this hall are on. Stated that she has complained many times about the lack of staffing and how it impacts care and all the facility tells her is "were are working on it and trying to hire people". 0n January 31, 2018 at 9:00 AM during an interview with Nurse #55 stated he usually works on second shift, only works on first shift occasionally. Stated one NA was on the 500 hall at 7:00 am this morning. Stated 2nd NA was supposed to come in at 8 -8:30 am but she was not at facility yet. Stated he believes the	F 725	out of bed per preference with no negative findings not already addressed. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of resident choice to get out of bed, and activities. Five grievances were placed regarding resident choice to get out of bed and activities. All five have been resolved. On 2/16/18 the facility consultant observed all non-interviewable residents for visible or olfactory signs of incontinence at 830am with 3 residents noted soiled. At 845am affected residents were being provided incontinent care by facility staff. On 2/16/18 the facility consultant observed and interviewed all unreviewable residents regarding incontinence with no negative findings noted. On 2/9/18 the facility consultant interviewed all interviewable residents regarding their ability to get up as they choose. No additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of resident choice to get out of bed, or dining location. Five grievances were placed regarding resident choice to get out of bed and dining location. All five grievances were resolved. On 2/16/18 the facility consultant reviewed residents in facility for showers given in the last 7 days for showers provided per resident preference. All negative findings will be addressed by facility staff by 3/1/18. On 2/16/18 during the morning meal the facility consultant spoke interviewable	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 51 breakfast meal trays came out a little before 8:00 am. He had reported to his supervisor that there was only 1 NA on the hall. Stated he thinks there are 10 plus residents that need to be fed their meals. On January 31, 2018 at 9:20 am during an interview with Nursing Assistant #85 stated she was a NA for the 500 hall; she started at 7:00 am. Stated she was the only NA and didn't know why the other NA didn't come in. She wasn't sure if there was supposed to be a GCA there or not. Stated she floats on different units. Stated she was trying to get residents up; the breakfast trays came out around 7:45 am. Stated she believes there are around 12 residents that have to be fed. Stated she really didn't know how the staffing typically was on the hall because she floats and only worked on this unit occasionally. An interview on 2/1/2018 at 4:30 pm with the Administrator revealed she expected that all halls were adequately staffed to provide the care the residents needed. She added that staffing has been a problem for this facility for since she got here.	F 725	residents to ensure they were having meal in location of choice with no negatives noted. On 2/16/18 the facility consultant completed an interview with interviewable residents to ensure residents are pleased with their snacks, no additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of snacks. No significant findings were noted. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on residents must be offered snacks including bedtime snacks. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hired licensed nurses and CNAs. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion providing supervision to prevent falls. No licensed nurse will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hires licensed nurses. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on completion residents should be out of bed daily unless they choose differently, residents should be provided with activity to provide stimulation, and a change in resident mobility must be communicated. No licensed nurse or CNA will be allowed to	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 52	F 725	work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hired licensed nurses and CNAs. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident providing incontinent care promptly. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. All licensed nurses and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on resident choice including resident right to choose when to be out of bed, shower preferences, and dining location. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service completed. This in-service will be added to the orientation process for all new licensed nurses and CNAs. On 2/2/18 the facility consultant in-serviced the administrator and director of nursing on staffing must be adequate to honor resident choices, provide supervision to prevent accidents, provide incontinent care, toileting, get residents up, and provide snacks. