STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/25/19

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

Electronically Signed | 01/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to treat Resident #67 in a dignified manner causing the resident to feel "worthless" and also failed to provide a privacy cover for a urinary catheter drainage bag to promote Resident #135 ' s dignity for 2 of 4 residents reviewed for dignity and respect. The findings included: 1. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included heart failure, dependence on supplemental oxygen, anxiety, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67 ' s cognition was fully intact. She was assessed with no behaviors and no rejection of care. Resident #67 required the extensive assistance of 2 or more for bed mobility, dressing, toileting, and personal hygiene. She was dependent on 2 or more for transfers. Resident #67 had impairment on both sides of her lower extremities and she utilized a wheelchair. An interview was conducted with Resident #67 on 12/17/18 at 9:29 AM. Resident #67 stated that during the most recent weekend (12/15/18 or 12/16/18) she had asked a staff member to pull out one of the drawers on her dresser and place it on her bed, so she could look for one of her	F 550	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. Based on record review, observation, resident interview, and staff interview, the facility failed to treat resident #67 in a dignified manner, causing her to feel "worthless" and also failed to provide a privacy cover for a urinary catheter drainage bag to promote resident #135's dignity. NA#6 was in-serviced and disciplined on policy infractions by the Director of Nursing (DON) on 1/19/2019. A dignity bag was placed on the foley drainage bag for resident #135 on 12/20/2018. The facility has determined that all residents have the potential to be affected. An audit was completed on 01/17/2019 by the DON and Clinical Supervisors on interviewable residents using the Resident Satisfaction Survey form to ensure dignity and respect has been honored to each Resident and that all residents needing catheter bag covers had them in place. Interviewable residents stated they have been treated with dignity and respect and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2	F 550		

belongings. Resident #67 was unable to recall the name of the staff member who assisted her. She stated the staff member removed her drawer and placed it on her bed. She indicated that when she was finished with the drawer she asked her assigned second shift Nursing Assistant (NA), NA #6, to put her drawer back into dresser as she was unable to complete this task independently. Resident #67 stated that NA #6 told her, "you got it out, you put it back". Resident #67 stated that this "made me feel like I was worthless". She indicated that she spoke to Nurse #6 about the incident and she gave permission for Nurse #6 to report the incident to the Director of Nursing (DON).

A phone interview was conducted with Nurse #6 on 12/18/18 at 4:15 PM. Nurse #6 confirmed that she was working this past weekend at the facility as the weekend Nurse Supervisor. She stated that over the past weekend (12/15/18 or 12/16/18) Nurse #7 reported to her that she overheard Resident #67 ask NA #6 to put her drawer back into her dresser. She indicated Nurse #7 informed her that NA #6 said something like "it ' s your drawer you put it back" to Resident #67. NA #6 then reportedly told the resident she was going on break. Nurse #6 reported that Resident #67 was not able to put the drawer back without assistance. She indicated that after the incident was reported to her by Nurse #7, she spoke to Resident #67. She stated that Resident #67 was tearful during this conversation and that she confirmed Nurse #7 ' s report of the incident with NA #6. She indicated that after speaking with the resident she reported the incident to the DON by phone. Nurse #6 stated that she also spoke with NA #6 and provided re-education on assisting residents timely and treating residents

no catheter bag covers were missing. Non-interviewable residents were observed on 01/17/2019 by the DON and Clinical Supervisors to insure they were being treated with dignity and respect and had catheter bag covers in place if needed.

Observations were conducted by the Corporate Director of Clinical Services on 1/18/19 5(five) staff members of first shift and 5 (five) staff members on second shift and by the Nurse Management team on 3rd shift and weekends. All Residents indicated they were treated with dignity and respect.

In-service education programs were conducted with all licensed and non-licensed staff on all shifts, including part-time and weekend staff on treating residents with dignity and respect to include providing care for each resident in an environment that promotes and protects their rights by the Corporate Director of Clinical Services and the Administrator on 01/25/2019. All staff will be in-serviced prior to working the floor.

The social worker will conduct additional interviews on 5 potentially affected residents daily times 5 days, and then 5 potentially affected residents weekly times 4 weeks using the facility's Resident Satisfaction Survey form to insure residents are being treated with dignity and respect. Observations will be conducted by the Nurse Management to ensure Resident's are being treated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 with dignity and respect. She additionally stated she instructed NA #6 not to return to Resident #67 ' s room during that shift. A phone interview was conducted with Nurse #7 on 12/18/18 at 4:30 PM. Nurse #7 confirmed she was working this past weekend and she was assigned to Resident #67. She stated that her medication cart was positioned in the hallway near Resident #67 ' s door when she observed Resident #67 ' s call light go off. She indicated she observed NA #6 enter Resident #67 ' s room and the resident asked her to put her drawer back into her dresser. She stated she overheard NA #6 say to Resident #67 something like "you made this mess ...I ' m not cleaning it up ...I ' m going on break.". NA #6 then left Resident #67 ' s room and "slammed the door". Nurse #7 indicated she then entered Resident #67 ' s room and observed the resident crying and visibly upset. She stated she reported the incident to Nurse #6 as she was the weekend Nurse Supervisor. Nurse #7 reported that Resident #67 was not able to put the drawer back without assistance. A phone interview was conducted with NA #6 on 12/18/18 at 4:25 PM. NA #6 confirmed she was working this past weekend and she was assigned to Resident #67. She stated she was getting ready to go on her 30-minute break when Resident #67 asked her to assist her back into bed. NA #6 indicated she told Resident #67 she was clocking out for her break and was not putting her back to bed until after her break. She denied that Resident #67 asked her to put her drawer away. NA #6 reported that after her break Nurse #6 spoke with her and told her she needed to assist the residents with whatever they needed	F 550	dignity and respect using an audit tool. Audits will be conducted using an audit tool on Monday and Tuesday for 5 staff members on 1st shift, Wednesday and Thursday for 5 staff members on 2nd shift, and on Friday and Saturday for 5 staff members on the 3rd shift x 4 weeks. Treatment nurse will conduct audits using an audit tool 2 times weekly including all shifts x 4 weeks to insure placement of catheter bag covers. No indication of additional residents affected has been found. Results of the interviews and observations will be kept in the DON office. The interview and observations results will be taken to the Monthly Quality Assurance meeting by the DON. The plan of correction will be monitored monthly by the Quality Assurance Committee until such time as consistent substantial compliance has been met. Completion Date 01/25/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

assistance with timely and instructed her not to re-enter Resident #67 ' s room that shift.

An interview was conducted with the DON on 12/18/18 at 4:40 PM. She stated that Nurse #6 phoned her over the past weekend and informed her of the incident with Resident #67 and NA #6. The DON indicated that this was the first instance of any complaints or concerns reported about NA #67 ' s interaction with residents. She stated that her expectation was for all residents to be treated with dignity and respect.

2) Resident #135 was admitted to the facility on 12/7/18 with diagnoses that included retention of urine and chronic kidney disease Stage 4.

Review of the hospital discharge summary dated 12/7/18 revealed an indwelling urinary catheter was placed secondary to bladder outlet obstruction and distal urethral stricture.

An admission MDS (Minimum Data Set) was in progress.

The baseline care plan dated 12/7/18, specified the resident was alert and cognitively intact with confusion at times.

On 12/17/18 at 12:35 PM, an observation was made of Resident #135 in his room. He was noted to have an indwelling urinary catheter with the drainage bag attached to the side of the bed. The urinary catheter drainage bag did not have a privacy cover and could be seen from the hallway.

On 12/18/18 at 1:55 PM a second observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 was made of Resident #135 in his room. The urinary catheter drainage bag did not have a privacy cover and could be seen from the hallway. During an interview on 12/19/18 at 9:30 AM with Resident #135, he stated that he felt better now that a cover was present on the urinary catheter drainage bag. An interview was completed with the Director of Nursing (DON) on 12/20/18 at 10:15 AM, the DON stated it was her expectation that nursing staff use a privacy cover for urinary catheter drain bags.	F 550		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		1/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician interviews, the facility failed to notify the Physician of continued unintended, significant (27%) weight loss for 1 (Resident #10) of 3 residents reviewed to nutrition. The findings included: Resident #10 was admitted on 3/15/18 with cumulative diagnoses of chronic respiratory failure, cerebral vascular accident and dysphagia. His weight on admission was 172 pounds.	F 580	Based on observations, staff and physician interviews, the facility failed to notify the Physician of continued unintended, significant (27%) weight loss for 1 (resident #10) & of 3 residents reviewed for nutrition. Resident #10 was re-weighted on 1/1/2019 by Restorative Aide to verify the weight change. The resident had a six (6)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 Review of Resident #10's admission orders dated 3/15/18 read his tube feeding was Isosource (tube feeding formula) 1.5 one can six times daily with 100 cubic centimeters (ccs) of water with each feeding. Review of Resident #10's care plan dated 3/16/18 read he was at risk for dehydration and weight fluctuations due to his nothing by mouth (NPO) status. Interventions include monitoring his labs, weights, tube feedings and a dietician per policy. Review of a dietary note dated 3/23/18 read Resident #10's admission weight was 172 pounds. The note read a referral was made to the Registered Dietician(RD) and recommendations were given to the nurse supervisor. The note Resident #10 would continue to be monitored and referral would be made to the RD and Physician as needed. This note was documented by the Dietary Manager (DM). Review of Resident #10's electronic medical record revealed his weight for April 2018 remained at 172 pounds. Review of a dietary note dated 5/9/18 read Resident #10's current weight was 172 pounds. The note read to continue the current tube feeding orders and Resident #10 would continue to be monitored and referral would be made to the Rd and Physician as needed. This note was documented by the DM. Review of Resident #10's electronic medical record revealed his weight for May 2018 remained at 172 pounds.	F 580	pound weight increase since his re-admission on 12/19/2018. The Medical Director was notified of the current weight of 131 pounds on 1/2/19 by the Clinical Supervisor. The facility has determined that all residents have the potential to be affected. All residents were re-weighted to establish a correct weight for January, 2019. All Resident's were re weighed by Restorative Aide on 1/17/19. Dietary Manager reviewed weights and determined 10 Resident's were identified with significant weight loss. Medical Director and Responsible Party were notified on 1/17/19 by the Clinical Supervisor. MDS Nurse updated care plans of identified Resident's on 1/17/19. An in-service education program was conducted by the Corporate Director of Clinical Services on 1/23/19 with all licensed staff on all shifts including weekend and part-time staff addressing circumstances that require notification of the resident's physician and resident's representative. All licensed staff was in-serviced prior to working the next scheduled shift. The Medical Director was advised by the Corporate Director of Clinical Services to add resident changes in his progress notes 1/2/19. The Dietary Manager will conduct an audit of five (5) residents weekly for four (4) weeks using an audit tool. These	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 Review of a dietary note dated 5/22/18 read Resident #10'sPhysican desired his tube feeding orders were to be changed from bolus feedings to continuous feedings. The note read Resident #10's weight would be monitored, and tube feeding would be adjusted as necessary. This note was documented by the RD. Review of a Physician order dated 5/22/18 read Resident #10's tube feeding was changed from bolus feedings to continuous feedings of Isosource 1.5 at 65 ccs per hour with 50 ccs of water per hour due to abdominal discomfort. Review of Resident #10's electronic medical record revealed no documented weight for the month of June 21018. Review of a dietary note dated 6/7/18 read Resident #10's weights was stable at 172 pounds and no changes to his continuous tube feeding orders. The note read Resident #10 was tolerating his tube feeding well, his weight would be monitored, and he would be referred to the RD as needed. This note was documented by the DM. Review of a nursing note and Physician order dated 6/8/18 read a recommendation to change Resident #10's tube feeding back to bolus of Isosource 1.5 one can every four hours with 200 ccs of water with each feeding. Review of a Physician History and Physical Examination note dated 6/19/18 made no mention of any weight loss. Review of a Physician History and Physical	F 580	residents will be newly assessed to ensure that any declines in weight loss have been identified, properly evaluated and communicated to the appropriate people. Audits will be kept in the Director of Nursing office. The Dietary Manager will report her audits to the monthly Quality Assurance meeting. The plan of correction will be monitored monthly until such time as consistent substantial compliance has been met. Completion Date 01/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

Examination note dated 7/3/18 made no mention of any weight loss.

Review of a dietary note dated 7/18/18 read as a late entry for 7/10/18 read Resident #10's weight was stable at 172 pounds. Resident #10's was changed to bolus feeding and Resident #10 would be referred to the RD on his next visit related to recent weight loss. The note read Resident #10 would continue to be monitored for weights and lab work. This note was documented by the RD.

Review of the electronic medical record revealed Resident #10's readmission weight on 7/20/18 was weight was 142 pounds.

Review of the Physician order dated 7/20/18 read Resident #10 readmitted from the hospital with tube feeding orders for Isosource 1.5 one can every four hours with 200 ccs of water with each feeding.

