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 03/01/2018

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PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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F 600 SS=G	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 record reviewed and staff interviews, the facility failed to prevent neglect as evidenced by dressing changes not being completed as ordered for 1 of 3 resident reviewed for wound care (resident #1). Findings included: Resident #1 was admitted the facility on 10/12/17 with the diagnosis peripheral vascular disease, Alzheimer's disease and hypertension. The resident had a care plan in place for combativeness due to dementia (updated 12/27/17), pressure ulcers dated (updated 12/27/17), state of nutrition is less then body requirements (updated 12/28/17). A physician's wound note from the wound care doctor dated 2/2/18 revealed the resident had a wound to the left foot (the note did not say	F 600	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. F600	3/19/18

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

Electronically Signed | 03/19/2018

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F 600	Continued From page 1 specifically where), which measured 3 centimeter (cm) x 2 cm x 0.5 cm and this was the initial evaluation. The duration of the wound was 8 days and it had 80% necrotic tissue and 20% granulation tissue present. The wound underwent surgical debridement. A physician's order dated 2/2/18 revealed that the left ankle wound was to be packed with sterile gauze, Anasept and wrapped with Kerlix every day. The Treatment Administration Record (TAR) for the left ankle revealed to pack with sterile gauze with Anasept and wrap with Kerlix everyday starting on 2/2/18. The TAR revealed that it was completed on 2/2/17. The TAR was blank for the following dates of 2/3/18, 2/4/18 and 2/5/18. There was no nursing or progress noted for 2/3/18 through 2/5/18 that indicated wound care was completed for this resident. Nurse #1 (Worked 1st shift with the resident on 2/2/18 and supervisor of facility on 2/3/18, 2/4/18 and 2/5/18 for 1st shift) was interviewed on 2/28/18 at 2:02 PM. She stated that the resident was not alert and oriented and was very confused. The resident had an amputation to one of her legs and a wound to her other leg. The wound physician was seeing the wound. She stated that she didn't know of any new recent wounds that the resident had. The resident had behaviors all the time. She stated that nurses and medication aides on the hall were supposed to do the dressing changes but medication aides could do dressing changes to stage 1 and 2 wounds. Medication Aide #1 was interviewed on 2/28/18 at 2:11 PM. She stated the resident would swat at you. She stated that the resident had a wound on	F 600	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 for wound care. Resident #1 was discharged on 2/5/2018. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 3/19/18 the director of nursing (DON), assistant director of nursing (ADON) and/or the quality assurance (QI) nurse will complete a skin inspection of all residents currently in the facility. Any negative findings were immediately addressed by the auditor. This audit will ensure all wounds are identified and treatments are being provided as ordered. No neglect noted related to treatments. On 3/13/18 the facility hired a treatment nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a plan to ensure treatments are completed if a treatment nurse is not available. This plan is for the hall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by hall so that every resident is assessed every 7 days. On 3/9/18 the facility consultant	

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F 600	Continued From page 2 her knee of the amputated leg and a splint in place and would pick at the dressing sometimes. The resident also had another wound on her other foot. She stated that she went one time to help the wound care nurse with dressing change and the resident never refused care. After the wound care nurse stopped working at the facility, the nurses would have to change the dressings for residents. She stated that she never changed the dressing to the resident feet, legs or knees but just went in and assisted the wound care nurse one time. She stated that the Nursing Assistants (NA) would tell the supervising nurse if a bandage needed to be changed after they gave a resident a bath or in between giving medication. She stated if the wound was a stage 1 or 2, it would be documented in the treatment book. Nurse #8 (The supervisor on 2/3/17 and 2/4/17 on second shift) was interviewed on 2/28/18 at 2:42 PM. He stated he did not think he directly took care of the resident in February, 2018. The resident needed extensive assistance with care. He thought the resident had a wound on her knee and sacrum. He did not remember any wounds to her feet or ankles or about any dressing changes. The Administrator was interviewed on 2/28/18 at 3:19 PM. The wound doctor was doing the wound assessments every week. The nurses should also be doing the wound assessments. The wound care nurse stopped working at the facility about a month ago. Nurse #7 (rounds with wound care doctor weekly and SDC nurse) was interviewed on 2/28/18 at 3:59 PM. She stated that her job included rounding with the wound care doctor on Fridays. She stated this resident had a wound on her ankle. When she first saw the wound, it was a	F 600	in-serviced the DON on wound assessment, including documentation and completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. By 3/19/18 all licensed nurses, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This in-service will be part of the orientation process for all newly hired 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 By 4/1/18 the treatment nurse QI, ADON, and DON will have follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, and treatment completion. The DON, ADON, and/or QI nurse will audit all treatment administration records (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR audit tool. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds	

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F 600	Continued From page 3 stage 3 or so. She stated that had called the resident's family on 1/26/18 to get permission to do debridement of the wound. The resident's ankle was wrapped in Kerlix so she thinks the resident was getting dressing changes. On 2/2/17, the resident's family was at the bedside and the family wanted to see the wound. The family agreed to have it debrided. They dressed the wound on 2/2/18 and the family was at the bedside. She stated the ankle wound was white with blackish tissue around it and the black area was preventing it from healing. She thinks that the dressing changes were usually completed on the first shift for this resident. The resident was getting anacept to the ankle wound. Nurse #5 (worked with resident on 2/3/17 and 2/4/17 on 2nd shift) was interviewed on 2/28/18 at 4:19 PM. The resident was very confused but followed simple commands. The resident had wounds and she would do wound care for residents if there was no treatment nurse. The resident had wounds on her toes, knee and sacral area and vulva. She stated she never knew of a wound on the resident's ankle and had never completed a dressing change to her ankle. She stated that her dressing changes could be done at any time during the day. They have a treatment book and that was where they documented wound care. She stated that the Medication aides could only do wound care dressing changes that were simple. She stated 1st shift doesn't do dressing changes often and 2nd shift would try to do them. She stated that they don't have a wound care nurse anymore and they really need one as she was trying to just keep up. Medication Aide # 9 (worked 2nd shift on 2/2/18	F 600	weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound 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.	