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 53	F 725	The director of nursing, or staff facilitator will audit 100% of falls x 4 weeks then 50% of falls for 8 weeks to observe any trends. This audit will be documented on the fall audit tool. The director of nursing, or staff facilitator will audit 20 residents weekly for 4 weeks, then 10 residents per week for 8 weeks to ensure resident out of bed per resident choice, activity provided if resident in room, and if change in mobility it is communicated. This audit will be documented on the Resident Care Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks resident is clean and dry. This audit will be documented on the Resident Care Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure showers were given and appropriate equipment available to accommodate resident need. This audit will be documented on the Resident Care Audit Tool. The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident out of bed per resident choice, showers were given per resident choice, and resident dining in area of choice. This audit will be	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 725	Continued From page 54	F 725	documented on the Resident Care Audit Tool. The administrator or director if nursing will review staffing 5 times weekly to include weekend staffing to ensure staffing is adequate to ensure residents are out of bed per choice, showers are given per resident choice, and residents are able to dine in location of choice. This audit will be documented on the sufficient staff audit tool. The monthly QI committee will review the results of the resident care audit tool, fall audit tool, and sufficient staff audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 761	Continued From page 55 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly dispose of expired medications and unlabeled, opened medications in 2 out of 2 medication storage rooms (the 500 hall medication storage room and the medication storage room that is used for halls 100,200, 300, and 400) that are used to supply medications for the residents of the facility. Findings include: 1. a. An observation was conducted on 1/31/18 at 12:21pm in the medication storage room that supplies the 100, 200, 300, and 400 halls with Nurse #1 present. In the locked box for narcotics, it was revealed a vial of Morphine 10mg/ml had a	F 761	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 761	Continued From page 56 manufacturer's expiration date of October 2017. Nurse #1 removed the vial to be discarded. In the refrigerator, two Humalog vials were open with no date noted on the vials as to when they were opened. Nurse #1 removed the vials to be discarded. Two PPD (Purified Protein Derivative) vials were observed to be open with no open date noted on either vial. Nurse #1 removed the vials to be discarded. An observation was made that revealed a pneumococcal vaccine had a manufacturer's expiration date of 1/17/18. Nurse #1 removed the vial to be discarded. b. An observation was conducted on 1/31/18 at 2:50pm in the medication storage for the 500 hall with Nurse #2 present. An observation revealed seventeen pneumococcal vaccine vials that had the manufacture expiration date of 1/17/18. Nurse #2 removed the vials to be discarded. In the cabinet, it was revealed three vials of sterile water that were opened but not dated. Nurse #2 removed the vials to be discarded. An interview with Nurse #1 was conducted on 1/31/18 at 12:40pm. During the interview, the nurse reported that all opened medications are to be dated with the date the medication was opened. Nurse #1 reported all medications that reach the manufacturer's expiration date are to be discarded. She reported it is the responsibility of the nurses, medication aides, and pharmacist to check the expiration dates of the medications in the medication storage rooms. An interview with Nurse #2 was conducted on 1/31/18 at 2:55pm. During the interview, Nurse #2 reported it is the nurses and pharmacists that should be checking the manufacturing expiration dates on the medications in the medication	F 761	correction. F761 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to properly dispose of expires and unlabeled, opened medications in 2 of 2 medication storage rooms- was the staff failure to follow policies for labeling of opened medication and proper disposal of expired medication. On 1/31/18 the staff nurse removed a vial of expired morphine, two Humalog vial which were open with dates, two purified protein derivative (PPD) vials, one expired pneumococcal vaccine from the medication storage room 1 and disposed of per facility policy. On 1/31/18 the staff nurse removed seventeen expired pneumococcal vaccines, and three open but undated vials of sterile water and disposed of per facility policy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/9/18 the facility consultant completed an audit of both medication storage rooms including refrigerators, and cabinets. All expired, and open but undated medications were disposed of per facility policy.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 761	Continued From page 57 storage room. Nurse #2 reported all opened medications should be dated with open date. He reported all expired medications should be discarded by the expiration date. An interview with the Administrator was conducted on 2/1/18 at 4:00pm. The administrator reported it is her expectation that all medications that are opened are labeled with the date opened. During the interview, the administrator reported it is her expectation that the nursing staff and pharmacy make sure all the medications in the storage rooms that have reached the manufacturer's expiration date are discarded.	