Review of a Physician History and Physical Examination note dated 7/25/18 made no mention of any weight loss.

Review of a dietary note dated 7/30/18 read Resident #10's weight was 142 pounds. The note read Resident #10 had several visits to the hospital since his admission. The note read Resident continued his bolus tube feedings and he would be referred to the RD on his next visit related to recent weight loss. There was no documentation that the Physician was notified of Resident #10's recent weight loss. The note read Resident #10 would continue to be monitored for weight loss and lab work. This note was documented by the DM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10	F 580		

Review of a dietary note dated 8/21/18 read Resident #10's weight was 141.6 pounds and that his weights had remained stable for the past four weeks. The note read Resident #10 had a history of removing his feeding tube and recent acute illness. The note read Resident continued his bolus tube feedings. There was no documentation that the Physician was notified of Resident #10's recent weight loss. The note read Resident #10 would continue to be monitor weekly weights. This note was documented by the DM.

Review of a Physician History and Physical Examination note dated 8/24/18 made no mention of any weight loss.

Review of a Physician History and Physical Examination note dated 9/20/18 made no mention of any weight loss.

Review of Resident #10's quarterly Minimum Data Set (MDS) dated 9/25/18 indicated severe cognitive impairment, no behaviors and total assistance with all of his activities of daily living. He was coded with known weight loss, a feeding tube and weight of 135 pounds.

Review of a dietary note dated 9/26/18 read Resident #10's weight was 134.5 pounds. The note read Resident #10 had experienced weight loss since the last dietary note. The note read Resident #10 had a recent hospitalization and he would be referred to the RD on his next visit. The note read Resident #10 had a history of removing his feeding tube and recent acute illness. The note read Resident continued his bolus tube feedings and his weight would continue to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11	F 580		

monitored. There was no documentation that the Physician was notified of Resident #10's recent weight loss. This note was documented by the DM.

Review of a dietary note dated 10/12/18 read Resident #10's weight was still trending down at 133.8 pounds. New orders to stop the bolus feeding and begin Isosource 1.5 at 60ccs per hour continuous with 35 ccs of water per hour. The note read this should provide a healthy weight goal and Resident #10's ideal body weight was 133-163 pounds. The note read Resident #10's tube feeding would be monitored for tolerance and adjusted as needed. There was no documentation that the Physician was notified of Resident #10's recent weight loss. This note was documented by the RD.

Review of a dietary note dated 11/9/18 read Resident #10's weight was 130 pounds on 11/8/18. The note read Resident #10's weight remained stable for four weeks. There was no change in his tube feeding orders. The note read to continue the plan since Resident #10 was stable with current interventions. He would remain on weekly weights. There was no documentation that the Physician was notified of Resident #10's recent weight loss. This note was documented by the RD.

Review of a Physician History and Physical Examination note dated 11/20/18 made no mention of any weight loss.

In an observation on 12/18/18 at 11:10 AM, Resident #10 was lying in bed with the head of his bed elevated 30 degrees. He was able to move his arms and legs on request and able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

answer yes/no questions. His tube feeding was connected and running Isosource 1.5 at 60 ccs per hour continuous with 35 ccs of water per hour.

In an interview on 12/18/18 at 3:10 PM, Nurse #4 stated Resident #10 had been very sick on and off since admission. She stated he was living at home with his wife prior to admission to the facility in March 2018. Nurse #4 stated Resident #10 frequently removed his feeding tube and required frequent hospitalizations.

In an interview on 12/18/18 at 3:26 PM, the Dietary Manager (DM) stated the Registered Dietician (RD) comes to the facility once a month and as needed. She stated Resident #10 was on weekly weights due to his known weight loss associated with his multiple hospitalizations due to illness with multiple incidents of removing his feeding tube. The DM stated Resident #10 was discussed at the Patients at Risk meetings and she contacted the RD for direction about Resident #10's weight loss. The DM stated the RD could make visits as needed but that she consulted with the RD for recommendations regarding Resident #10's weight loss. The DM stated she did not inform the Physician.

In a telephone interview on 12/18/18 at 5:15 PM, the RD stated Resident #10's weights were stable at 172 pounds up until sometime in July 2018 when he hospitalized several times. The RD stated bolus tube feedings were implemented at one time because it was felt he would be less likely to remove his feeding tube but when his weights continued to decline, the Physician changed Resident #10 back to continuous feedings. The RD stated he was at the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

monthly and as needed. He stated the DM contacted him about Resident #10's weight loss and he thought the Physician was aware of Resident #10's weight loss but he did not notify the Physician.

Review of a dietary note dated 12/19/18 read Resident #10's weight continues to trend downward due to multiple hospitalizations and a history of removing his feeding tube. His current weight on readmission was 125 pounds and continued to trend downward despite adjustment to address his weight loss. New orders dated 12/19/18 for Isosource 1.5 at 65 ccs per hour continuous with 35 ccs of water per hour. There was no documentation that the Physician was notified of Resident #10's recent weight loss. This note was documented by the DM.

In an observation on 12/19/18 at 8:20 AM, Resident #10 was lying in bed with his tube feeding running continuously as the ordered rate. He was observed to be alert and able to answer yes/no questions without difficulty. He was not observed attempting to removing his feeding tube but rather moving his arms in a continuous upward motion.

In an interview on 12/19/18 at 11:02 AM, Unit Manager #1 stated the DM was in contact with the RD about Resident #10's weight loss. She stated she contacted the Physician about changing Resident #10's tube feedings to bolus feedings back in June 2018 to keep Resident #10 from removing his feeding tube. The Unit Manager stated Resident #10 was being followed in the Patients at Risk meetings and it was her impression that the Physician was aware of Resident #10's weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14 In an interview on 12/20/18 at 9:10 AM, the Medical Director stated he was aware of at least nine hospitalizations since being admitted to the facility and multiple incidences of Resident #10 removing his feeding tube. The Medical Director stated some weight loss was to be expected but he was not notified of the continued unintended, significant weight loss. The MD stated it was his expectation that the facility would have notified him of Resident #10 continued unintended significant weight loss. He stated Resident #10 may require a higher calorie tube feeding to prevent further weight loss and he would follow up with the facility RD. In an interview on 12/20/18 at 10:15 AM, the Director of Nursing stated it was her expectation that the Physician of continued weight loss by the Unit Manager or the RD so that other interventions could have been considered to prevent continued unintended, significant weight loss.	F 580		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses (Residents #31 and #73), bladder and bowel (Residents #40 and #73), medications (Residents #67 and #40), prognosis (Resident #40), hospice (Resident #86), activities	F 641	The facility failed to code the Minimum Data Set (MDS) assessment accurately for 8 of 17 residents reviewed in the areas of Resident #73 (active diagnosis, bowel and bladder incontinence), Resident #63 (skin conditions), Resident #54 (therapies), Resident #40 (hospice	1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 15	F 641		

of daily living assistance (Resident #42), skin conditions (Resident #63), and therapies (Resident #54) for 8 of 17 residents reviewed.

The findings included:

1. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included diabetes mellitus type 2.

The quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67 ' s cognition was intact. She was noted to have received injections on 6 of 7 days and insulin injections on 6 of 7 days during the MDS look back period.

A review of the Medication Administration Records (MARS) for the look back period of Resident #67 ' s 11/5/18 MDS (10/30/18 through 11/5/18) indicated Resident #67 was administered Novolog (insulin) injections on 7 of 7 days.

An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The medications section of Resident #67 ' s 11/5/18 MDS that indicated she had received injections on 6 of 7 days and insulin injections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period of Resident #67 ' s 11/5/18 MDS that indicated she received insulin injections on 7 of 7 days was reviewed with MDS Nurse #1. She revealed this coding was an error and indicated the MDS should have been coded for 7 of 7 injections and 7 of 7 insulin injections.

An interview was conducted with the Director of

prognosis, urinary appliance, antipsychotic medications), Resident #45 (diagnosis), Resident #86 (hospice), Resident #42 (ADL assistance).

Resident #67 was reassessed on 12/20/18 and injections were corrected to include all injections received and transmitted on 12/26/2018. Resident #73 was reassessed on 1/11/2019 to include all active diagnoses and bowel and bladder incontinence and was transmitted on 1/11/2019. Resident #63 was reassessed on 1/11/2019 to include skin conditions and was transmitted on 1/11/2019. Resident #54 was reassessed on 1/11/2019 to include therapies and transmitted on 1/11/2019. Resident #40 was reassessed on 1/11/2019 to include hospice prognosis, urinary appliances and antipsychotic medications and transmitted on 1/11/2019. Resident #45 does not have seizure disorder diagnosis. However, Resident #31, who's MDS assessment dated 10/9/2018 indicated that assessment did not include diagnosis of seizure disorder was reassessed to include active diagnosis of seizure disorder on 1/11/2019 and transmitted on 1/11/2019. Resident #86 was reassessed on 12/20/2018 to include hospice prognosis and transmitted on 12/26/2018. Resident #42 was reassessed on 1/11/2019 to include accurate ADL information and transmitted on 1/11/2019. All MDS corrections and transmission were completed by MDS coordinator.

The facility has determined that all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 16 Nursing on 12/20/18 at 10:15 AM. She stated she expected the MDS to be coded accurately. 2a. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included periprosthetic fracture around the prosthetic right hip joint. The admission Minimum Data Set (MDS) assessment dated 11/21/18 indicated Resident #73 ' s cognition was severely impaired. She was noted with an active diagnosis of an "other fracture". The additional diagnoses section indicated Resident #73 had a periprosthetic fracture around the prosthetic right hip joint. An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The active diagnoses section of Resident #73 ' s 11/21/18 MDS was reviewed with MDS Nurse #1. She indicated she was not sure why she had coded Resident #73 for "other fracture". She reported the active diagnosis for Resident #73 ' s fracture was a periprosthetic fracture around the prosthetic right hip joint as she had noted in the additional diagnoses section. She stated Resident #73 had no other fractures. An interview was conducted with the Director of Nursing on 12/20/18 at 10:15 AM. She stated she expected the MDS to be coded accurately. 2b. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included periprosthetic fracture around the prosthetic right hip joint. The admission Minimum Data Set (MDS)	F 641	resident have the potential to be affected. Audits were conducted on MDS assessments transmitted on 1/11/18 and 1/18/18 by clinical Director of Clinical Services. All MDS assessments had correct information coded on MDS. An in-service was conducted by the Corporate Director of Clinical Services with the MDS Nurses on 12/20/18 addressing the importance of identifying and coding the MDS correctly prior to closing and submission. MDS assessments will be audited by licensed nursing staff using audit tool. 10 MDS's completed within a 7-day period using an audit tool for four (4) weeks to ensure proper coding on Activities of Daily Living, Bowel/Bladder continence, skin conditions, medications, health conditions, therapies and active diagnosis. Audits will be kept in Director of Nursing (DON) office. The Director of Nursing will report to the Quality Assurance Committee monthly the results of the audits. The plan of correction will be reviewed monthly until such time as consistent substantial compliance has been met. Completion Date 01/31/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17	F 641		

assessment dated 11/21/18 indicated Resident #73 ' s cognition was severely impaired. Resident #73 required the extensive assistance of 2 or more for bed mobility and transfers and the extensive assistance of 1 for toileting. She was not steady on her feet and was only able to stabilize with staff assistance. Resident #73 had impairment on one side of her lower extremities and she utilized a walker and a wheelchair. She was noted to always be continent of bladder and bowel.

A review of the documentation related to bladder and bowel continence included, in part, the following information:

- An incident report dated 11/18/18 at 1:27 AM indicated Resident #73 was incontinent.

- An incident report dated 11/18/18 at 3:19 AM indicated Resident #73 was incontinent.

- An incident report dated 11/18/18 at 10:29 AM indicated Resident #73 was incontinent.

- A nursing note dated 11/18/18 indicated Resident #73 was incontinent of bladder and bowel.

- A nursing note sated 11/21/18 indicated Resident #73 was incontinent of bladder and bowel.

An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The bladder and bowel section of Resident #73 ' s 11/21/18 MDS that indicated she was always continent of bladder and bowel was reviewed with MDS Nurse #1. MDS Nurse #1 stated that she interviewed some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18	F 641		

of the Nursing Assistants (NAs) who worked with Resident #73 to code this section of her 11/21/18 MDS. She revealed that she had not reviewed the nursing notes or incident report documentation related to Resident #73 ' s bladder and bowel continence when she coded the 11/21/18 MDS.

An interview was conducted with the Director of Nursing on 12/20/18 at 10:15 AM. She stated she expected the MDS to be coded accurately.

3. Resident #63 was admitted to the facility on 11/8/18 with diagnoses that included vascular dementia.

The 11/15/18 admission Minimum Data Set (MDS) assessment indicated Resident #63 ' s cognition was severely impaired. The skin and ulcer/injury treatments indicated Resident #63 had no applications of dressings to the feet (with or without topical medications).