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F 600	Continued From page 4	F 600		

and 2/3/18) was interviewed on 2/28/18 at 4:37 PM. She stated that she help the wound care doctor change a dressing a while ago but had never done dressing changes this month for this resident. She stated that the supervising nurse would do the wound care on 1st shift most of the time. The resident was getting dressing change completed in the morning unless something happens. She never knew of a wound to the resident's ankle.

Nurse #6 (worked on 2/3/18 and 2/4/18 on third shift and was the supervisor for the facility those days) was interviewed on 3/1/18 at 9:14 AM. She stated that the resident was asleep most of the time and was anxious at times. The resident could be restless at times. The resident had a wound to her inguinal area, left knee and sacral area. The resident was combative sometimes during care. The resident had many contractions and they tried to clean her as much as possible. She stated that she does not remember about a wound to the resident's foot/ankle area and had never completed/attempted a dressing change to a wound on her foot/leg. She only had completed a dressing to the resident's knee occasionally when the resident wound pull off the dressing. Since the treatment nurse left, the even numbered rooms, the 1st shift nurse would complete the dressing changes and the odd numbered rooms, 2nd shift would complete the dressing changes for. She does not recall anything about a wounds on the resident's ankle. She stated she could not even remember if the resident had a dressing on her foot or not before she was discharge. She stated she usually worked 300 and 400 halls and would have to cover when the Nursing Assistant called out. She stated they tried their best to do things for this

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F 600	Continued From page 5	F 600		

resident but they have to prioritize their work and she wouldn't necessary wake up this resident to change a dressings and typically another shift should do it. Wound care usually does not fall on her shift so she cannot say if the wound care was being done for residents but if she was told that it was not done then she would typically do it.

Nurse #2 (supervising nurse on 2/2/18 on second shift for this resident) was interviewed on 3/1/18 at 9:27 AM. She stated that usually she would work 200 hall and would supervise the 400 hall if there was a medication aide working. She stated that if they dressing changes to do, that 1st shift wound do the even numbered rooms and 2nd shift would do the odd numbered rooms for that hall. For major wounds, the nurses had to do the dressing changes. The medication aides were allowed to do skin preps and creams but not major dressing's changes. The medication aides and nurses are responsible for dressing changes now. She stated that she would typically go through the TAR and do the major dressing changes that needed to be completed for residents. She stated that she had never done dressing changes on this resident and doesn't remember the resident's wounds in particular but does remember the resident. She stated the resident's wound care should have been completed on 1st shift because she was in an even numbered room.

Nurse #4 (worked 1st shift on 2/3/18 and on 2/4/18) was interviewed on 3/1/18 at 9:51 AM. He stated the resident was only oriented to person. The resident had behaviors and had intermittent combativeness. However, he never personally witnessed the resident being combative. He knows the resident had a wound on her left knee

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F 600	Continued From page 6	F 600		

and coccyx area. He stated he does not recall any wounds to her other leg (non-amputated leg). He stated that he has only completed the dressing changed to the resident's knee and the resident would let him do the dressing change. If a dressing change is completed, it is documented on the TAR or in the nursing notes. Since there was no treatment nurse, the dressing change are not done as regularly.

Nurse #3 (worked on 2/2/18 on 3rd shift) was interviewed on 3/1/18 at 10:04 AM. She stated that she worked night shift from 11:00 PM to 7:00 AM. She stated she had never cared for any of the resident's wounds and did not know about them specifically because she had never changed the dressings. The resident would be resistive with care but she usually could provide her with care. At night, if there was a new wound then she wound do the wound care if needed.

A nursing note dated 2/5/18 revealed that at 1:30 PM, the resident's family and relative stated there was something wrong with the resident. Vitals were taken and revealed the following: Temperature was 99.7, heart rate was 114 and irregular, respirations were 20 and blood pressure was 110/70. The writer was unable to hear breath sounds and the physician was notified. The resident's family insisted that the resident needed to go to the hospital and Emergency Medical Services (EMS) were called and the resident was transported at 1:45 PM to the hospital.

The resident was admitted to the hospital on 2/5/18.

Hospital records dated 2/5/18 revealed that the resident was admitted to the hospital. Hospital

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F 600	Continued From page 7	F 600		

records revealed the resident presented to the hospital with a wound to her left ankle that measured 7 cm x 3 cm and had exposed underlying tendon, black eschar and smelled infected per the Emergency department note. Hospital records also revealed that the resident was diagnosed with sepsis with the suspected source related to infected wound to her ankle as it was the worst. Antibiotics were started and it was recommended that the resident had an above the knee amputation. However, the risks were spoken with to the family and the resident was placed on hospice care instead and transferred to a skilled nursing facility.

Resident's #1 discharge Minimum Data Set dated 2/5/18 revealed that the resident was severely cognitively impaired for daily decision making and had short term memory problems. The resident had behaviors of rejection of care 1 to 3 days per week and physical behavioral symptoms that occurred 1 to 3 days. The resident required extensive assistance with bed mobility, locomotion and eating. The resident required total assistance with personal hygiene, toilet use, dressing and transfers. The resident was always incontinent of bowel and of bladder. The resident had a stage 3 pressure ulcer and 1 stage 4 pressure ulcer. The pressure ulcer measured 2.8 cm x 2.1 cm x 00.2 cm.