F 761	On 2/2/18 an in-service was started by the staff facilitator (SF) on labeling of opened medications, and removal disposal of expired medications per facility policy for all licensed nurses. This in-service will be complete by 3/1/18. This in-service will be included with orientation for all newly hired licensed nursing staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of medication storage rooms weekly x 4 weeks then 50% weekly x 8 weeks to ensure no expired or open but undated medications are present. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 761	Continued From page 58	F 761	correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and residents interviews the facility failed to follow the planned menu and the food substitutions	F 803	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific	3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 803	Continued From page 59 provided were not of similar nutritional value as the planned menu. This was evident in 1 of 2 meals observed. Observation of the kitchen on Sunday January 28, 2018 at 4:35 pm revealed the planned menu for the supper meal was cream of potato soup, ham & cheese sandwich melt, tator tots, beet & onion salad and Hawaiian fruit cup. During an interview with Cook #1 at 4:40 pm on January 28, 2018 she revealed she didn't see any ham or croissants available in the kitchen to make the ham & cheese melt so she substituted chicken salad. Cook #1 also indicated she only had one can of beets and no onions so she substituted green beans for this. She stated she had not notified her supervisor about the menu changes and she had not written the changes on the menu or substitution log. Cook #1 added that she had been working at the facility about 3 months and sometimes she had to change the menu because the food wasn't available. During an interview with Dietary aide #1 at 4:45pm on January 28, 2018 she stated "the kitchen is always running out of food." A continued observation on January 28, 2018 of the dinner meal service at 4:50pm until 7pm. The chicken salad in a bowl behind the steam table. Food on the steam table, green beans, tator tots, corn nuggets, meatballs, and soups. Saltine crackers and fruit cup was also on the side of steam table. At 5:50 pm during the plating of the resident's dinner the chicken salad ran out and was substituted with tuna salad. At 6:10pm the green	F 803	deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F803 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to follow the planned menu and the food substitutions provided were not of similar nutritional value as the planned meal. On 2/16/18 the facility consultant observed the breakfast menu which was served according to menu. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/20/18 the dietary consultant in-serviced the dietary manager on 1. Following the approved menu, 2. If needed following the substitutions lists, and 3. Ensuring food items needed to	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 803	Continued From page 60 beans ran out and were replaced with corn nuggets (a breaded cream style type corn that was fried). At 6:40 pm the corn nuggets ran out and were replaced with vegetable sticks (a breaded variety of mixed vegetables that were fried.) Saline crackers that were being served to replace the croissant ran out and a slice of bread was served on 10 meal trays. There were 30 resident meal trays served with no bread, crackers or bread alternative. During an interview with Resident #62 on January 28, 2018 at 7:35 he revealed that the dinner he received that night was cold and nasty. Resident #62 indicated he cannot eat fish and he was served tuna on his tray. Resident # 62 indicated that tuna was not on the menu for tonight. During an interview with Resident #33 on January 28, 2018 at 7:43 pm she revealed her dinner was cold, the soup looked like milk and like nothing. Resident #33 stated 'What a dinner." During an interview with Resident #74 on January 28, 2018 at 7:57 pm she revealed the food was cold and looked like it was thrown together. Resident #74 indicated she was looking forward to having the ham and cheese sandwich that was on the menu for tonight but she received tuna salad instead. During an interview with Resident #430 on January 29, 2018 at 8 am she revealed her meal was cold when severed to her last night (Sunday, January 28, 2018). Resident #430 indicated that the soup was cold not lukewarm but cold and so were the tator tots. She was unsure what the other item was, but it was cold. Resident #430 also indicated that on Friday night January 26,	F 803	provide approved menu were available in the facility. On 2/20/18 the dietary manager in-serviced the dietary staff on 1. Following the approved menu, 2. If substitutions are needed the correct process, and 3. When to notify the dietary manager when food items are not available. This in-service will be complete by 3/1/18. The in-service will be part of the orientation process for all newly hired dietary staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided according to approved menu. This audit will occur on random days, at different meal times. This audit will be documented on the menu audit tool. The monthly QI committee will review the results of the menu audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 803	Continued From page 61 2018 she did not receive a dinner tray at all. Resident #430 was told the kitchen ran out of food. She stated she received a sandwich after 8:00 pm. Resident # 430 also indicated that she have that the