A review of the treatment orders and Treatment Administration Records (TAR) for the look back period of Resident #63 ' s 11/15/18 MDS (11/9/18 through 11/15/18) indicated a physician ' s order dated 11/11/18 for skin prep (liquid that when applied to the skin forms a protective film or barrier) to bilateral heels and foam protective dressing wrap every three days. This treatment was administered to Resident #63 on 11/14/18.

An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The skin conditions section of Resident #63 ' s 11/15/18 MDS that indicated she had not received dressings to her feet was reviewed with MDS Nurse #1. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19	F 641		

physician ' s orders and TAR that indicated Resident #63 was administered a treatment on 11/14/18 that included foam protective dressing wrap to her bilateral heels was reviewed with MDS Nurse #1. MDS Nurse #1 revealed this coding was an error and that she should have coded the 11/15/18 MDS to indicate the application of dressings to Resident #63 ' s feet.

An interview was conducted with the Director of Nursing on 12/20/18 at 10:15 AM. She stated she expected the MDS to be coded accurately.

4. Resident #54 was admitted to the facility with diagnoses that included heart disease and adult failure to thrive.

The significant change Minimum Data Set (MDS) assessment dated 11/12/18 indicated Resident #54 ' s cognition was severely impaired. She was coded as not receiving Speech Therapy (ST) during the MDS look back period.

A physician ' s order dated 11/1/18 indicated an ST evaluation order as well as an ST order to treat 5 times per week for 4 weeks for oral phase dysphagia.

A review of ST documentation indicated Resident #54 received ST from 11/1/18 through 11/14/18.

An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The 11/12/18 MDS that indicated Resident #54 received no ST during the MDS look back period was reviewed with MDS Nurse #1. The physician ' s order and the ST documentation that indicated Resident #54 received ST from 11/1/18 through 11/14/18 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

reviewed with MDS Nurse #1. MDS Nurse #1 revealed this MDS was coded inaccurately for Resident #54.

An interview was conducted with the Director of Nursing on 12/20/18 at 10:15 AM. She stated she expected the MDS to be coded accurately.
5a. Resident #40 was admitted to the facility on 10/5/18 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that Resident #40 did not have an indwelling urinary catheter.

Resident #40 had a physician's order dated 10/5/18 for indwelling urinary care every shift.

The Treatment Administration Record (TAR) for October 2018 revealed that catheter care was provided from 10/5/18 through the end of the month.

On 12/19/18 at 3:50 PM, The MDS Nurse was interviewed. The MDS Nurse verified that Resident #40 had an indwelling urinary catheter on admission. She stated that she coded the admission MDS assessment dated 10/12/18 incorrectly for the indwelling urinary catheter.

On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

5b. Resident #40 was admitted to the facility on 10/5/18 with multiple diagnoses including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21	F 641		

dementia. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that Resident #40 was receiving hospice care and she did not have a condition or chronic disease that may result in a life expectancy of less than 6 months under prognosis.

Resident #40 had a physician's order dated 10/5/18 to admit to hospice.

Resident #40 was care planned dated 10/5/18 to receive hospice care.

On 12/19/18 at 3:50 PM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #40 was receiving hospice care since admission on 10/5/18. She further indicated that she coded the admission MDS assessment dated 10/12/18 incorrectly under the prognosis. She indicated that the prognosis should have been checked indicating that the resident had a condition or chronic disease that may result in life expectancy of less than 6 months but it was not.

On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

5c. Resident #40 was admitted to the facility on 10/5/18 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that Resident #40 had received an anti-psychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22	F 641		

medication for 7 days during the assessment period. The assessment under the section "anti-psychotic medication review" indicated that the review was not conducted because Resident #40 did not receive anti-psychotic medication.

On 12/19/18 at 3:50 PM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #40 had received anti-psychotic medication during the assessment period. She further indicated that she coded the admission MDS assessment dated 10/12/18 incorrectly under the anti-psychotic medication review.

On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

6. Resident #45 was admitted to the facility on 11/18/16 with multiple diagnoses including seizures. The quarterly Minimum data Set (MDS) assessment dated 10/9/18 indicated that Resident #45's cognition was intact. The assessment did not indicate that Resident #45 had a diagnosis of seizure disorder.

Resident #45 had a physician's order dated 4/20/18 for keppra 250 milligrams (mgs) by mouth twice a day for seizures.

Resident #45's Medication Administration Records (MARs) for October 2018 was reviewed. The MARs revealed that Resident #45 had received keppra during the assessment period.

On 12/19/18 at 3:53 PM, the MDS Nurse was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23	F 641		

interviewed. The MDS Nurse verified that Resident #45 had received keppra during the assessment period. She indicated that she coded the quarterly MDS assessment dated 10/9/18 incorrectly, seizure disorder should have been checked under diagnoses but it was not.

On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

7) Resident #86 was admitted to the facility 10/25/18 and expired in the facility 11/1/18. His diagnoses included malignant neoplasm of the head of the pancreas.

A review of the resident's baseline care plan dated 10/26/18 revealed the resident received Hospice Care

The most recent comprehensive MDS (Minimum Data Set) coded as an admission assessment and dated 11/1/18 revealed the resident was marked with an active diagnosis of cancer and a prognosis of less than six months but not coded with receiving Hospice care.

During an interview with MDS Nurse #1 on 12/19/18 at 8:10 AM, she confirmed she was aware the resident was receiving Hospice care and that Hospice was not marked on the MDS assessment. She stated that it was an error.

An interview was conducted 12/20/18 at 10:15 AM with the Director of Nursing. She stated that it was her expectation for the MDS to be coded accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24	F 641		

8) Resident #42 was admitted to the facility 7/17/18 with diagnoses that included CVA (stroke), dysphagia (difficulty swallowing), aphasia (unable to express speech), tracheostomy and gastrostomy status.

A review a physician note dated 7/19/18 revealed Resident #42 was not able to smile or follow simple commands and did not move any extremities.

During a review of a care plan conference form dated 7/20/18 it was indicated that the resident was in a vegetative state and required total assistance with all ADL's (Activities of Daily Living).

A review of a nursing note dated 7/24/18 revealed the resident was in a vegetative state and all needs were anticipated by staff.

The most recent comprehensive MDS (Minimum Data Set) coded as an admission assessment and dated 7/24/18 revealed the resident had impaired memory and was unable to make self-known or to make decisions. She was coded as receiving extensive assistance of two staff members for all ADL's except for bathing and eating in which she was dependent on one to two staff members. She was coded as having limited range of motion to bilateral upper and lower extremities.

A review of the most recent MDS coded a Quarterly assessment and dated 10/18/18 revealed the resident had impaired memory and was unable to make self-known or make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25	F 641		

decisions. She was coded as receiving extensive assistance of two staff members for all ADL's except she was dependent on one to two staff members for eating and bathing. She was marked with limited range of motion to both upper and lower extremities.

A review of the resident's active care plan dated 10/18/18 revealed she was total care regarding her ADL's as well as with turning and repositioning.

During an interview with MDS Nurse #1 on 12/19/18 at 8:45 AM, she stated that she coded based on the ADL flow record that was completed by the aides. She explained that she was aware through observation and staff interviews that the resident was totally dependent on staff for all ADL's and felt the problem was with training and education of completing the ADL flow record accurately. She stated that she was unable to state whether the assessments should have been coded as an accurate reflection of the resident based on observations and staff interviews or with the ADL flow record.

An interview was conducted with Nurse #3 on 12/19/18 at 2:00 PM. She confirmed that Resident #42 required total care of 2 staff members for all ADL's and one staff member for eating. She stated that the resident made no attempts to assist with her care or move her arms or legs.

An interview was conducted on 12/20/18 at 10:15 AM with the Director of Nursing. She stated that it was her expectation for the MDS to be coded accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 26	F 655		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 27 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to include indwelling urinary catheter (Resident #135) and Dialysis (Resident #235) on the baseline care plan for 2 of 2 new admissions reviewed. The findings included: 1) Resident #135 was admitted to the facility on 12/7/18 with diagnoses that included retention of urine and chronic kidney disease Stage 4. A review of the hospital discharge summary dated 12/7/18 noted that an indwelling urinary catheter was placed secondary to bladder outlet obstruction and distal urethral stricture. A review of the physician orders dated 12/7/18 revealed catheter care every shift. An admission MDS (Minimum Data Set) was in progress. A review of the baseline care plan dated 12/7/18 revealed no mention of an indwelling urinary catheter and had the resident marked as continent of bladder. A review of the Nurse Tech Information Kardex noted the resident had an indwelling urinary	F 655	Based on staff interviews and record reviews, the facility failed to include Indwelling Urinary Catheter (resident #135) and Dialysis (resident #235) on the baseline care plan for 2 of 2 new admissions reviewed. Residents #135 and #235 were given a revised summary of their baseline care plan with the additional information added to the care plan on 12/19/18 by the MDS Nurse. Resident #135 and #235 are no longer residing at the facility. All residents have the potential to be affected. All interdisciplinary care plan team members responsible for writing baseline care plans will be in-serviced by the Director of Nursing (DON) and or Corporate Director of Clinical Services on the procedure for developing baseline care plans. An audit was performed on 5 residents admitted between 1/14/2019 to 1/18/2019 to ensure base line care plans accurately reflected the resident and care received All care plans accurately reflected each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 28 catheter. During an interview with the MDS Nurse #1 on 12/19/18 at 4:00 PM, she confirmed that the resident was marked as continent of bladder and not marked for an indwelling urinary catheter on the baseline care plan. She stated that it was an error. An interview was completed with the Director of Nursing (DON) on 12/20/18 at 10:15 AM, she stated that it was expectation for baseline care plan to be completed as an accurate reflection of the resident. 2) Resident #235 was admitted to the facility on 12/11/18 with end stage renal disease on hemodialysis. An admission MDS (Minimum Data Set) was in progress. A review of the baseline care plan dated 12/11/18 revealed dialysis was not marked in the other treatment/procedure, other conditions or in the outside coordination for Hemodialysis sections. During an interview on 12/20/18 at 9:30am, MDS Nurse #1 confirmed that she was aware the resident received Hemodialysis and failed to mark it on the baseline care plan. An interview was completed with the Director of Nursing on 12/20/18 at 10:15 AM, she stated that it was her expectation for the baseline care plan to be completed as an accurate reflection of the resident.	F 655	resident audited. These audits were conducted by the DON. The DON, or licensed nursing staff will complete weekly audits of 5 residents to ensure the baseline care plans accurately reflect the resident for six (6) consecutive weeks using an audit tool. Audits will be kept in the Director of Nursing office. The DON will report the findings to the Quality Assurance Committee monthly until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 29	F 656		
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 - (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	F 656		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 30 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 observations, staff interviews and record review, the facility failed to develop a care plan for weight loss (Resident #10) and for the use of an antipsychotic medication (Resident #73). The facility also failed to implement a care planned intervention to prevent falls (Resident #31). This was for 3 of 17 residents reviewed for the development and implementation of care plan. The findings included: 1. Resident #10 was admitted on 3/15/18 with cumulative diagnoses of chronic respiratory failure, cerebral vascular accident, dysphagia and a feeding tube. Review of Resident #10's electronic medical record revealed his weights remained stable at 172 pounds up until a readmission from the hospital on 7/20/18 when his weight was 142 pounds on return from the hospital. Review of Resident #10's care plan dated 3/16/18 and last revised 9/24/19 read he was at risk for dehydration and weight fluctuations due to his nothing by mouth (NPO) status. Interventions include monitoring his labs, weights, tube feedings and a dietician per policy. Resident #10 did not have a care plan addressing his 30lb weight loss. Resident #10's quarterly Minimum Data Set (MDS) dated 9/25/18 indicated severe cognitive	F 656	Based on observations, staff interviews and record review, the facility failed to develop a care plan for weight loss (resident #10) and for the use of an antipsychotic medication (resident #73). The facility also failed to implement a care planned intervention to prevent falls (resident #31). This was for 3 of 17 residents reviewed for the development and implementation of care plans. Care Plans of residents #10 for weight loss and #73 for the use of antipsychotic medication were reviewed and updated as indicated on 1/20/19 by the MDS Nurse. The care plan intervention for resident #31's wheelchair for anti-tippers has been implemented and anti-tippers applied to her wheelchair on 12/18/18. All residents have the potential to be affected. All interdisciplinary care plan team members that are responsible for writing care plans will be in-serviced by the Corporate Director of Clinical Services on the procedure for developing Comprehensive Care Plans and implementation of the care plans on 1/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 31 impairment with total assistance with all of his activities of daily living. (ADLs). He was coded as having a feeding tube, weight of 135 pounds and coded for weight loss. Review of Resident #10's electronic medical record revealed his weight in October 2018 was 134 pounds, 130 pounds November 2018 and 131pounds December 2018. In an interview on 12/20/18 at 10:15 AM, the Director of Nursing (DON) stated it was her expectation the Resident #10 would have been care planned for the actual weight loss. 2. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included periprosthetic fracture around prosthetic right hip joint, disorientation, alcohol dependence with withdrawal, and major depressive disorder. The admission Minimum Data Set (MDS) assessment dated 11/21/18 indicated Resident #73' s cognition was severely impaired. She was not administered antipsychotic medication during the MDS look back period. A physician ' s order dated 12/6/18 for Resident #73 indicated Haldol (antipsychotic medication) 1 milligram (mg) every 6 hours as needed (PRN) for agitation. A review of the December 2018 Medication Administration Record (MAR) from 12/6/18 through 12/17/18 indicated Resident #73 was administered PRN Haldol 11 times (12/7 (x3), 12/8 (x2), 12/11, 12/12, 12/13, and 12/17 (x3). A review of Resident #73 ' s active care plan was	F 656	All Resident's were reweighed on 1/17/19 by the Restorative Aide. Dietary Manager Reviewed weights on 1/17/19 and determined 10 Resident's were identified with significant weight loss. Medical Director and Responsible Party notified by Clinical Supervisor on 1/17/19. Care plans updated on identified Resident's on 1/17/19. An audit was conducted on 1/18/2019 on all residents receiving antipsychotic medications to ensure an appropriate Care Plan was in place, which was done by the Clinical Supervisor using the Drug Usage Report. Each resident receiving antipsychotic had an appropriate care plan in place. An audit on 100% of residents was conducted on 1/15/19 by the Quality Assurance team to ensure all fall interventions are in place using Fall Interventions Sheet. All interventions were in place. Care Plans will be reviewed weekly in accordance with the care plan schedule by the Clinical Supervisor. All Care Plans will be updated as indicated. The Director of Nursing (DON), or licensed nursing staff member will complete weekly audits of 5 resident's care plans for six (6) consecutive weeks to ensure that the comprehensive care plans are developed for residents. Weekly audits of Care Plans for 5 residents with falls will be completed weekly for six (6) weeks to ensure implementation of Care Plans for residents with falls. All audits will be completed using an audit tool. All audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 32 conducted on 12/18/18. There was no care plan related to the use of antipsychotic medication. An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. She indicated she was responsible for updating care plans related to psychotropic medications. She stated that a care plan was implemented within one to two business days when an antipsychotic medicated was initiated for a resident who was not previously on an antipsychotic medication. The 12/6/18 physician ' s order for PRN Haldol for Resident #73 was reviewed with MDS Nurse #1. The active care plan for Resident #73 that had not addressed the use of antipsychotic medication was reviewed with MDS Nurse #1. She revealed a care plan related to antipsychotic medication use should have been implemented for Resident #73 as she had not previously received an antipsychotic medication during her stay at the facility. An interview was conducted with the Director of Nursing (DON) on 12/20/18 at 10:15 AM. She stated she expected all antipsychotics to have an adequate clinical indication for use. She additionally indicated that agitation was not an appropriate clinical indication for the use of PRN Haldol. The DON reported that all PRN antipsychotic medications were to have behavior monitoring documented on the MAR or in the nursing notes for each administration to justify the use of the medication. She indicated that side effect monitoring was also to be documented on the MAR. 3. Resident #31 was admitted to the facility on 11/18/16 with multiple diagnoses including left above the knee amputation. (AKA). The quarterly Minimum Data Set (MDS) assessment dated	F 656	will be kept in the DON's office. The Director of Nursing will report findings to the Quality Assurance Committee monthly meetings until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 33	F 656		