The Wound Care Doctor was interviewed on 3/1/18 at 10:38 AM. The resident had a wound to her foot near the ankle that had occurred at the facility (when asked specifically about where the new left foot wound was in his note). He thought that nursing discovered the wound but wasn't sure. The wound started as a scab and at some point had deteriorated. The last time he saw the

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F 600	Continued From page 8	F 600		

wound it was covered in necrotic tissue and it was debrided. He stated he assumed that the dressing changes were being done and had not been told otherwise. It was just a scab earlier on his previous assessment then had formed into a wound. He stated that he didn't know of any concerns with wound care and they used to have a great wound care nurse. Since she was not here anymore, he thought the wound care was still being completed. He did not think that the wound was avoidable. The resident had an above the knee amputation already and had multiple contractures. The resident would always let him do they wound care but had dementia and he thought it may have been difficult for staff at times.

The Administrator was interviewed on 3/1/18 at 12:51 PM. She stated that the wounds had gotten worse and the resident was combative with staff and had an above the knee amputation with vascular issues. The family had come back to the facility after the resident was discharged and said they were possibly amputating the resident's other leg. She stated that she read the hospital notes and the hospital said the resident was not doing that bad. The treatments for dressing changed were being completed by the hall nurses and the wound care doctor was seeing the resident. There were no concern of dressing changes that she knew of. Usually the dressing changes were completed daily and documented on the TAR. The medication aide could complete a stage 1 and 2 pressure ulcer but a nurse were the only ones that could stage a wound. She stated that the wound care nurse's last work day was on 1/14/18. She stated she would expect for there to be adequate staffing to provide wound care to residents.

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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 code significant weight loss that was not a physician prescribed on a Minimum Data Set assessment for 1 of 3 residents reviewed for nutrition (Resident #1). The findings included: Resident #1 was admitted the facility on 10/12/17 with the diagnosis of pneumonia, pressure ulcer and Alzheimer's disease. A physician's order dated 11/24/17 revealed that the resident was on a regular, ground textured diet. Resident #1 had a care plan in place for eating (dated 12/13/17) and for nutrition was less than the body's requirements related to inadequate intake (dated 12/28/17). A note from the Registered Dietitian (RD) dated 1/16/18 revealed Resident #1 required full assistance with meals, was getting ice cream with lunch and dinner and mashed potatoes with gravy at lunch and dinner. The Resident was on regular ground diet and was getting 2 different nutrional supplements. The resident had a 14.6 % weight loss in the last 3 months and her weight was 106 pounds. Weights were reviewed and revealed on 1/4/18, Resident #1 weighed 106 pounds and on 2/2/18,	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 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 with significant weight loss that was not physician prescribed related to knowledge deficit. On 3/1/18 resident # 1□s MDS dated	3/19/18

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F 641	Continued From page 10	F 641		

the resident weighed 99 pounds. This revealed that the resident had a significant weight loss of 6.60% in the last month.

Resident's #1 discharge Minimum Data Set (MDS) dated 2/5/18 revealed the Resident #1 had severely impaired cognition for daily decision making and had short term memory problems. The resident required extensive assistance with eating. The discharge MDS noted the resident weighed 99 pounds, was 86 inches in height and was on a physician prescribed weight loss regimen.

The Registered Dietitian (RD) was interviewed on 2/28/18 at 2:12 PM. The RD stated Resident #1 had 14.5 % weight loss in the 3 months according to her note in January. The Resident had been ordered 2 different types of nutritional supplements for weight loss and was taking her supplements. The Resident was on a regular, ground diet and was getting ice cream, mashed potatoes with gravy and supplements with meals. She stated the Resident #1 was never on a planned weight loss diet and the MDS Nurse had coded that section of the discharge MDS.

The MDS Nurse was interviewed on 2/28/18 at 2:50 PM. She stated she coded the nutrition section of the MDS dated 2/5/18 and Resident #1 did have significant weight loss. She stated the discharge MDS dated 2/5/18 revealed that Resident #1 was on a prescribed weight loss regimen and this was an error as the resident was not on a physician prescribed weight loss regimen. She added that normally dietary would code this section but the RD must have been out because she coded this section of the MDS. The MDS Nurse explained that she normally reviewed 2/5/18 was modified by the minimum data set nurse (MDS). The modified assessment was submitted and accepted by the national repository on 3/1/18.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited
On 3/8/18 the facility consultant completed an audit of minimum data set (MDS) assessment completed and transmitted in the past 90 days to ensure section K coding for weight loss was correct. Five MDS assessments were noted to be coded incorrectly for physician prescribed weight loss in section K.
On 3/9/18 the dietary manager modified the 5 incorrectly coded MDS section K□s.
On 3/8/18 the facility consultant in-serviced the MDS coordinator on MDS accuracy to reflect the residents current status including coding of section K based on the RAI manual.
On 3/9/18 the facility consultant in-serviced the dietary manger on MDS accuracy to reflect the residents current status including coding of section K based on the RAI manual.
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, MDS coordinator, or administrator will audit 100% of submitted MDS assessments weekly x 4 weeks then 50% of submitted MDS assessments x 8 weeks to ensure section K is accurately coded to reflect 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 03/01/2018

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 11 the dietary notes, physician's orders for supplements and the resident's actual weights in order to code this section correctly. The Administrator was interviewed on 3/1/18 at 12:51 PM. She stated the MDS should accurately reflect the resident's current health status.	F 641	residents current status 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 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 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 684	An acceptable plan of correction must	3/19/18