facility does not offer snack during the night since her placement on Friday. During an interview with the DM on January 29, 2018 at 9:30 am she revealed that all foods should be held and served at the required temperatures. The DM also indicated that all the food should not be put on the steam table at the same time to hold the temperatures. The DM stated she wanted all of the residents to be satisfied with their meals and she expected that their food would be served hot and cooked correctly. The DM also stated she expected that the cook follow the planned menu for all meals. That if a menu substitutions was done it needed to be recorded and residents needed to be informed. All substitution needed to be the same nutritional value. During an interview with the Administrator on February 1, 2018 at 4:30 pm she stated it was her expectation that all meals were served timely, were palatable and at an appropriate temperature.	F 803	The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable,	F 804		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 804	Continued From page 62 attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to serve food that was palatable and at an acceptable temperature for 5 of 5 residents (Resident #32, Resident #33, Resident #62, Resident #72 and Resident #430) that were reviewed for food palatability. Findings included: An observation was made of the steam table in the kitchen on January 28, 2018 at 4:25pm. The dinner meal was already on the steam table and Cook #1 revealed she had placed the food on the steam table at 1:30pm. Cook #1 stated the soup of the day had been placed on the steam table for 45 minutes to an hour to cook. She also stated that she usually took the food temperatures around 4:30 to 4:45 pm. Cook #1 started taking the food temperatures but she left during the process and the Dietary Manager (DM) completed taking the temperatures using a calibrated thermometer. The temperatures were: chicken salad 38 degrees F, tuna salad 38 degrees F, tator tots 145 degrees F, soup 204 degrees F, mashed potatoes 163 degrees F, meatballs 142 degrees F, corn nuggets 163 degrees F and green beans 163 degrees F. A test tray was prepared at 6:34 pm on January 28, 2018 from the kitchen steam table and contained the tatot tots, corn nuggets, cream of potato soup, tuna salad and tropical fruit. The test tray was delivered to the 200 hall with 15 resident meal trays at 6:40 pm. The last resident meal tray	F 804	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F804 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to serve food that was palatable and at an acceptable temperature. On 2/16/18 the facility consultant observed the breakfast meal which was served according to menu, and the last tray was served to hall at 910am resident reported his food was warm and tasted good.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 804	Continued From page 63 was delivered at 7:02 pm. The facility Administrator was present when the temperatures of the test tray were taken using a calibrated thermometer. The internal food temperatures were: tator tots 103 degrees F, corn nuggets 96.5 degrees F, cream of potato soup 119 degrees F, and tuna salad 53 degrees F. The food items were tasted by the Administrator and surveyor. The tator tots tasted barely warm, the corn nuggets tasted cool, were chewy and greasy, the cream of potato soup was very thin and tasted warm, the tuna salad and fruit tasted cool. During an interview with Resident #62 on January 28, 2018 at 7:35 he revealed that the dinner he received that night was cold and nasty. Resident #62 indicated he cannot eat fish and he was served tuna on his tray. Resident # 62 indicated that tuna was not on the menu for tonight. During an interview with Resident #33 on January 28, 2018 at 7:43 pm she revealed her dinner was cold, the soup looked like milk and like nothing. Resident #33 stated 'What a dinner." During an interview with Resident #32 on January 28, 2018 at 7:45 pm she revealed her dinner was "cold and nasty, nothing good." During an interview with Resident #74 on January 28, 2018 at 7:57 pm she revealed the food was cold and looked like it was thrown together. Resident #74 indicated she was looking forward to having the ham and cheese sandwich that was on the menu for tonight but she received tuna salad instead. During an interview with Resident #430 on	F 804	The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/20/18 the dietary consultant in-serviced the dietary manager on 1. The process for placing food onto the steam table to maintain food temperatures, 2. Food quantity will be sufficient to serve all residents, 3. Trays will be served at the appropriate temperature. On 2/20/18 the dietary manager in-serviced the dietary staff on 1. The process for placing food on the steam table to maintain temperature, 2. The need temperatures for each food type, 3. Quantity must be sufficient to feed all residents, 4. Trays must be served timely and according to the established meal schedule. This in-service will be complete by 3/1/18. The in-service will be part of the orientation process for all newly hired dietary staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature and food is palatable. This audit will occur on random days, at different meal times. This audit will be documented on the menu audit tool. The monthly QI committee will review the results