10/9/18 indicated that Resident #31's cognition was intact. The assessment further indicated that Resident #31 was independent with locomotion and she had 2 falls since admission/entry/reentry or prior assessment with no injury.
Resident #31's care plan initiated on 4/11/18 was reviewed. One of the care plan problems was resident was at risk for injuries related to falls. The goal was resident would not experience any injuries related to falls through next review. The interventions included anti-tippers to back of wheelchair (added 7/25/18) and therapy to evaluate for wheelchair safety (added 12/8/18).

Resident #31's nurse's notes and incident reports were reviewed. The note/report dated 7/20/18 at 1:22 AM revealed that Resident #31 was trying to transfer from bed to wheelchair, the wheelchair rolled and she fell onto the floor. The intervention to prevent further fall was to install an anti-roll back brake to the wheelchair. The note/report dated 7/25/18 at 8:03 AM revealed that Resident #31 stated that she was outside the building and while she was going up the ramp the wheelchair tipped backwards causing her to fall. The intervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/8/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building feeding the birds and her wheelchair flipped over backwards ejecting her. Resident #31 had denied any injury except soreness on her back and she had requested for a pain medication.

On 12/17/18 at 3:10 PM, Resident #31's wheelchair was observed and there was no anti-tipper nor anti-roll back brake noted.

On 12/18/18 at 2:11 PM, Resident #31's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34 wheelchair was observed with Nurse #2. The wheelchair was observed with no anti-tipper nor anti-roll back brake. Nurse #2 stated that the resident's wheelchair was supposed to have anti-tippers due to her recent fall. On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON expected that care plan intervention be followed to prevent further falls.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide care to promote healing of pressure ulcer by not setting the alternating pressure reducing air mattress according to the resident's weight for 1 of 3 sampled residents reviewed for pressure ulcer (Resident #45). Findings included:	F 686	Based on record review, observation, and staff interview, the facility failed to provide care to promote healing of a pressure ulcer by not setting the alternating pressure reducing air mattress according to the resident's weight for 1 of 3 sampled residents reviewed for pressure ulcer (resident #45).	1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 35 Resident #45 was originally admitted to the facility on 2/14/18 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 10/25/18 indicated that Residents #45 had severe cognitive impairment and she had one stage 3 and two stage IV pressure ulcers. The assessment further indicated that Resident #45 needed extensive assistance with bed mobility. Resident #45 had a doctor's order dated 8/14/18 for alternating pressure reducing mattress to bed. Resident #45's care plan dated 9/19/18 was reviewed. One of the care plan problems was resident was at risk for further skin breakdown and deterioration of current areas due to limited mobility; stage IV on right and left hip and stage 3 on sacrum. The goal was resident's pressure ulcer would have measurable healing through the next review. The approaches included pressure alternating mattress to bed. Resident #45's weight on 10/10/18 and 11/12/18 was 143 lbs. On 12/19/18 at 11:20 AM, Resident #45 was observed in bed on his back. The alternating pressure reducing mattress machine was set at 300 pounds (lbs.). The machine had settings from 50 to 450 lbs. and indicated to set according to resident's weight per lbs. On 12/20/18 at 9:20 AM, Resident #45 was observed in bed on his back. Resident #45's alternating pressure reducing mattress was again observed and the machine was set at 300 lbs. On 12/20/18 at 9:22 AM, the Treatment Nurse	F 686	The setting on the alternating pressure reducing mattress for resident #45 was corrected on 12/20/2018 per the resident's correct weight by the Treatment Nurse. All residents who have been identified as having tan alternating pressure mattress are at risk. The Corporate Director of Clinical Services reviewed with the Wound Nurse on 12/20/2018 how to set the weight setting on the alternating pressure reducing air mattress. All residents on alternating pressure reducing air mattresses were evaluated by the Wound Nurse on 12/20/2018 to ensure all mattresses were set correctly for each resident's individual weight. The pressure on each alternating pressure mattress was set on correct settings for each resident with one in use. The Wound Nurse educated all wound care nurses including part time, weekend and all shifts on 1/18/2019 on how to set the weight settings on the alternating pressure mattress. All staff was educated prior to working scheduled shift. The Wound Nurse will do audits with an audit tool five (5) days a week for four (4) weeks of all alternating pressure reducing air mattresses to ensure mattresses are set for the correct weight for each resident, then two (2) times weekly for 3 months. All audits will be kept in the Director of Nusing office. The Wound Nurse will report the results of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 36 was interviewed. She stated that she was responsible for setting up the air mattress machine according to the resident's weight. She indicated that she was checking the setting of the air mattress machine twice a week and the last time she checked the machine of Resident #45 was 6 days ago (Friday). The Treatment Nurse indicated that Resident #45's machine should have been set at 145 lbs. because his weight was 143 lbs. She further stated that she didn't know who had changed the setting on the machine because the machine was locked. On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the air mattress to be set according to the resident's weight for residents with pressure ulcer to promote healing.	F 686	her audits to the Quality Assurance committee monthly until substantial compliance has been achieved. Completion Date 01/31/2019	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to install the anti-tipper or anti-roll back brake as care planned to prevent repeated falls for 1 of 2 sampled residents reviewed for falls (Resident #31).	F 689	Based on record review, observation, and resident and staff interviews, the facility failed to install the anti-tipper or anti-roll back brake as care planned to prevent repeated falls for 1 of 2 sampled residents reviewed for falls (resident #31).	1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37 Findings included: Resident #31 was admitted to the facility on 11/18/16 with multiple diagnoses including left above the knee amputation. (AKA). The quarterly Minimum Data Set (MDS) assessment dated 10/9/18 indicated that Resident #31's cognition was intact. The assessment further indicated that Resident #31 was independent with locomotion and she had 2 falls since admission/entry/reentry or prior assessment with no injury. Resident #31's care plan initiated on 4/11/18 was reviewed. One of the care plan problems was resident was at risk for injuries related to falls. The goal was resident would not experience any injuries related to falls through next review. The interventions included anti-tippers to back of wheelchair (added 7/25/18) and therapy to evaluate for wheelchair safety (added 12/8/18). Resident #31's nurse's notes and incident reports were reviewed. The note/report dated 7/20/18 at 1:22 AM revealed that Resident #31 was trying to transfer from bed to wheelchair, the wheelchair rolled and she fell onto the floor. The intervention to prevent further fall was to install an anti-roll back brake to the wheelchair. The note/report dated 7/25/18 at 8:03 AM revealed that Resident #31 stated that she was outside the building and while she was going up the ramp the wheelchair tipped backwards causing her to fall. The intervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/8/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building feeding the birds and her wheelchair flipped backwards ejecting her. Resident #31 had denied any injury except soreness on her back.	F 689	The anti-tippers were installed on resident #31's wheelchair on 12/18/2018 by the Facility Maintenance Director. The nursing management team reviewed all residents identified through assessment as having a potential risk for falls on 12/26/18. All interventions are currently in place and appropriate. Licensed Nursing Staff including all shifts, part time and weekend staff was in-serviced by the Corporate Director of Clinical Services on 1/23/2019 on the facility policy for Accidents and Supervision. All staff will be in-serviced prior to working the floor. All residents with falls/accidents will be reviewed daily by the nursing management team in the Morning Clinical Meeting to ensure appropriate implementation of safety interventions including the updating of the care plan. Observations were conducted on 1/15/19 by the Quality Assurance Team using fall Interventions Sheet to ensure every Resident had appropriate intervention in place. All interventions were in place. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and the care plan is updated. The Director of Nursing (DON), or nursing management member will complete weekly chart audits for six (6) weeks using the incident report log and review all fall incident reports to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38 On 12/17/18 at 3:10 PM, Resident #31 was interviewed. She stated that she had a fall outside the building couple of days ago while she was feeding the birds. Her wheelchair had flipped backward. Resident #31 stated that the therapy department had told her that anti-tippers had been ordered for her wheelchair. Resident #31's wheelchair was observed and there was no anti-tipper or anti-roll back brake noted. On 12/18/18 at 2:11 PM, Nurse #2, assigned to Resident #31, was interviewed. She stated that Resident #31 was supposed to have anti-tippers on her wheelchair due to her recent fall. Resident #31's wheelchair was observed with Nurse #2. The wheelchair was observed with no anti-tipper or anti-roll back brake. On 12/18/18 at 2:35 PM, the Physical Therapist (PT) was interviewed. The PT stated that she was informed of Resident #31's fall about a week ago and she had screened the resident. She had recommended anti-tippers to Resident #31's wheelchair to prevent her from falling. The PT stated that the maintenance department was responsible for installing the anti-tippers to wheelchair and she had informed the maintenance department to install them. On 12/18/18 at 2:53 PM, the two maintenance staff members were interviewed. They both indicated that they were not informed by nursing nor therapy staff that Resident #31 needed anti-tippers to her wheelchair. They indicated that they had not received a work order request form for Resident #31's anti-tippers. On 12/19/18 at 8:40 AM, Nurse #3 was	F 689	that appropriate interventions have been put in place to reduce the risk of falls or accidents. This information will be kept in the DON's office. The DON will report the findings of the audit to the Quality Assurance committee monthly meeting until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 interviewed. Nurse #3 was the nurse assigned to Resident #31 on 7/25/18. The nurse stated that after the fall, she completed a work order for the maintenance to install anti-tippers on Resident #31's wheelchair. Nurse #3 added that she was not able to check if they were installed because she was assigned to different halls. She also stated that the facility had new maintenance staff members. These new maintenance staff members were not here in July 2018. On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she didn't know what happened to Resident #31's anti-tippers but she expected that anti-tippers should have been installed on Resident #31's wheelchair as care planned to prevent further falls. The DON further indicated that the maintenance department was responsible for installing the anti-tippers or anti-roll back and they should be informed by completing a work order form and this did not happened for Resident #31.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 40 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide catheter care by not securing and anchoring the catheter to prevent excessive tension and to facilitate flow of urine for 3 of 3 sampled residents reviewed for indwelling urinary catheter (Residents # 40, # 45 and #135). Findings included: 1. Resident #40 was admitted to the facility on 10/5/18 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that	F 690	Based on observation, record review, and staff interview, the facility failed to provide catheter care by not securing and anchoring the catheter to prevent excessive tension and to facilitate flow of urine for 3 of 3 sampled residents reviewed for indwelling urinary catheter (residents #40, #45, and #135). On 12/18/2018 catheter straps were placed on residents #40, #45, and #135 to prevent excessive tension and to facilitate flow of urine by the Charge Nurse. All residents with indwelling catheters were checked for placement of catheter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 41 Resident #40 did not have an indwelling urinary catheter. Resident #40 had a physician ' s order dated 10/5/18 for indwelling urinary care every shift. Resident #40 had a care plan problem dated 10/5/18 for potential for injury related to presence of indwelling urinary catheter with diagnosis of urinary retention. The goal was for Resident #40 to receive no injury secondary to catheter manipulation through next review. The approaches included to secure the catheter to thigh to prevent pulling on tubing. On 12/18/18 at 10:48 AM, Resident #40 was observed during the incontinent care and catheter care. The catheter was observed not secured or anchored to the resident ' s thigh. On 12/18/18 at 3:53 PM, Resident #40 was observed in bed. The catheter was observed not secured or anchored to her thigh. On 12/18/18 at 3:54 PM, Nurse #2, assigned to Resident #40, was interviewed. Nurse #2 stated that there was no requirement to secure or anchor the catheter. She added that Resident #40 was care planned to secure the catheter but that was only when the resident was out of bed. On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected catheters to be secured/anchored at all times. 2. Resident #45 was originally admitted to the	F 690	straps, each resident had a catheter strap in place on 12/18/18 by the Treatment Nurse. Licensed and unlicensed nursing staff including all shifts, weekend, and part time were in-serviced on the placement of catheter straps for residents to prevent excessive tension and to facilitate the flow of urine 1/23/19 by Corporate Director of Clinical Services and Nurse Management Team. All staff was in-serviced prior to working scheduled shift. The Treatment Nurse or member of the Nurse Management Team will do audits twice per week using an audit tool for four weeks including all shifts to ensure catheter straps are in place. All audits will be kept in the DON's office. The DON will report the findings of the audits to the Quality Assurance Committee monthly meeting until such time as substantial compliance is met. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 42	F 690		