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 03/01/2018

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PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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F 684	Continued From page 12 facility failed to complete dressing changes for a wound for 1 of 3 resident reviewed for wound care (Resident #1). Findings included: Resident #1 was admitted the facility on 10/12/17 with the diagnosis peripheral vascular disease, Alzheimer's disease and hypertension. The resident had a care plan in place for combativeness due to dementia (updated 12/27/17), pressure ulcers dated (updated 12/27/17), state of nutrition is less then body requirements (updated 12/28/17). A physician's wound note from the wound care doctor dated 2/2/18 revealed the resident had a wound to the left foot (the note did not say specifically where), which measured 3 centimeter (cm) x 2 cm x 0.5 cm and this was the initial evaluation. The duration of the wound was 8 days and it had 80% necrotic tissue and 20% granulation tissue present. The wound underwent surgical debridement. A physician's order dated 2/2/18 revealed that the left ankle wound was to be packed with sterile gauze, Anasept and wrapped with Kerlix every day. The Treatment Administration Record (TAR) for the left ankle revealed to pack with sterile gauze with Anasept and wrap with Kerlix everyday starting on 2/2/18. The TAR revealed that it was completed on 2/2/17. The TAR was blank for the following dates of 2/3/18, 2/4/18 and 2/5/18. There was no nursing or progress noted for	F 684	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-failed to complete dressing changes for a wound was staff failure to follow established policy related to knowledge deficit. Resident #1 was discharged to the emergency room on 2/5/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 3/19/18 the director of nursing (DON), assistant director of nursing (ADON)	

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 03/01/2018

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

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F 684	Continued From page 13 2/3/18 through 2/5/18 that indicated wound care was completed for this resident. Nurse #1 (Worked 1st shift with the resident on 2/2/18 and supervisor of facility on 2/3/18, 2/4/18 and 2/5/18 for 1st shift) was interviewed on 2/28/18 at 2:02 PM. She stated that the resident was not alert and oriented and was very confused. The resident had an amputation to one of her legs and a wound to her other leg. The wound physician was seeing the wound. She stated that she didn't know of any new recent wounds that the resident had. The resident had behaviors all the time. She stated that nurses and medication aides on the hall were supposed to do the dressing changes but medication aides could do dressing changes to stage 1 and 2 wounds. Medication Aide #1 was interviewed on 2/28/18 at 2:11 PM. She stated the resident would swat at you. She stated that the resident had a wound on her knee of the amputated leg and a splint in place and would pick at the dressing sometimes. The resident also had another wound on her other foot. She stated that she went one time to help the wound care nurse with dressing change and the resident never refused care. After the wound care nurse stopped working at the facility, the nurses would have to change the dressings for residents. She stated that she never changed the dressing to the resident feet, legs or knees but just went in and assisted the wound care nurse one time. She stated that the Nursing Assistants (NA) would tell the supervising nurse if a bandage needed to be changed after they gave a resident a bath or in between giving medication. She stated if the wound was a stage 1 or 2, it would be documented in the treatment book.	F 684	and/or the quality assurance (QI) nurse will complete a skin inspection of all residents currently in the facility. Any negative findings were immediately addressed by the auditor. This audit will ensure all wounds are identified and treatments are being provided as ordered. On 3/13/18 the facility hired a treatment nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a plan to ensure treatments are completed if a treatment nurse is not available. This plan is for the hall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by hall so that every resident is assessed every 7 days. On 3/9/18 the facility consultant in-serviced the DON on wound assessment, including documentation and completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. By 3/19/18 all licensed nurses, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This in-service will be part of the orientation process for all newly hired licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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 03/01/2018

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 14 Nurse #8 (The supervisor on 2/3/17 and 2/4/17 on second shift) was interviewed on 2/28/18 at 2:42 PM. He stated he did not think he directly took care of the resident in February, 2018. The resident needed extensive assistance with care. He thought the resident had a wound on her knee and sacrum. He did not remember any wounds to her feet or ankles or about any dressing changes. The Administrator was interviewed on 2/28/18 at 3:19 PM. The wound doctor was doing the wound assessments every week. The nurses should also be doing the wound assessments. The wound care nurse stopped working at the facility about a month ago. Nurse #7 (rounds with wound care doctor weekly and SDC nurse) was interviewed on 2/28/18 at 3:59 PM. She stated that her job included rounding with the wound care doctor on Fridays. She stated this resident had a wound on her ankle. When she first saw the wound, it was a stage 3 or so. She stated that had called the resident's family on 1/26/18 to get permission to do debridement of the wound. The resident's ankle was wrapped in Kerlix so she thinks the resident was getting dressing changes. On 2/2/17, the resident's family was at the bedside and the family wanted to see the wound. The family agreed to have it debrided. They dressed the wound on 2/2/18 and the family was at the bedside. She stated the ankle wound was white with blackish tissue around it and the black area was preventing it from healing. She thinks that the dressing changes were usually completed on the first shift for this resident. The resident was getting anacept to the ankle wound. Nurse #5 (worked with resident on 2/3/17 and	F 684	and/or in compliance with the regulatory requirements By 4/1/18 the treatment nurse QI, ADON, and DON will have follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, and treatment completion. The DON, ADON, and/or QI nurse will audit all treatment administration records (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR audit tool. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound 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.	