of the menu audit tool monthly for	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 804	Continued From page 64 January 29, 2018 at 8 am she revealed her meal was cold when severed to her last night (Sunday, January 28, 2018). Resident #430 indicated that the soup was cold not lukewarm but cold and so were the tator tots. She was unsure what the other item was, but it was cold. Resident #430 also indicated that on Friday night January 26, 2018 she did not receive a dinner tray at all. Resident #430 was told the kitchen ran out of food. She stated she received a sandwich after 8:00 pm. During an interview with the DM on January 29, 2018 at 9:30 am she revealed that all foods should be held and served at the required temperatures. The DM also indicated that all the food should not be put on the steam table at the same time to hold the temperatures. The DM stated she wanted all of the residents to be satisfied with their meals and she expected that their food would be served hot and cooked correctly. During an interview with the Administrator on February 1, 2018 at 4:30 pm she stated it was her expectation that all meals were served timely, were palatable and at an appropriate temperature.	F 804	3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 809	Continued From page 65 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 3 of 3 residents (Resident # 403, Resident # 124, and Resident #74). Finding included: During an observation on Sunday January 28, 2018 from 8pm until 9pm, no one was observed passing out snack and/or offering Residents snack in the facility on the 200 hall, 300 hall and 400 halls. During an interview with Resident #74 on January 28, 2018 at 7:57 pm he revealed the food was cold and looked like it was thrown together. Resident #74 indicated he was looking forward to having the ham and cheese sandwich that was on the menu for tonight but he received tuna salad instead. During a second interview with Resident #74 on January 28, 2018 at 8:30pm, he revealed that	F 809	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F809 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 809	Continued From page 66 snacks are not offered or passed out during the night. "We need more staff here." We have to wait for everything around here. Resident #74 indicated he believes that the facility was low on food. Observation in Resident #124's room revealed no snacks left in her room, observation revealed Resident #124 up in bed and looking around at 8:35pm. Second observation in Resident #124's room on January 28, 2018 at 9pm revealed no snacks left in her room. During an interview with Nurse #22 on January 28, 2018 at 9:10pm revealed that snacks are passed out between 8pm and 9pm. Nurse #22 revealed that dinner was late tonight and we only have one Nursing Assistance. "We just need more staff." During an interview with Resident #430 on January 29, 2018 at 8 am she revealed her meal was cold when severed to her last night (Sunday, January 28, 2018). Resident #430 indicated that the soup was cold not lukewarm but cold and so were the tator tots. She was unsure what the other item was, but it was cold. Resident #430 also indicated that on Friday night January 26, 2018 she did not receive a dinner tray at all. Resident #430 was told the kitchen ran out of food. She stated she received a sandwich after 8:00 pm. Resident # 430 also indicated that the facility had not offered her snacks during the nights since her placement on Friday. During an interview on January 29, 2018 at 9am with a family member who indicated that we are	F 809	Rehabilitation center regarding the process that lead to this deficiency-failure to offer or deliver bedtime snacks is knowledge deficit. Resident #430 was offered a bedtime snack and accepted on 2/2/18. Resident #124 was offered a bedtime snack in the dining room and accepted on 2/2/18. Resident # 74 was offered a bedtime snack and refused on 2/2/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/16/18 the facility consultant completed an interview with interviewable residents to ensure residents are pleased with their snacks, no additional negative findings noted. On 2/24/18 the administrator audited the last 60 days of concerns with the focus of snacks. No significant findings were noted. All licensed nurses, and CNAs will be in-serviced by 3/1/18 by the director of nursing, or staff facilitator on residents must be offered snacks including bedtime snacks. No licensed nurse or CNA will be allowed to work after 3/1/18 until in-service is complete. This in-service will be added to the orientation for all newly hired licensed nurses and CNAs. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 809	Continued From page 67 here weekly, day and night for my relative. FM indicated that she had asked several time for Residents to get bedtime snacks and was told that "we only have one NA on the hall and she will get to your relatives as soon as possible." During an interview with Dietary Manager on January 29, 2018 at 9:30 am, she revealed that snack are prepared daily for all residents in the facility and the NA on the hall are responsible for passing out the snack on the hall between 8pm and 9pm. During an interview with the Administrator on February 1, 2018 at 4pm indicated that her expectation that all be offered a bedtime snack every night.	F 809	The director of nursing, or staff facilitator will audit 20 residents weekly for 4 weeks, then 10 residents per week 8 weeks to ensure resident is offered bedtime snack. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced	F 867		3/1/18