facility on 2/14/18 with multiple diagnoses including urinary retention. The significant change in status Minimum Data Set (MDS) assessment dated 10/25/18 indicated that Resident #45 had severe cognitive impairment and had an indwelling urinary catheter.

Resident #45 had a physician ' s order dated 5/10/18 for suprapubic catheter care daily.

Resident #45 had a care plan dated 10/25/18 for risk for complications due to use of suprapubic catheter. The goal was Resident #45 would not experience infections/complications from catheter use through next review. The approaches included monitor tubing for kinks or twist in tubing and to provide catheter care per order. The care plan did not include securement of the catheter,

On 12/18/18 at 3:55 PM, Resident #45 was observed up in wheelchair in his room. Resident #45 ' s catheter was observed with NA #1. The catheter was observed not anchored or secured.

On 12/18/18 at 3:54 PM, Nurse #2, assigned to Resident #45, was interviewed. Nurse #2 stated that there was no requirement to secure or anchor the catheter. She added that Resident #45 was not care planned and did not have a doctor ' s order to secure the catheter.

On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected catheters to be secured/anchored at all times.

3) Resident #135 was admitted to the facility on 12/7/18 with diagnoses that included retention of urine and chronic kidney disease Stage 4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 43	F 690		

Review of the hospital discharge summary dated 12/7/18 revealed an indwelling urinary catheter was placed secondary to bladder outlet obstruction and distal urethral stricture.

An admission MDS (Minimum Data Set) was in progress.

The baseline care plan dated 12/7/18, specified the resident was alert and cognitively intact with confusion at times.

A review of the Nurse Tech Information Kardex revealed the resident had an indwelling urinary catheter.

On 12/18/18 at 1:55 PM, an interview was conducted with Resident #135 in his room. He stated that he did not have any type of strap on his leg for the urinary catheter tubing and moved his covers to the side to reveal the tubing.

During an interview with NA #1 on 12/18/18 at 3:56 PM, she stated that a strap should be in place for indwelling urinary catheters.

On 12/18/18 at 4:01 PM, Nurse #2 stated that urinary catheter tubing straps were not required and that it wasn't ordered or on the baseline care plan to secure the catheter tubing.

An interview was completed with the Director of Nursing (DON) on 12/20/18 at 10:15 AM, she stated that it was expectation for indwelling catheter tubing's to be secured or anchored properly to the resident's thigh to prevent accidental pulling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 44	F 692		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician interviews, the facility failed to adequately address continued unintended, significant (27%) weight loss and implement effective interventions to prevent the self-removal of a feeding tube for 1 (Resident #10) of 3 residents reviewed to nutrition. The findings included: Resident #10 was admitted on 3/15/18 with cumulative diagnoses of chronic respiratory failure, cerebral vascular accident and dysphagia. Review of Resident #10's admission orders dated	F 692	Based on observations, staff and Physician interviews, the facility failed to adequately address continued unintended, significant weight loss (27%) and implement effective interventions to prevent the self-removal of a feeding tube for 1 (resident #10) of 3 residents reviewed for nutrition. Resident #10 on 1/7/2019 is presently 131 pounds for an increase of 6 pounds since his readmission on 12/17/2018.	1/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 45 3/15/18 read his tube feeding was Isosource (tube feeding formula) 1.5 one can six times daily with 100 cubic centimeters (ccs) of water with each feeding. Review of Resident #10's care plan dated 3/16/18 read he was at risk for dehydration and weight fluctuations due to his nothing by mouth (NPO) status. Interventions include monitoring his labs, weights, tube feedings and a dietician per policy. Review of a Physician order dated 5/22/18 read Resident #10's tube feeding was changed from bolus feedings to continuous feedings of Isosource 1.5 at 65 ccs per hour with 50 ccs of water per hour due to abdominal discomfort. Review of a nursing note dated 5/22/18 read Resident #10 disconnected his tube feeding and the tube feeding was draining into his bed. The tubing was reconnected. Review of a nursing note dated 5/24/18 read Resident #10 removed his feeding tube and was sent to the hospital due to bleeding from the feeding tube site. Review of a nursing note dated 6/8/18 read Resident #10 removed his feeding tube and orders received to replace the feeding tube. The feeding tube was replaced without difficulty. Review of a nursing note and Physician order dated 6/8/18 read a recommendation to change Resident #10's tube feeding back to bolus of Isosource 1.5 one can every four hours with 200 ccs of water with each feeding. Review of a nursing note dated 6/13/18 read	F 692	All residents with G-tubes have the potential of self-removing their G-tubes. Dietician made recommendations to increase resident's tube feeding on 12/19/2018, Medical Director and responsible party was notified and orders carried out on same date. Facility obtained a Physician's order to place an abdominal binder on the resident to decrease his pulling out his G-tube due to poor safety awareness secondary to cerebral vascular accident. The Responsible Party (RP) was notified on 1/14/2019 by the Clinical Coordinator regarding the medical reason for the placement of the binder. Resident #10's Care Plan was updated to reflect the use of the abdominal binder on 1/14/2019 by the MDS Coordinator. Skin Assessments will be conducted every 2 hours by charge nurse with release of binder. All Resident's with G-tubes were reweighed on 1/17/19 by the Restorative Aide. Dietary Manager reviewed weights on 1/17/19 and determined no other Resident' with g-tubes experienced weight loss. Licensed and unlicensed staff including all shifts part time and weekend staff have been in-serviced by the MDS nurse on 1/14/2019 for the use of the abdominal binder and how to release and replace. All staff was in-serviced prior to working the floor. The Director of Nursing (DON), or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 46 Resident #10 removed his feeding tube and was sent to the hospital after failed attempts to replace it at the facility. He was hospitalized for urinary tract infection, Clostridium difficile (c-diff-a bacterial infection of the colon) and sepsis (blood infection). Resident #10 was readmitted to the facility 6/15/18. Review of a nursing note dated 6/26/18 read Resident #10 was sent to the hospital due to increased respiratory secretions and a drop in his oxygen saturation level. He was readmitted to the facility on 6/29/18. Review of a nursing note dated 7/16/18 read Resident #10 was sent to the hospital for suspected sepsis. He was readmitted to the facility on 7/20/18 with tube feeding orders for Isosource 1.5 one can every four hours with 200 ccs of water with each feeding. Review of Resident #10's weights remained stable at 172 pounds for the month of March, April and May 2018 at 172 with no documentation of a weight obtained in June 2018. On readmission from the hospital on 7/20/18 when his weight was 142 pounds on return from the hospital. Review of a nursing note dated 8/5/18 read Resident #10 removed his feeding and was sent to the hospital after failed attempts to replace it at the facility. He was admitted to the hospital for a urinary tract infection and returned to the facility on 8/10/18. There was no change in his tube feeding orders. Review of a nursing note dated 8/28/18 read Resident #10 removed his feeding tube and	F 692	licensed nursing staff will do audits using an audit tool five (5) times weekly for four (4) weeks including all shifts, then weekly for four (4) weeks including all shifts, to ensure the placement of the abdominal binder to prevent self-removal of the G-tube. The audits will be kept in the DON's office. The DON will report the findings of the audit to the Quality Assurance Committee monthly until substantial compliance has ben achieved. Completion Date 01/25/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 47	F 692		

orders received to replace the feeding tube. The feeding tube was replaced without difficulty.

Review of a nursing note dated 9/5/18 read Resident #10 was sent to the hospital for increased respiratory secretions and a drop in his oxygen saturation level. He was readmitted to the facility on 9/18/18 with no change in his tube feeding orders.

Review of a nursing note dated 9/23/18 read Resident #10 removed his feeding tube with orders received to replace the feeding tube with a larger size. The tube was replaced without difficulty.

Review of Resident #10's quarterly Minimum Data Set (MDS) dated 9/25/18 indicated severe cognitive impairment, no behaviors and total assistance with all of his activities of daily living. He was coded with known weight loss, a feeding tube and weight of 135 pounds.

Review of a dietary note dated 9/26/18 read Resident #10 had a history of removing his feeding tube and recent acute illnesses with repeat hospitalizations. His weight was 135 pounds and there was no change in his tube feeding orders.

Review of a dietary note dated 10/12/18 read Resident #10's weight was still trending down at 134 pounds. New orders to stop the bolus feeding and begin Isosource 1.5 at 60ccs per hour continuous with 35 ccs of water per hour.

Review of a nursing note dated 10/30/18 read Resident #10 removed his feeding tube with unsuccessful attempts to reinsert the tube. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 48	F 692		

was sent to the hospital to have his feeding tube reinserted.

Review of a dietary note dated 11/9/18 read Resident #10's weight was 130 pounds. There was no change in his tube feeding orders.

Review of a nursing note dated 11/14/18 read Resident #10 removed his feeding tube and orders were received to replace the tube. The feeding tube was replaced without difficulty.

Review of a nursing note dated 12/11/18 read Resident #10 was sent to the hospital due to blood in his stool. He returned to the facility on 12/17/18 with no change in his tube feeding orders.

In an observation on 12/18/18 at 11:10 AM, Resident #10 was lying in bed with the head of his bed elevated 30 degrees. He was able to move his arms and legs on request and able to answer yes/no questions. His tube feeding was connected and running Isosource 1.5 at 60 ccs per hour continuous with 35 ccs of water per hour.

In an interview on 12/18/18 at 3:10 PM, Nurse #4 stated Resident #10 had been very sick on and off since admission. She stated he was living at home with his wife prior to admission to the facility in March 2018. Nurse #4 stated Resident #10 was having a difficult time adjusting to the facility and that there were a lot of family dynamics involved. She stated Resident #10 frequently removed his feeding tube and required frequent hospitalizations. Nurse #4 stated the facility tried using an abdominal binder to prevent him from pulling out his feeding tube, but he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 49	F 692		

started to develop skin issues, so it had to be discontinued. Nurse #4 stated the only other intervention attempted to prevent Resident #10 from removing his feeding tube was to change his feedings from continuous to bolus. She stated that was not effective at preventing him from removing his feeding tube. She stated psychiatric services were involved in Resident #10's care.

In an interview on 12/18/18 at 3:26 PM, the Dietary Manager (DM) stated the Registered Dietician (RD) comes to the facility once a month and as needed. She stated Resident #10 was on weekly weights due to his known weight loss associated with his multiple hospitalizations due to illness and multiple incidents of removing his feeding tube.