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 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15 2/4/17 on 2nd shift) was interviewed on 2/28/18 at 4:19 PM. The resident was very confused but followed simple commands. The resident had wounds and she would do wound care for residents if there was no treatment nurse. The resident had wounds on her toes, knee and sacral area and vulva. She stated she never knew of a wound on the resident's ankle and had never completed a dressing change to her ankle. She stated that her dressing changes could be done at any time during the day. They have a treatment book and that was where they documented wound care. She stated that the Medication aides could only do wound care dressing changes that were simple. She stated 1st shift doesn't do dressing changes often and 2nd shift would try to do them. She stated that they don't have a wound care nurse anymore and they really need one as she was trying to just keep up. Medication Aide # 9 (worked 2nd shift on 2/2/18 and 2/3/18) was interviewed on 2/28/18 at 4:37 PM. She stated that she help the wound care doctor change a dressing a while ago but had never done dressing changes this month for this resident. She stated that the supervising nurse would do the wound care on 1st shift most of the time. The resident was getting dressing change completed in the morning unless something happens. She never knew of a wound to the resident's ankle. Nurse #6 (worked on 2/3/18 and 2/4/18 on third shift and was the supervisor for the facility those days) was interviewed on 3/1/18 at 9:14 AM. She stated that the resident was asleep most of the time and was anxious at times. The resident could be restless at times. The resident had a wound to her inguinal area, left knee and sacral	F 684	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 03/01/2018

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F 684	Continued From page 16	F 684		

area. The resident was combative sometimes during care. The resident had many contractions and they tried to clean her as much as possible. She stated that she does not remember about a wound to the resident's foot/ankle area and had never completed/attempted a dressing change to a wound on her foot/leg. She only had completed a dressing to the resident's knee occasionally when the resident wound pull off the dressing. Since the treatment nurse left, the even numbered rooms, the 1st shift nurse would complete the dressing changes and the odd numbered rooms, 2nd shift would complete the dressing changes for. She does not recall anything about a wounds on the resident's ankle. She stated she could not even remember if the resident had a dressing on her foot or not before she was discharge. She stated she usually worked 300 and 400 halls and would have to cover when the Nursing Assistant called out. She stated they tried their best to do things for this resident but they have to prioritize their work and she wouldn't necessary wake up this resident to change a dressings and typically another shift should do it. Wound care usually does not fall on her shift so she cannot say if the wound care was being done for residents but if she was told that it was not done then she would typically do it.

Nurse #2 (supervising nurse on 2/2/18 on second shift for this resident) was interviewed on 3/1/18 at 9:27 AM. She stated that usually she would work 200 hall and would supervise the 400 hall if there was a medication aide working. She stated that if they dressing changes to do, that 1st shift wound do the even numbered rooms and 2nd shift would do the odd numbered rooms for that hall. For major wounds, the nurses had to do the dressing changes. The medication aides were

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 03/01/2018

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

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F 684	Continued From page 17	F 684		

allowed to do skin preps and creams but not major dressing's changes. The medication aides and nurses are responsible for dressing changes now. She stated that she would typically go through the TAR and do the major dressing changes that needed to be completed for residents. She stated that she had never done dressing changes on this resident and doesn't remember the resident's wounds in particular but does remember the resident. She stated the resident's wound care should have been completed on 1st shift because she was in an even numbered room.

Nurse #4 (worked 1st shift on 2/3/18 and on 2/4/18) was interviewed on 3/1/18 at 9:51 AM. He stated the resident was only oriented to person. The resident had behaviors and had intermittent combativeness. However, he never personally witnessed the resident being combative. He knows the resident had a wound on her left knee and coccyx area. He stated he does not recall any wounds to her other leg (non-amputated leg). He stated that he has only completed the dressing changed to the resident's knee and the resident would let him do the dressing change. If a dressing change is completed, it is documented on the TAR or in the nursing notes. Since there was no treatment nurse, the dressing change are not done as regularly.

Nurse #3 (worked on 2/2/18 on 3rd shift) was interviewed on 3/1/18 at 10:04 AM. She stated that she worked night shift from 11:00 PM to 7:00 AM. She stated she had never cared for any of the resident's wounds and did not know about them specifically because she had never changed the dressings. The resident would 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 03/01/2018

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

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F 684	Continued From page 18	F 684		

resistive with care but she usually could provide her with care. At night, if there was a new wound then she wound do the wound care if needed.
A nursing note dated 2/5/18 revealed that at 1:30 PM, the resident's family and relative stated there was something wrong with the resident. Vitals were taken and revealed the following: Temperature was 99.7, heart rate was 114 and irregular, respirations were 20 and blood pressure was 110/70. The writer was unable to hear breath sounds and the physician was notified. The resident's family insisted that the resident needed to go to the hospital and Emergency Medical Services (EMS) were called and the resident was transported at 1:45 PM to the hospital.
The resident was admitted to the hospital on 2/5/18.

Hospital records dated 2/5/18 revealed that the resident was admitted to the hospital. Hospital records revealed the resident presented to the hospital with a wound to her left ankle that measured 7 cm x 3 cm and had exposed underlying tendon, black eschar and smelled infected per the Emergency department note. Hospital records also revealed that the resident was diagnosed with sepsis with the suspected source related to infected wound to her ankle as it was the worst. Antibiotics were started and it was recommended that the resident had an above the knee amputation. However, the risks were spoken with to the family and the resident was placed on hospice care instead and transferred to a skilled nursing facility.

Resident's #1 discharge Minimum Data Set dated 2/5/18 revealed that the resident was severely cognitively impaired for daily decision making and had short term memory problems. The resident

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 03/01/2018

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

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F 684	Continued From page 19	F 684		

had behaviors of rejection of care 1 to 3 days per week and physical behavioral symptoms that occurred 1 to 3 days. The resident required extensive assistance with bed mobility, locomotion and eating. The resident required total assistance with personal hygiene, toilet use, dressing and transfers. The resident was always incontinent of bowel and of bladder. The resident had a stage 3 pressure ulcer and 1 stage 4 pressure ulcer. The pressure ulcer measured 2.8 cm x 2.1 cm x 00.2 cm.