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 68 by: Based on staff interview, and record review the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place for the following surveys: 1: 1-27-17 annual recertification survey. This was for 5 recited deficiencies in the areas of: Accuracy of assessments (Was F278 and now F641), QAPI/QAA improvement activities (Was F520 and now F867), Self-determination (Was F242 and now F561), and Safe/ Clean home like environment (Was F253 and now F584), Develop/Implement comprehensive care plan (Was F279 and Now F656). 2: The complaint investigation dated 9-20-17 had 2 recited deficiencies in the areas of: Sufficient nursing staffing (Was F353 and now F725) and ADL care for a dependent resident (Was F312 and now F677). 3: The complaint investigation dated 9-7-17 had one recited deficiency in the area of: Sufficient nursing staffing (Was F353 and now F725). 4: The complaint investigation dated 6-29-17 had one recited deficiency in the area of: Sufficient nursing staffing (Was F353 and now F725). These deficiencies were cited again on the current Recertification investigation survey of 1-28-18. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included:	F 867	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F 867 QAPI Committee The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 2/15/18 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 69 This tag is cross referenced to: 1: F641 (was F278) Accuracy of assessments - Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for hospice services involving 1 of 1 residents (resident #120) reviewed for hospice care. During the recertification survey dated 1-27-17, the facility was cited for F278 for failing to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents to reflect hospice services (resident #3) and accurately code on the MDS the dental status for 2 of 3 residents (Resident #78 and Resident #70). During the current annual recertification survey dated 1-28-18 the facility failed to accurately code the Minimum Data Set (MDS) for hospice services involving 1 of 1 residents (resident #120) reviewed for hospice care. 2: F867 (was F520) QAPI/QAA improvement activities - Based on staff interview, and record review the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1-27-17 annual recertification survey. During the recertification survey dated 1-27-17 the facility was cited for F520 - failing to monitor interventions that the facility put into place December 2015, June 2016 and July 2016. During the current annual recertification survey dated 1-28-18 the facility failed to maintain implemented procedures and monitor	F 867	on-going compliance issues. The Administrator, DON, MDS nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/20/18 the corporate facility consultant in-serviced the administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641-accuracy of assessments, F867-QAPI/QAA, F561 self-determination, F584- clean homelike environment, 656-develop/Implement comprehensive care plan, F725- sufficient nursing staff, and F677- ADL care for dependent residents. On 2/20/18 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641-accuracy of assessments, F867-QAPI/QAA, F561 self-determination, F584- clean homelike environment, 656-develop/Implement comprehensive care plan, F725- sufficient nursing staff, and F677- ADL care for dependent residents. As of 2/20/18 after the facility consultant in-service, the facility QAPI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools,	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 70 interventions that the committee put into place following the 1-27-17 annual recertification survey. 3: F561 (was F242) Self-Determination - Based on record review, staff interview, resident interview and resident observation the facility failed to provide 1 of 3 residents (resident #45) the choice of when to be out of bed and failed to provide 2 of 3 residents (Resident #45 and resident #80) showers for two and a half weeks when reviewed for activities of daily living (ADL) and failed to honor a resident's choice to have dinner in the dining room for 1 of 3 residents reviewed for choices (Resident # 124). During the recertification survey dated 1-27-17, the facility was cited for F242 for failing to honor the wishes of resident #38's responsible party to discontinue obtaining weights when care and comfort measures were initiated. During the current annual recertification survey dated 1-28-18 the facility failed to provide 1 of 3 residents (resident #45) the choice of when to be out of bed and failed to provide 2 of 3 residents (Resident #45 and resident #80) showers for two and a half weeks when reviewed for activities of daily living (ADL) and failed to honor a resident's choice to have dinner in the dining room for 1 of 3 residents reviewed for choices (Resident # 124). 4: F656 (was F279) Develop/Implement a comprehensive care plan - Based on record review and staff interviews the facility failed to develop a care plan to address activities of daily living (ADL) care, specifically toileting with no goals, measureable objectives or time frames for a dependent resident in 1 of 1 residents (resident #71).	