In a telephone interview on 12/18/18 at 5:15 PM, the RD stated Resident #10's weights were stable at 172 pounds up until sometime in July 2018 when he hospitalized several times for sepsis, c-diff and respiratory issues. The RD stated Resident #10 was receiving plenty of calories to support weight gain. The RD stated bolus tube feedings were implemented at one time because it was felt he would be less likely to remove his feeding tube but when his weights continued to decline, the Physician changed Resident #10 back to continuous feedings.

Review of a dietary note dated 12/19/18 read Resident #10's weight continues to trend downward due to multiple hospitalizations and a history of removing his feeding tube. His current weight on readmission was 125 pounds. New orders dated 12/19/18 for Isosource 1.5 at 65 ccs per hour continuous with 35 ccs of water per hour.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 50	F 692		

In an observation on 12/19/18 at 8:20 AM, Resident #10 was lying in bed with his tube feeding running continuously as the ordered rate. He was observed to be alert and able to answer yes/no questions without difficulty. He was not observed attempting to removing his feeding tube but rather moving his arms in a continuous upward motion.

In an interview on 12/20/18 at 9:00 AM, Nurse #3 stated Resident #10 was known to remove his feeding tube and required frequent hospitalizations. She stated he often acted out after visits from his family.

In an interview on 12/20/18 at 9:10 AM, the Medical Director stated he was aware of at least nine hospitalizations since being admitted to the facility and multiple incidences of Resident #10 removing his feeding tube. The Medical Director stated some weight loss was to be expected but he was not notified of the continued unintended, significant weight loss. The MD stated the facility tried an abdominal binder at one time, but he started to develop skin issues, so it was discontinued. He stated he also changed his feedings from continuous to bolus on few instances in hopes that it would deter Resident #10 from removing his feeding tube. The MD stated it was also his expectation that the facility attempts other interventions to prevent Resident #10 from removing his feeding tube. He stated Resident #10 may require a higher calorie tube feeding to prevent further weight loss and he would follow up with the facility RD.

In an interview on 12/20/18 at 10:15 AM, the Director of Nursing stated it was her expectation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 51 that facility staff would have notified the Physician of continued weight loss so that other interventions could have been considered to prevent continued unintended, significant weight loss.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 52 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and pharmacist and staff interview, the facility failed to act upon the irregularities reported and identified by the pharmacist (Resident #40) and the pharmacist failed to identify and to report the use of anti-psychotic medication prescribed without a specific diagnosis (Resident #73) for 2 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #40 was admitted to the facility on 10/5/18 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that Resident #40 had received an anti-psychotic medication for 7 days during the assessment period. Resident #40 had a physician's order dated 10/5/18 for Risperdal (an anti-psychotic drug) 1 milligrams (mgs) by mouth twice a day for anxiety. Review of Resident #40's drug regimen review (DRR) was conducted. The DRR dated 10/11/18 was addressed to the Director of Nursing (DON).	F 756	Based on record review and pharmacist and staff interviews, the facility failed to act upon the irregularities reported and identified by the Pharmacist (resident #40) and the pharmacist failed to identify and to report the use of anti-psychotic medication prescribed without a specific diagnosis (resident #73) for 2 of 5 sampled residents reviewed for unnecessary medications. The Dyskinesia Identification System Condensed User Scale (DISCUS) for resident #40 was completed, signed and closed on 12/18/2018 by the Assistant Director of Nursing. The psychotic disorder diagnosis was added to the Medication Administration Record (MAR) and diagnosis list for resident #40 per Medical Director's orders on 12/20/2018 by Medical Records. The medication regimen for resident #73 was reviewed by the physician on 12/18/2018. The antipsychotic prescribed as needed for agitation was discontinued on 12/18/2018. The facility has determined that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 53 The pharmacist had requested to complete Dyskinesia Identification System Condensed User Scale (DISCUS) and to have a justification for the use of Risperdal. The DRR dated 11/1/18 was addressed to the DON. The pharmacist had requested a second time to complete DISCUS and to add diagnosis (psychotic disorder) for Risperdal on the Medication Administration Record (MAR). The DRR dated 12/14/18 was addressed to the DON. The pharmacist had requested a third time to complete DISCUS and to add diagnosis (psychotic disorder) for the Risperdal on the MAR. Review of Resident #40's medical records including electronic records revealed that DISCUS was not completed as of 12/18/18. Review of Resident #40's November and December 2018 MARs revealed that the diagnosis of psychotic disorder was not added on the MARs. On 12/18/18 at 11:20 AM, Unit Manager (UM) #1 was interviewed. UM #1 stated that she was responsible for ensuring that the pharmacist recommendations were acted upon. She verified that she signed off the October 2018 recommendations but failed to ensure that DISCUS was completed by the admitting nurse and she failed to add the diagnosis of psychotic disorder on the November MAR. UM #1 also indicated that starting November 2018, UM #2 was responsible for ensuring the pharmacist recommendations were acted upon on residents residing on the west hall. On 12/19/18 at 8:50 AM, UM #2 was interviewed. UM #2 stated that she started working at the	F 756	residents have the potential to be affected. All Resident's charts were audited to ensure that current DISCUS is in place on 1/18/19 by Clinical Nurse. All Resident's have current DISCUS in place. A review of all as needed medication orders and indications for use was completed on 1/15/2019 by the Clinical Nurse Supervisor. All medications had an indication for use. The Pharmacy Consultant was in-serviced on 1/12/2019 by the Corporate Director of Clinical Services about addressing the use of an antipsychotic medication prescribed without an adequate clinical indication for use. Licensed Nursing staff including all shifts, part time and weekend were in-serviced on 1/23/2019 by the Corporate Director of Clinical Services on how to complete a DISCUS, sign and close the assessment. All staff was in serviced prior to working their shift. The Director of Nursing (DON), or licensed nursing staff, will complete weekly audits using an audit tool for six (6) weeks for new anti psychotic medication orders to ensure that appropriate indications for use of any antipsychotic drugs are clearly documented in the medical record and that a DISCUS has been completed. The DON, or licensed nursing staff, will complete weekly audits using an audit tool for six (6) weeks on all new admissions and current Resident's to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54 facility in October and was in training until November 2018. She stated that she signed off the November and December 2018 recommendations today, 12/19/18. She also added that she had completed DISCUS also today 12/19/18 but had not added the diagnosis yet to the MAR. On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she had delegated the responsibility to address/act upon the pharmacist recommendations to the UM and she expected them to act upon the recommendations within 3-5 days after receiving the recommendations. 2. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included, disorientation, and alcohol dependence with withdrawal. The admission Minimum Data Set (MDS) assessment dated 11/21/18 indicated Resident #73' s cognition was severely impaired. She had other behavioral symptoms and rejection of care on 1 to 3 days. Resident #73 had two or more falls with no injury since admission. She was administered antianxiety medication on 5 of 7 days and no antipsychotic medication during the MDS look back period. A nursing note dated 12/6/18 at 9:29 AM indicated Resident #73 continued with behavioral outbursts, crying, and screaming out. She was noted with delusions and hallucinations. The physician was contacted and informed that as needed (PRN) Ativan (antianxiety medication) 2 milligrams (mg) was ineffective. A new order was	F 756	DISCUS was completed. All audits will be kept in the DON's office. The DON will report the findings of audits to the Quality Assurance Committee monthly until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55	F 756		

received to start Haldol (antipsychotic medication) mg every 6 hours PRN.

A physician ' s order dated 12/6/18 for Resident #73 indicated Haldol 1 mg by mouth (PO) every 6 hours PRN for agitation. A review of the December 2018 MAR indicated behavior monitoring and/or side effect monitoring had not been added to the Medication Administration Record (MAR) in relation to this PRN Haldol order.

Review of Resident #73 ' s medical record revealed from 12/06/18 to 12/15/18 she was administered Haldol 1 mg PRN on the following dates: 12/07/18 (x3), 12/08/18 (x2), 12/11/18, 12/12/18 and 12/13/18.

A monthly Drug Regimen Review (DRR) dated 12/15/18 completed by the Pharmacy Consultant indicated Resident #73 was receiving PRN Haldol for agitation. This DRR noted a recommendation was to be made for a 14 day stop date for the PRN Haldol as well as the need for behavior monitoring added to the MAR. There was no indication the Pharmacy Consultant addressed the need for a diagnosis related to the PRN Haldol to ensure there was an adequate clinical indication for use.

A review of Resident #73 ' s active care plan was conducted on 12/18/18. There was no care plan related to the use of antipsychotic medication.

An interview was conducted with Unit Manager (UM) #2 on 12/19/18 at 2:25 PM. She reported Resident #73 was admitted to the facility for rehabilitation following a hospitalization related to a fracture. She indicated Resident #73 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56	F 756		

agitation, restlessness, and rejection of care which was affecting her rehabilitation. She explained that Resident #73 would not stay still and let herself rest. UM #2 stated that the PRN Haldol was prescribed for agitation. She explained that PRN Ativan had previously been prescribed for agitation, but it was not consistently effective. She revealed the PRN Haldol had helped to calm Resident #73 and also resulted in the resident being more cooperative. She stated that according to her primary care physician, Resident #73 ' s only psychiatric diagnosis prior to her admission to the facility was depression.

An interview was conducted with Resident #73 ' s physician on 12/20/18 at 9:15 AM. He stated he was the Medical Director at the facility as well as the attending physician for Resident #73. The physician stated he gave the order for PRN Haldol after staff phoned him and said the PRN Ativan wasn ' t working and they had not known what to do. He explained that the PRN Ativan was previously prescribed for Resident #73 to calm her behaviors of hollering out and being physically combative with staff.

An interview was conducted with the Pharmacy Consultant by phone on 12/19/18 at 4:00 PM. The monthly drug regimen review for Resident #73 related to PRN Haldol prescribed for agitation was reviewed with the Pharmacy Consultant. He stated that he had not requested for the physician to provide a qualifying diagnosis on this initial review of the PRN Haldol as he expected it to be used minimally and on a short-term basis related to Resident #73 ' s adjustment to the facility. He indicated if Resident #73 was still on the Haldol at the time of his next review he would have asked for a specific diagnosis as there may have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 57 an underlying reason for her agitation. The Pharmacy Consultant stated that he had requested behavior monitoring be added to the MAR for the use of the PRN Haldol. An interview was conducted with the Director of Nursing (DON) on 12/20/18 at 10:15 AM. She stated she expected all antipsychotics to have an adequate clinical indication for use. She additionally indicated that agitation was not an appropriate clinical indication for the use of PRN Haldol. The DON stated that she expected the Pharmacy Consultant to identify and address the use of an antipsychotic medication prescribed without an adequate clinical indication for use.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 58 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the physician, pharmacy consultant, and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication and to monitor the effectiveness and adverse consequences of the antipsychotic (Resident #73) and also failed to assess a resident who was on an antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder (Resident #40) for 2 of 5 residents reviewed for unnecessary	F 758	Based on record review, observations, and interviews with the physician, pharmacy consultant, and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication and to monitor the effectiveness and adverse consequences of the antipsychotic (resident #73) and also failed to assess resident who was on an antipsychotic medication for extrapyramidal symptoms (EPS), a drug	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 59 medications. The findings included: 1. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included, disorientation, and alcohol dependence with withdrawal. The plan of care for Resident #73, initiated on 11/14/18, included, in part, the following problems areas: - The risk for side effects from antianxiety medication use. This problem was initiated on 11/14/18 and the interventions included, in part, monitor and record resident ' s target behaviors and observe resident for adverse side effects. - Impaired thought processes with episodes of crying out. This problem was initiated on 11/14/18 and the interventions included, in part, approach resident warmly and positively in a calm manner and monitor and document resident behaviors with any change in cognitive status reported to the physician. The admission Minimum Data Set (MDS) assessment dated 11/21/18 indicated Resident #73 ' s cognition was severely impaired. She had other behavioral symptoms and rejection of care on 1 to 3 days. Resident #73 had two or more falls with no injury since admission. She was administered antianxiety medication on 5 of 7 days and no antipsychotic medication during the MDS look back period. The Psychotropic Medication Care Area Assessment (CAA) related to Resident #73 ' s 11/21/18 MDS indicated she had problems with delirium as noted in hospital notes and nursing	F 758	induced movement disorder (resident #40) for 2 of 5 residents reviewed for unnecessary medications. The medication regimen for Resident #73 was reviewed by the physician on 12/18/2018. The antipsychotic medication prescribed as needed for agitation was discontinued on 12/18/2018. The Dyskinesia Identification System Condensed User Scale (DISCUS) for Resident #40 completed, signed and closed on 12/18/2018 by the Assistant Director of Nursing. The facility has determined that all residents receiving medications and new admissions are at risk. All Medication Administration Records (MAR) were reviewed for psychotropic medications to ensure that behavior monitoring was being completed for any resident receiving psychotropic medications on 1/17/2019 by the Clinical Supervisor. All resident's receiving psychotropic medications have behavior monitoring in place on Medication Administration Records. Care Plans for all residents on antipsychotic medications were reviewed to ensure that an appropriate care plan was in place on 1/18/2019 by the Nursing Management Team. All residents receiving psychotropic medication had an appropriate care plan in place. All Resident's charts were audited to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 60 notes from the facility. She was indicated to be pleasant, alert, and oriented to self only. The Behavioral CAA related to Resident #73 ' s 11/21/18 MDS indicated she had episodes of confusion and agitation. Resident #73 was noted as unable to understand why she was at the facility and she wanted to go home. She had packed up her belongings and pulled her call light out of the wall. She was sent to the hospital for evaluation and returned to the facility the same day. The nursing notes indicated she had refused to have vital signs taken at times as well as some exercises in therapy. A nursing note dated 12/6/18 at 9:29 AM indicated Resident #73 continued with behavioral outbursts, crying, and screaming out. She was noted with delusions and hallucinations. The physician was contacted and informed that as needed (PRN) Ativan (antianxiety medication) 2 milligrams (mg) was ineffective. A new order was received to start Haldol (antipsychotic medication) mg every 6 hours PRN. A physician ' s order dated 12/6/18 for Resident #73 indicated Haldol 1 mg by mouth (PO) every 6 hours PRN for agitation. A review of the December 2018 MAR indicated behavior monitoring had not been added to the Medication Administration Record (MAR) in relation to this PRN Haldol order. Review of Resident #73 ' s medical record revealed from 12/06/18 to 12/17/18 she was administered Haldol 1 mg PRN on the following dates: 12/07/18 (x3), 12/08/18 (x2), 12/11/18, 12/12/18, 12/13/18 and 12/17/18 (x3). Further review of the resident ' s medical record revealed	F 758	ensure that current DISCUS is in place on 1/18/19 by the clinical nurse. All Resident's had current DISCUS in place. The Pharmacy Consultant was in-serviced by the Corporate Director of Clinical Services on 1/12/2019 about addressing the use of an antipsychotic medication prescribed without an adequate clinical indication for use. All licensed nurses including all shifts, part time and weekend were in-serviced on completing DISCUS on admission and quarterly by the Corporate Director of Clinical Services on 1/23/2019. All were in-serviced prior to working the floor. The Director of Nursing (DON), or licensed staff member, will complete audits with an audit tool of all new psychotropic medications to ensure that behavior monitoring is attached to the MAR and DISCUS are completed for all new admissions during daily clinical meeting 5x (five) times weekly for six (6) weeks. Care plans for residents on antipsychotic medication will be reviewed 5x (five) weekly for six (6) weeks to ensure that appropriate care plan is in place. All audits will be kept in the DON's office. The DON will report the findings of the audits to the Quality Assurance Committee monthly until such time as consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 61	F 758	Completion Date 01/31/2019	