The Wound Care Doctor was interviewed on 3/1/18 at 10:38 AM. The resident had a wound to her foot near the ankle that had occurred at the facility (when asked specifically about where the new left foot wound was in his note). He thought that nursing discovered the wound but wasn't sure. The wound started as a scab and at some point had deteriorated. The last time he saw the wound it was covered in necrotic tissue and it was debrided. He stated he assumed that the dressing changes were being done and had not been told otherwise. It was just a scab earlier on his previous assessment then had formed into a wound. He stated that he didn't know of any concerns with wound care and they used to have a great wound care nurse. Since she was not here anymore, he thought the wound care was still being completed. He did not think that the wound was avoidable. The resident had an above the knee amputation already and had multiple contractures. The resident would always let him do they wound care but had dementia and he thought it may have been difficult for staff at times.

The Administrator was interviewed on 3/1/18 at 12:51 PM. She stated that the wounds had gotten

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 03/01/2018

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 20 worse and the resident was combative with staff and had an above the knee amputation with vascular issues. The family had come back to the facility after the resident was discharged and said they were possibly amputating the resident's other leg. She stated that she read the hospital notes and the hospital said the resident was not doing that bad. The treatments for dressing changed were being completed by the hall nurses and the wound care doctor was seeing the resident. There were no concern of dressing changes that she knew of. Usually the dressing changes were completed daily and documented on the TAR. The medication aide could complete a stage 1 and 2 pressure ulcer but a nurse were the only ones that could stage a wound. She stated that the wound care nurse's last work day was on 1/14/18. She stated she would expect for there to be adequate staffing to provide wound care to residents.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		3/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 by: Based on record review and staff interviews, the facility failed to assess a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #2). Findings included: 1. Resident #2 was admitted to the facility on 8/11/14 with the current diagnosis of dementia, Parkinson's disease, peripheral vascular disease and multiple contractures. Resident #2 quarterly Minimum Data Set (MDS) dated 12/22/17 revealed that the resident was not cognitively intact. The resident required extensive assistance with bed mobility and transfers, dressing and eating and total assistance with locomotion, toilet us and personal hygiene. The resident was always incontinent of bowel and bladder. The resident had no unhealed pressure ulcers noted but had a reducing pressure device for the bed. The resident had a care plan in place updated on 1/30/18 for pressure ulcers. A wound care assessment dated 1/2/18 revealed that resident #2 had a wound to his right heel which occurred in house that measured 0.5 cm x 0.3 cm x 0 cm and was unstageable. The resident's representative and physician was notified on 1/2/18. Physician's orders dated 1/2/18 revealed that the resident had current order to cleanse the area with wound cleanser, pat dry and apply medihoney and a dry dressing and to change every 2 days.	F 686	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. F686 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 assess a pressure ulcer- was staff failure to follow established policy and procedure. Resident # 2 had a skin check completed on 3/2/18 by facility nurse. Resident #2□s right heel wound was assessed and documented in the skin check on 3/2/18 by facility nurse. 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 03/01/2018

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 686	Continued From page 22 Another wound care assessment dated 1/9/18 revealed that the resident had a wound to his right heel, which measured 0.5 cm x 0.2 cm x 0 cm. A note from the wound care doctor dated 2/1/18 revealed the resident had a pressure ulcer to his heel that was unstageable and this was a chronic wound. The resident also had a sacral wound, which had now resolved. There was no wound care assessment or skin checks or documentation of wound measurements of the wound from 2/2/18 through 3/1/18 on the resident's paper or electronic chart. There were no other wound assessments from the physician from 2/1/18 to 3/1/18. The TAR was reviewed for 2/2018 and revealed that dressing changes were being completed as ordered. Wound care was observed on 2/28/18 at 12:26 PM. The resident had a wound approximately the size of a quarter dollar to his right outer heel. It was circular in size and approximately 80% was yellow/white colored tissue. The wound had a moderate of yellow drainage on the old dressing. The dressing change was performed as ordered by nurse #8. The Administrator was interviewed on 2/28/18 at 3:19 PM. She stated that the wound doctor was doing the wound assessment every week on wounds. The nurses should also be doing the wound assessments. The wound care nurse stopped working at the facility about a month ago. The nurses were supposed to be documenting	F 686	specific deficiency cited By 3/19/18 the director of nursing (DON), assistant director of nursing (ADON) and/or the quality assurance (QI) nurse will complete a skin inspection of all residents currently in the facility. Any negative findings were immediately addressed by the auditor. This audit will ensure all wounds are identified, assessments completed, and treatments are being provided as ordered. On 3/13/18 the facility hired a treatment nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a plan to ensure treatments and wounds assessments are completed if a treatment nurse is not available. This plan is for the hall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by hall so that every resident is assessed every 7 days. On 3/9/18 the facility consultant in-serviced the DON on wound assessment, including documentation and completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. By 3/19/18 all licensed nurses, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This in-service will be part of the 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 03/01/2018

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F 686	Continued From page 23 the skin assessment in the electronic documentation system. The Nursing Assistants (NA) do the full skin checks and only document if there is a new skin issue and would tell the nurse and the nurse would put it in the computer system. She stated they are working on the skin checks and that they have had a lot of staff turnover lately. The wound care doctor would not do a full skin check on the residents. Nurse #7 was interviewed on 2/28/18 at 3:59 PM. She stated that she would round with the wound care doctor on Fridays. She stated the nurses are responsible for doing the skin check and the NAs would report any issues to the nurse. In the nurse's note, there was something about skin checks being completed and the NA's would check the resident's skin when they give baths to residents. She stated that the wounds should be measured. She stated that she was not sure how often the wound were supposed to be measured or where it should be documented. She stated that she just rounds with the physician and then makes sure the order is written in the TAR as well as in the orders. Nurse #8 nurse was interviewed on 2/28/17 at 4:46 PM. He stated that the NA's would look the resident's skin then the nurse will go and look at the skin if there was an skin issue. The treatment nurse was measuring the wounds when he was here. He stated that he tried his best to get to everything. He stated he hopes that the wounds were being measured but wasn't sure where that would be documented. He stated that it was not communicated to him about being responsible for measuring the wounds since they don't have a wound care nurse. He stated that if a skin check was done and there was no skin problems, he	F 686	process for all newly hired 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 DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound 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.	