F 867	review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F641-accuracy of assessments, F867-QAPI/QAA, F561 self-determination, F584- clean homelike environment, 656-develop/Implement comprehensive care plan, F725- sufficient nursing staff, and F677- ADL care for dependent residents. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAPI committee will continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 71 During the recertification survey dated 1-27-17 the facility was cited for F279 - failing to create a care plan for a resident for weight loss for 1 of 4 residents (resident #169). During the current annual recertification survey dated 1-28-18 the facility failed to develop a care plan to address activities of daily living (ADL) care, specifically toileting with no goals, measureable objectives or time frames for a dependent resident in 1 of 1 residents (resident #71). 5: F584 (was F253) Safe/Clean home like environment - Based on observation, staff and resident interviews the facility failed to provide an odor free environment and in walls, floor and windows for 4 out of 5 halls (100 hall, 200 hall, 300 hall and 400 hall). During the recertification survey dated 1-27-17 the facility was cited for F253 for failing to have functional closet doors in resident rooms #207, #209 and #211 and failed to have clean filters in the heating and air conditioning units (room #400, #405, #407 and #415) evident in 2 of 5 resident care units. During the current annual recertification survey dated 1-28-18 the facility failed to provide an odor free environment and in walls, floor and windows for 4 out of 5 halls (100 hall, 200 hall, 300 hall and 400 hall). Complaint investigation dated 9-20-17: 1: F677 (was 312) ADL care for a dependent resident - Based on resident observation, resident representative interview and staff interview the facility failed to provide Activities of Daily Living (ADL) care, incontinence care for 1 of 1 residents (resident #51).	F 867	The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 72 During the complaint investigation dated 9-20-17 the facility was cited for F312 - the facility failed to provide ADL care. During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide Activities of Daily Living (ADL) care, incontinence care for 1 of 1 residents (resident #51). 2: F725 (was F353) Sufficient nursing staff - Based on observations, record reviews, staff, family and resident interview the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403) During the complaint investigation dated 9-20-17 the facility was cited for F353 - The facility failed to provide sufficient nursing staff. During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403) Complaint investigation dated 9-7-17: 1: F725 (was F353) Sufficient nursing staff - Based on observations, record reviews, staff,	F 867		

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 73	F 867		

family and resident interview the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403)

During the complaint investigation dated 9-7-17 the facility was cited for F353 - The facility failed to provide nursing staff of sufficient quantity and quality to provide the required assistance needed with eating for 1 resident (Resident #3), apply equipment as ordered to maintain range of motion for 2 residents (resident #1 and resident #11) and provide a dignified dining experience for 1 resident (resident #1) for 3 of 7 residents that were dependent for care. During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403)

Complaint investigation dated 6-29-17:

1: F725 (was F353) Sufficient nursing staff - Based on observations, record reviews, staff, family and resident interview the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide

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 _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD 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 867	Continued From page 74	F 867		

incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403)

During the complaint investigation dated 6-29-17 the facility was cited for F353 - The facility failed to provide staff of sufficient quantity and quality to provide incontinence care and for residents who required assistance with meals. This effected 7 out of 12 residents (resident #1, resident #5, resident #6, resident #8, resident #9, resident #10 and resident #12). During the current annual recertification/complaint investigation dated 1-28-18 the facility failed to provide, staffing of sufficient quantity and quality to honor resident's choices, failed to provide supervision to prevent accidents, failed to provide incontinence care, toileting, and snack for residents who required assistance. This affected 8 of 131 residents. (Resident #33, Resident #45, Resident #51, Resident #54, Resident #71, Resident #74, Resident #80, and Resident #403).

An interview with the Administrator occurred on 2-1-18 at 5:45pm. The Administrator stated that quarterly the members consist of the Director of Nursing, the Medical Director, activities and the pharmacy consultant. She stated that the last meeting was 1-16-18 and the next scheduled quarterly was 4-17-18. During the interview the Administrator stated that the department heads meet monthly to discuss concerns and issues that cannot wait for the quarterly meeting and that she expected the team would meet in February to discuss improvements.