the following entries and monthly pharmacy drug regimen review regarding the administration of Haldol:

On 12/07/18 at 12:09 AM Resident #73 was administered PRN Haldol 1 mg PO and PRN Ativan 2 mg IM. A nursing note dated 12/7/18 at 3:03 AM, written by Nurse #8, indicated Resident #73, "had multiple behavioral issues this shift. Began to hit at staff while being helped to stand ...called staff names for no apparent reason. Staff was not able to make her happy or please her."

On 12/07/18 at 10:26 AM Resident #73 was administered PRN Haldol 1 mg PO. There was no behavioral documentation to indicate the reason this PRN Haldol was administered.

On 12/07/18 at 10:55 PM a nursing note, written by Nurse #9, specified Resident #73 was administered PRN Haldol 1 mg PO for increased agitation with effective results. Resident #73 was noted to be resting in bed with her eyes closed.

On 12/08/18 at 12:06 PM Resident #73 was administered PRN Haldol 1 mg PO. There was no behavioral documentation to indicate the reason this PRN Haldol was administered.

On 12/08/18 at 8:16 PM Resident #73 ' s medical was administered PRN Haldol 1 mg PO on 12/8/18 at 8:16 PM. There was no behavioral documentation to indicate the reason this PRN Haldol was administered.

On 12/11/18 at 10:50 PM Resident #73 was administered PRN Haldol 1 mg PO and PRN Ativan 2 mg IM. A nursing note dated 12/12/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 62	F 758		

2:56 AM, written by Nurse #8, indicated Resident #73 was agitated, crying loudly, and was unable to be consoled. She was noted to be restless and she walked herself into her bathroom. Resident #73 was noted to be medicated for anxiety and was put to bed.

On 12/12/18 at 4:22 PM Resident #73 was administered PRN Haldol 1 mg PO and PRN Ativan 2 mg IM. A nursing note dated 12/12/18 at 6:33 PM, written by Nurse #2, indicated Resident #73 had intermittent confusion throughout the day. She was noted to be cooperative for periods of time and then without provocation becoming very tearful, agitated, yelling out, and resistant to care. Redirection was ineffective. She was administered PRN Haldol during the afternoon medication pass with little effect. She continued with agitation and was going into other resident rooms and trying to give them her wheelchair and take their chairs. Resident #73 was then medicated with PRN Ativan 2 mg IM which was effective within the hour.

On 12/13/18 at 3:30 PM Resident #73 was administered PRN Haldol 1 mg PO. A nursing note dated 12/13/18 at 8:14 PM, written by Nurse #2, indicated Resident #73 had one episode of tearfulness and she was medicated with PRN Haldol. She was noted to be less agitated overall.

A monthly Drug Regimen Review (DRR) dated 12/15/18 completed by the Pharmacy Consultant indicated Resident #73 was receiving PRN Haldol for agitation. This DRR noted a recommendation was to be made for a 14 day stop date for the PRN Haldol as well as the need for behavior monitoring added to the MAR. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 63	F 758		

indication the Pharmacy Consultant was addressing the need for a diagnosis related to the PRN Haldol to ensure there was an adequate clinical indication for use.

On 12/17/18 at 12:48 AM, 3:08 PM and 8:34 PM Resident #73 was administered PRN Haldol 1mg PO. There was no behavioral documentation to indicate the reason these doses of PRN Haldol were administered. A nursing note dated 12/17/18 at 7:39 PM, written by Nurse #2, indicated Resident #73 was much more cooperative and appropriate. She was noted to have one short period of tearfulness and she was able to regain her composure.

A review of Resident #73 ' s active care plan was conducted on 12/18/18. There was no care plan related to the use of antipsychotic medication.

Resident #73 was observed on 12/19/18 at 3:00 PM. She was lying in bed her room reading a book. There were no behavioral issues noted.

An interview was conducted with Nurse #2 on 12/20/18 at 9:40 AM. She stated she was familiar with Resident #73 and was aware that since her admission to the facility Resident #73 had received orders for PRN Ativan PO and IM as well as PRN Haldol PO. She reported that the PRN Ativan was utilized for Resident #73 ' s episodes of agitation, tearfulness, exit seeing, and resistance to care. Nurse #2 was asked why PRN Haldol was administered to Resident #73. She stated it was used for agitation accompanied by psychotic symptoms. She explained that these psychotic symptoms included the false beliefs that she was going home, she had been discharged, and that she could walk. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64	F 758		

Resident #73 ' s agitation and psychotic symptoms were impacting her participation in therapy as well as causing the resident to have several falls due to repeated attempts to get out of bed unassisted. She revealed the PRN Haldol calmed Resident #73 and made her less restless. She was asked what type of interventions were implemented prior to the administration of PRN Haldol for Resident #73. She indicated the interventions included redirection, verbal consoling, increased monitoring, and offering her a glass of wine as ordered by the physician. Nurse #2 was asked where documentation of behavior monitoring and side effect monitoring related to the administration of Resident #73 ' s PRN Haldol was located. She indicated it was documented on the MAR or in the nursing notes. She was unable to recall if Resident #73 ' s MAR included behavior monitoring and side effect monitoring related to the PRN Haldol.

An interview was conducted with Unit Manager (UM) #2 on 12/19/18 at 2:25 PM. She reported Resident #73 was admitted to the facility for rehabilitation following a hospitalization related to a fracture. She indicated Resident #73 had agitation, restlessness, and rejection of care which was affecting her rehabilitation. She explained that Resident #73 would not stay still and let herself rest. UM #2 stated that the PRN Haldol was prescribed for agitation. She explained that PRN Ativan had previously been prescribed for agitation, but it was not consistently effective. She revealed the PRN Haldol had helped to calm Resident #73 and also resulted in the resident being more cooperative. She stated that according to her primary care physician, Resident #73 ' s only psychiatric diagnosis prior to her admission to the facility was depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 65	F 758		

An interview was conducted with Resident #73 ' s physician on 12/20/18 at 9:15 AM. He stated he was the Medical Director at the facility as well as the attending physician for Resident #73. The physician stated he gave the order for PRN Haldol after staff phoned him and said the PRN Ativan wasn ' t working and they had not known what to do. He explained that the PRN Ativan was previously prescribed for Resident #73 to calm her behaviors of hollering out and being physically combative with staff.

An interview was conducted with the Pharmacy Consultant by phone on 12/19/18 at 4:00 PM. The monthly drug regimen review for Resident #73 related to PRN Haldol prescribed for agitation was reviewed with the Pharmacy Consultant. He stated that he had not requested for the physician to provide a qualifying diagnosis on this initial review of the PRN Haldol as he expected it to be used minimally and on a short-term basis related to Resident #73 ' s adjustment to the facility. He indicated if Resident #73 was still on the Haldol at the time of his next review he would have asked for a specific diagnosis as there may have been an underlying reason for her agitation. The Pharmacy Consultant stated that he had requested behavior monitoring be added to the MAR for the use of the PRN Haldol.

An interview was conducted with the Director of Nursing (DON) on 12/20/18 at 10:15 AM. She stated she expected all antipsychotics to have an adequate clinical indication for use. She additionally indicated that agitation was not an appropriate clinical indication for the use of PRN Haldol.
2. Resident #40 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 66	F 758		

10/5/18 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 10/12/18 indicated that Resident #40 had memory and decision making problems. The assessment further indicated that Resident #40 had received an anti-psychotic medication for 7 days during the assessment period.

Resident #40 had a physician's order dated 10/5/18 for Risperdal (an anti-psychotic drug) 1 milligrams (mgs) by mouth twice a day.

Resident #40's care plan dated 10/5/18 was reviewed. One of the care plan problems was Resident #40 was at risk for negative effects from anti-anxiety and anti-psychotic medications use. The goal was Resident #40 will have no negative effects from medications use through the next review. The approaches included DISCUS (dyskinesia identification system condensed user scale) per policy.

Review of Resident #40's medical records including electronic records revealed that DISCUS was not completed to assess for EPS on admission.