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	345144	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 686	Continued From page 24	F 686		

wasn't sure if it was even documented but stated that he would usually try to put a note in about it.

Nurse #5 was interviewed on 2/28/18 at 4:19 PM. She stated she wasn't sure who was doing the skin checks/assessments for residents. The NA's would usually report it to them if the resident had new skin breakdown. She stated she wasn't sure who was doing the skin assessments for residents (when asked about Resident #2 skin assessments).

Nurse #2 was interviewed on 3/1/18 at 9:27 AM. She stated that she was not sure who was measuring/assessing/documenting the wounds now that there was no wound care nurse. She stated that maybe the administrator would know who supposed to do the skin assessments but she was not sure.

Nurse #9 was interviewed on 3/1/18 at 10:15 AM. She stated that the resident was alert but was very confused. She stated that she had no time to do treatments and it is to be done early on the night shift unless the dressing comes off. She thinks that Nurse #10 measured the wounds. She stated that when she started here, she talked to the facility about not having to do dressing changes because she already had so much to do. She stated that she does not do this resident's dressing change unless it is needed. She stated that she think nurse #10 does the wound care and measurement.

Nurse #10 was attempted to be interviewed but attempts were unsuccessful.

Nursing Assistant #1 was interviewed on 3/1/18 at 11:01 AM. She stated that the resident could only

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 03/01/2018

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F 686	Continued From page 25	F 686		

say simple commands and had no behaviors that she knew of. The resident will let them reposition him and change him. She stated that the nurses do the dressing changes to his wound.

The Nurse Practitioner was interviewed on 3/1/18 at 12:46 PM. She stated that the resident had a wound on his right heel that was unstageable. She stated that she sees the patient monthly unless there was something acute going on. She stated that when she comes in, she would measure the wounds. She stated she was not made aware of any concerns related to the wounds and would expect that the wound were being assessed weekly.

The administrator was interviewed on 3/1/18 at 1:24 PM. She stated that the resident had a wound to his heel and no concerns have been brought to her attention. The nurses were responsible for measuring wounds every 7 days. She stated that she would expect measurements/assessments of wounds would be documented in a wound ulcer flowsheet in the electronic chart.

The corporate nurse consultant stated on 3/1/18 at 1:24 PM stated there used to be skin assessment sheets for skin checks that the Nursing Assistants would draw on if there was an issue with the resident's skin. She stated that she went to check for these sheet for resident #2. However, she stated that she could not find any of these sheets for resident #2 and had interviewed some NAs and they stated they do not use those sheets anymore. She also added that these sheets that the NA's would draw wounds on were not a part of the resident's official medical record.

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	345144	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 725 SS=D	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 record reviews, observations, and staff interviews, the facility failed to provide sufficient nursing staff to provide dressing changes for one resident and properly assess one resident's pressure ulcers for 2 of 3 resident reviewed for wound care (Resident #1, Resident #2).	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 cited; " The procedure for implementing the acceptable plan of correction for the	3/19/18

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 03/01/2018

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F 725	Continued From page 27 Findings included: This tag was crossed referenced to: F684: Based on record review and staff interviews, the facility failed to complete dressing changes for a wound for 1 of 3 resident reviewed for wound care (resident #1). F686: Based on record review and staff interviews, the facility failed to assess a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #2). Nurse #2 was interviewed on 3/1/18 at 9:27 AM. She stated that the acuity of the residents isn't as bad as it was before, if she was the supervising nurse for a few halls then she would have 55 to 60 resident and would be supervising the medication aide. She stated that amount of residents was overwhelming and the staff had verbalized their concerns to administration. She stated there was a time when they were able to effectively do their medication passes and treatments but now they couldn't like they used to. She stated that many times she has to stay late at the facility to get things done. The turnover is really fast and she stated that she wasn't exactly sure when the staffing issue started. She stated that the work was quite overwhelming but they just try to keep on working the best they can. Nurse #4 was interviewed on 3/1/18 at 9:51 AM. He stated there was not enough staff to get the dressings done regularly for all residents. Since there was no treatment nurse, the dressing changes were not done as regularly. He stated that when he was supervising the medication aide, he would have 60 patients. If he was not	F 725	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 dressing changes for one resident and properly assess one resident□s pressure ulcers was failure to communicate staffing need. Resident #1 was discharged to the emergency room on 2/5/18. Resident # 2 had a skin check completed on 3/2/18 by facility nurse. Resident #2□s right heel wound was assessed and documented in the skin check on 3/2/18 by facility nurse. Facility is actively recruiting and hiring nursing staff utilizing online resources, and onsite interviews when an application is submitted. Facility is utilizing incentive pay for facility staff to cover as needed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited	

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	345144	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 725	Continued From page 28 supervising the medication aide then he would have 30 patients or so. Nurse #5 (worked with resident #1 on 2/3/17 and 2/4/17 on 2nd shift) was interviewed on 2/28/18 at 4:19 PM. She stated that the staffing was horrible. She stated 1st shift doesn't do dressing changes often and 2nd shift would try to do them. She stated that they don't have a wound care nurse anymore and they really need one as she was trying to just keep up. She stated she wasn't sure who was doing the skin assessments for residents (when asked about Resident #2 skin assessments). The NA's would usually report it to the nurse if the resident had any new skin breakdown. A nurse was the one responsible for measuring/assessing resident's wounds but there were typically only 2 nurses for halls 300 and 400 and for the extension hall (which has 8 residents on it) and they just don't have anyone to help them (nurses). Nurse #6 was interviewed on 3/1/18 at 9:14 AM. She stated that the facility was trying to hire staff. She stated the nurses tried their best to do things for Resident #1 but they have to prioritize their work and she wouldn't necessary wake up Resident #1 up to change a dressing and typically another shift should do it. She stated she was so busy and she won't get a break sometimes. She stated that she typically has 52 resident and at night they don't have any medications aides. It's hard and she has to act fast and hope there was no acute episodes that she runs into. She stated that if something acute happens then she would be behind on her medication pass. Wound care usually does not fall on her shift so she cannot say if the wound care was being done for residents but if she was told that it was not done	F 725	By 3/19/18 the director of nursing (DON), assistant director of nursing (ADON) and/or the quality assurance (QI) nurse will complete a skin inspection of all residents currently in the facility. Any negative findings were immediately addressed by the auditor. This audit will ensure all wounds are identified, assessments completed, and treatments are being provided as ordered. On 3/13/18 the facility hired a treatment nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a plan to ensure treatments, and wound assessments are completed if a treatment nurse is not available. This plan is for the hall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by hall so that every resident is assessed every 7 days. On 3/9/18 the facility consultant in-serviced the DON on wound assessment, including documentation and completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. By 3/19/18 all licensed nurse, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This in-service will be part of the orientation process for all newly hired licensed nurses.	

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	345144	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 725	Continued From page 29 then she would typically do it. The administrator was interviewed on 3/1/18 at 12:51 PM. The treatments for dressing changed were being completed by the hall nurse and the wound care doctor was seeing Resident #1. There were no concerns regarding dressing changes that she knew about. Usually the dressing changes were completed daily and documented on the Treatment Administration Record. The medication aide could complete treatments for a stage 1 and 2 pressure ulcer but nurses were the only ones that can stage a wound. She stated that the wound care nurse's last work day was on 1/14/18. She stated she would expect for there to be adequate staffing to provide wound care to residents. She stated they are interviewing staff and trying to recruit staff. She stated they did just hire an administration nursing team (Director of nursing and Associate Director of Nursing).	F 725	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 By 4/1/18 the treatment nurse QI, ADON, and DON will have follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, and treatment completion. The DON, ADON, and/or QI nurse will audit all treatment administration records (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR audit tool. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool. The administrator or director if nursing will review staffing 5 times weekly x 12 weeks to include weekend staffing to ensure staffing is adequate to provide treatments as ordered, and wounds are assessed. 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,	

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	345144	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 725	Continued From page 30	F 725	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 835 SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility's administration failed to provide leadership and management to ensure the needs of the resident were met in the areas of wound care and treatments (Resident #1, Resident #2).The failure of administration to address these concerns resulted in one resident's hospitalization for sepsis related to an infected ankle wound (Resident #1). Finding Included:	F 835	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	3/19/18

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 03/01/2018

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F 835	Continued From page 31 This tag is cross referenced to F684: Based on record review and staff interviews, the facility failed to complete dressing changes for a wound for 1 of 3 resident reviewed for wound care (resident #1). F686: Based on record review and staff interviews, the facility failed to assess a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #2). The Administrator (Director of Nursing, Associate Director of Nursing, and corporate consultant were present) was interviewed on 3/1/18 at 12:51 PM. She stated she would expect for there to be adequate staffing to provide wound care to residents. She stated they were interviewing staff and trying to recruit staff. She stated they did just hire an administration nursing team (Director of Nursing and Associate Director of Nursing). She stated they have a quality assurance meeting every two months and she would expect for the quality assurance committee to recognize and address any quality issues/concerns. She stated there were no concerns about wound dressing changes that she knew of.	F 835	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. F835 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency-facility administration failed to provide leadership and management to ensure the needs of residents were met in the areas of wound care and treatments was lack of knowledge. Resident #1 was discharged to the emergency room on 2/5/18. Resident # 2 had a skin check completed on 3/2/18 by facility nurse. Resident #2□s right heel wound was assessed and documented in the skin check on 3/2/18 by facility nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 3/19/18 the director of nursing (DON), assistant director of nursing (ADON) and/or the quality assurance (QI) nurse will complete a skin inspection of all residents currently in the facility. Any negative findings were immediately	

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F 835	Continued From page 32	F 835	addressed by the auditor. This audit will ensure all wounds are identified, assessments completed, and treatments are being provided as ordered. On 3/13/18 the facility hired a treatment nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a plan to ensure treatments, and wound assessments are completed if a treatment nurse is not available. This plan is for the hall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by hall so that every resident is assessed every 7 days. On 3/9/18 the facility consultant in-serviced the DON on wound assessment, including documentation and completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. On 3/12/18 the administrator was in-serviced by the facility consultant on a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including wound care and treatments. By 3/19/18 all licensed nurse, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This	

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 03/01/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 33	F 835		

in-service will be part of the orientation process for all newly hired licensed nurses.
On 3/16/18 the administrator reviewed all above audits and in-services.

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 DON, ADON, and/or QI nurse will audit all treatment administration records (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR audit tool. The administrator will review this completed audit tool weekly x 12 weeks to ensure treatments were completed.
The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool. The administrator will review this completed audit tool weekly x 12 weeks to ensure wound care (assessments) have been completed.

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

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 03/01/2018

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 835	Continued From page 34	F 835	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.	