On 12/18/18 at 11:20 AM, Unit Manager (UM) #1 was interviewed. UM #1 stated that the facility's policy for completing the DISCUS was on admission and then quarterly. She indicated that she was responsible for ensuring that residents on anti-psychotic medication had DISCUS completed by the admitting nurse. UM #1 verified that DISCUS was not completed for Resident #40. She indicated that she failed to check behind the admitting nurse to ensure that DISCUS was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 67 On 12/19/18 at 8:50 AM, UM #2 was interviewed. She stated that she was informed that Resident #40 needed to have DISCUS and she had completed one today (12/19/18). On 12/20/18 at 10:15 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected residents on anti-psychotic medication to have DISCUS completed within 3 days after admission.	F 758		
F 761 SS=D	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 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	F 761		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 68 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard two expired insulin pens and failed to date when opened three insulin pens (400 even/600 hall cart) for 1 of 2 medication carts reviewed for medication storage. The findings included: A review of the facility policy titled Injectable Medication Administration: Insulin Pen Delivery and dated January 2017, read in part that all opened insulin pens should be labeled with the date opened. Once opened the insulin pen must be used within the number of days specified in the product stability information of manufacturer for that product. On 12/19/18 at 4:30 PM, an observation of the medication cart for 400 even/600 halls was conducted with Nurse #1. Items discovered included: *Humalog Kwik Insulin Pen for Resident #236 was opened and undated. *Basaglar Kwik Insulin Pen for Resident #8 was opened and undated. *Humalog Kwik Insulin Pen for Resident #135 was opened and undated. *Novolog Insulin Pen for Resident #28 dated opened on 10/20/18. A label was present that read to discard after 28 days on the Insulin Pen. *Humalog Kwik Insulin Pen for Resident #55 dated opened on 11/15/18. In an interview on 12/19/18 at 4:30 PM, Nurse #1	F 761	Based on observations and staff interviews, the facility failed to discard two expired insulin pens and failed to date when opened three (3) insulin pens (400/600 hall cart) for 1 of 2 medication carts reviewed for medication storage. The insulin pens that were expired and not dated were discarded on 12/19/18 by the charge nurse and insulin pens were obtained with proper labeling of the date being opened. All other Med Carts were checked for expired pens on 12/19/18 by the Corporate Director of Clinical Services and the charge nurses. All carts were free of expired medications and dated appropriately. The facility has determined that all residents receiving insulin have the potential to be affected. An in-service was conducted by the Corporate Director of Clinical Services with licensed nurses, including all shifts, part time and weekends addressing the proper storage and labeling of medication on 01/23/19. Staff was in-serviced prior to working their shifts. Clinical Supervisors will inspect all medication carts daily using an audit tool for two (2) weeks then weekly for one (1) month for medication containers to ensure appropriate dating on an on-going basis. The Director of Nursing will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 69 stated that he hadn't noticed the medications were expired and or not dated. He was unable to state why the insulins had not been dated when opened. On 12/20/18 at 7:45 AM, an interview was conducted with Nurse #2 who stated that the Clinical Coordinator checked the medication carts weekly for expired and undated medications, but that the nurses should also be checking for expired and undated medications. During an interview on 12/20/18 at 8:00 AM, the Director of Nursing stated that it was her expectation for all insulins to be dated when opened and expired insulins to be discarded by any nurse that finds them. In an interview on 12/20/18 at 9:10 AM, the Pharmacist stated that he audits all the medication carts in the facility quarterly and had just completed an audit 10/30/18. He stated that he lets the facility know of his findings to include expired medications and undated medications. He stated that the discard recommendations for Humalog, Basaglar and Novolog insulins was 28 days after they were opened. The Pharmacist stated that it was his expectation for expired insulin to be discarded and replaced when found as well as insulin to be dated when opened.	F 761	findings of the audits to the QAA Committee monthly until consistent substantial compliance is met. Completion Date 01/31/2019	
F 791 SS=G	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities.	F 791		1/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 70 The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician	F 791	Based on observations, staff and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 71 interviews, the facility failed to provide dental services for a resident with expressed tooth pain for 1 (Resident #10) of 1 residents reviewed to dental care. The findings included: Resident #10 was admitted on 3/15/18 with cumulative diagnoses of chronic respiratory failure, cerebral vascular accident and dysphagia. Review of a nursing note dated 5/1/18 read Resident #10 was experiencing tooth pain. He was seen by the Medical Director with new orders given for Anbesol (oral topical pain reliever), and antibiotic and for Resident #10 to see the dentist when he completed the antibiotics. The note read the Responsible Party (RP) preferred Resident #10 to see the in-house dentist. Review of a History and Physical Examination completed by the Medical Director dated 5/1/18 read Resident #10 was complaining of a toothache to the right lower quadrant. An antibiotic was prescribed for 10 days for a possible periodontal abscess, the application of Anbesol to his tooth and for him to be put on the list to be seen by the dentist as soon as possible. Review of the medical record revealed Physician orders dated 5/1/18 that read as follows: Anbesol Maximum Strength Gel-Apply to painful tooth three times a day, Penicillin VK 500 mg (milligrams) per feeding tube every 6 hours for 10 days to stop on 5/11/18 for painful tooth, Next Week, Contact Emergency Dental Clinic for an Appointment due to a painful tooth. Review of a care plan dated 5/2/18 read Resident #10 was experiencing tooth pain. Interventions included medications as ordered, antibiotics as	F 791	Physician interviews, the facility failed to provide dental services for a resident with expressed tooth pain for 1 (resident #10) of 1 residents reviewed for dental care. Resident #10 was seen by the in-house Dentist on 1/8/2019 who made a referral to an Oral Surgeon which was made on 1/29/19 by the Social Worker. The facility has determined that most residents have the potential to be affected. The in-house Dentist made visits to residents on 1/8/2019, 26 residents were seen on this date. There is a list of the residents seen in the Director of Nursing (DON)'s office. Of the 26 residents seen on this date, 2 residents were noted toned outside referrals to the oral Surgeon. These referrals were made on 1/29/2019 by the Social Worker. The Social Worker and Licensed Nurses on all shifts including weekends and part time staff were in-serviced on the importance of assisting residents in obtaining routine and 24-hour emergency dental care by the Corporate Director of Clinical Services on 01/23/19. Staff was in-serviced prior to working their scheduled shift. The Social Worker will conduct a monthly audit using an audit tool of all dental referrals for 1 year to ensure residents are being seen by the dentist as needed. Audits will be kept in the DON's office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 72 ordered, dental services as ordered and for the application of an ice pack as ordered. The care plan was documented as resolved on 11/28/18. Review of the medical record revealed Resident #10 was in the hospital from 5/9/18 through 5/14/18. Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 5/14/18. Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 5/14/18. Review of the Dental Notes-Summary revealed the facility Dental Hygienist visited the facility on 6/4/18. Resident#10 was not of the list of residents to be seen by the Dental Hygienist on the Dental Notes-Summary dated 6/4/18 and he was not in the hospital at the time of the Dental Hygienist visit. Review of the medical record revealed Resident #10 was in the hospital from 6/26/18 through 6/29/18. Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 6/27/18. Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 6/27/18 but would have been unavailable due to hospitalization. Review of a nursing note dated 7/13/18 read Resident #10 continues to have dental pain. An order already in place for Anbesol. New order for ice packs as needed. Review of the medical record revealed a Physician order dated 7/13/18 that read as follows: May use Ice Pack to side of the face with tooth pain as needed every four hours for twenty	F 791	The Social Worker will report the findings of the audit to the Quality Assurance Committee monthly meetings until consistent substantial compliance has been achieved. Completion Date 01/25/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 73	F 791		

minutes.

Review of the medical record revealed no documentation related to tooth pain after 7/13/18 to present.

Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 8/20/18. Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 8/20/18 and he was not in the hospital at the time of the in-house Dentist visited the facility.

Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 9/5/18. Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 9/5/18 and he was not in the hospital at the time of the in-house Dentist visited the facility.

Review of Resident #10's quarterly Minimum Data Set (MDS) dated 9/25/18 indicated severe cognitive impairment, no behaviors and total assistance with all of his activities of daily living. He was coded with for experiencing mouth pain.

Review of the Dental Notes-Summary revealed the facility Dental Hygienist visited the facility on 10/22/18. Resident#10 was not of the list of residents to be seen by the in-house Dental Hygienist on the Dental Notes-Summary dated 10/22/18 and he was not in the hospital at the time of the in-house Dental Hygienist visited the facility.

Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 11/19/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 74	F 791		

Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 11/19/18 and he was not in the hospital at the time of the in-house Dentist visited the facility.

Review of the Dental Notes-Summary revealed the facility Dentist visited the facility on 11/30/18. Resident#10 was not of the list of residents to be seen by the in-house Dentist on the Dental Notes-Summary dated 11/30/18 and he was not in the hospital at the time of the in-house Dentist visited the facility.

In an interview on 12/18/18 at 3:10 PM, Nurse #4 stated Resident #10 had expressed any tooth ache that she could recall. She confirmed the facility had in-house dental services.

In an interview on 12/19/18 at 8:25 AM, the Social Worker (SW) stated it was her understanding that the in-house dentist came to the facility every 6 months and there had been a change in dental providers. The SW confirmed she was responsible to updating the list of residents to be seen by the in-house dentist on each visit to the facility. She stated Resident #10 was likely in the hospital when the dentist came to the facility in May. The SW stated she did not recall anyone informing her to place Resident #10 on the list to be seen by the in-house Dentist.

In an interview on 12/19/18 at 11:02 AM, Unit Manager #1 stated she wrote the orders in May 2018 when she was made aware that Resident #10 was experiencing tooth pain. She stated at that time, she contacted Resident #10's Responsible Party (RP) and informed him that to see the emergency Dentist, he would have to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 75	F 791		

out of the facility. The RP refused to send Resident #10 out to the emergency Dentist but rather opted to have Resident #10 seem on the next scheduled visit of the in-house Dentist. Unit Manager #1 stated it was at the time, she thought she spoke with the SW and asked her to add Resident #10 to the dental list to be seen at the next scheduled visit in May 2018 and if he was in the hospital at the time of the Dentist visit in May 2018, he would have been added to the next Dental visit in June 2018.

In an observation on 12/19/18 at 8:20 AM, Resident #10 was lying in bed. He confirmed he was not experiencing any tooth pain at present but refused visualization. There was no noted mouth odor detected.

In an interview on 12/19/18 at 3:00 PM, Nursing Assistant (NA) #4 stated Resident #10 was not always cooperative with his oral care.

In an interview on 12/20/18 at 9:00 AM, Nurse #3 stated she was not aware that Resident #10 was experiencing tooth pain but if he was, she would report it to Unit Manager #1.

In an interview on 12/20/18 at 8:24 AM, The MDS Nurse stated she resolved the tooth pain care plan on 11/28/18 because she was not aware of any recent complaints of tooth pain and that the Anbesol order was discontinued on 11/23/18. She stated she spoke to Resident #10 in November 2018 and he expressed no tooth pain and he had not required the use of any ice packs since July 2018.

In an interview on 12/20/18 at 9:10 AM, the Medical Director stated it was his expectation that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 76 Resident #10's tooth pain would have been addressed as soon as possible and he was not aware that his order for Dental Consult was not followed. The MD stated he would follow up with the facility to expediate a Dental Consult. In an interview on 12/20/18 at 10:15 AM, the Director of Nursing stated it was her expectation the Resident #10 receive a timely Dental Evaluation for reported tooth pain. She stated if Resident #10 was in the hospital in May 2018, it was her expectation that he would have been seen on the next scheduled in-house Dentist visit in June 2018.	F 791		
F 804 SS=E	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, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents, family, and staff, the facility failed to ensure food was served at an appetizing temperature for 8 of 14 interviewable residents reviewed for palatable food (Residents #9, #19, #20, #22, #27, #30, #43, and #67). The findings included: 1. Resident #30 was admitted to the facility on	F 804	Based on observation, record review, and interviews with residents, family, and staff, the facility failed to ensure food was served at an appetizing temperature for 8 or 14 interviewable residents reviewed for palatable food (residents #9, #19, #20, #22, #27, #30, #43, and #67). No residents were harmed as a result from this alleged deficiency. The facility	1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 77 7/18/18. Her quarterly Minimum Data Set (MDS) assessment dated 10/19/18 indicated her cognition was fully intact. The Resident Council minutes and concern follow up form dated 11/14/18 indicated Resident #30 stated that her grits were cold. This form was addressed to the Dietary Manager and indicated the cooks were spoken to related to food concerns. An observation and interview were conducted with Resident #30 on 12/19/18 at 8:09 AM. Resident #30 had been served breakfast in her room and she was eating independently. She had scrambled eggs and grits on her tray. She stated that her food was not warm enough indicating that she ate her french toast, but she was unable to eat the remaining items as they were not served at an appetizing temperature. She indicated that her food was consistently served at an unappetizing temperature when she ate in her room. An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough. An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in	F 804	has purchased new Heat Keeper Insulating Base and Dome Systems to extend the temperature holding time by twenty (20) minutes or more. 3 dozen were ordered on 01/02/19 and 3 dozen were ordered on 01/22/19. This solution maintains meals at safe temperatures during short distance deliveries. The facility has determined that all residents receiving meals have the potential to be affected. Audit was conducted on 1/17/2019 by the Nursing Management team using the audit tool on all residents lunch meal to ensure food is at an appetizing temperature and food is palatable to Resident's liking. All residents were satisfied with temperature and palatability of food. An in-service was provided by Dietary Manager on 1/23/2019 to the nursing assistants including all shifts, part time and weekends. Focusing on the proper/timely way to handle the meal delivery system and the importance of getting the meal trays to the residents as quickly as possible. All were in-serviced prior to working scheduled shifts. The Dietary Manager will conduct five (5) resident tray audits using an audit tool weekly across all three meals including weekends for six (6) weeks to ensure compliance. All audits will be kept in the Director of Nursing's office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 78 September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented. An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. 2. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18. Her quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated her cognition was fully intact. An observation and interview were conducted with Resident #67 on 12/19/18 at 8:05 AM. Resident #67 had been served breakfast in her room and she was eating independently. She had french toast sticks and sausage on her plate.	F 804	The Dietary Manager will report the findings of the audits to the Quality Assurance Committee until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 79	F 804		

She stated that her food was not warm enough. She further stated that she ate all her meals in her room and that her food was consistently served at an unappetizing temperature. She indicated this was consistent issue and she had not reported it to anyone recently as she believed everyone was aware of it and nothing had changed. She stated that she had not asked to have her food heated up because it would have taken too long.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 80	F 804		

the food, so it was served at a more appetizing temperature.

3. Resident #43 was admitted on 7/18/18. Her quarterly Minimum Data Set (MDS) assessment dated 10/18/18 indicated her cognition was intact.

An interview was conducted with Resident #43 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 81	F 804		

temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.

4. Resident #20 was most recently readmitted to the facility on 7/2/18. Her quarterly Minimum Data Set (MDS) assessment dated 10/5/18 indicated her cognition was fully intact.

An interview was conducted with Resident #20 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 82	F 804		

facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 83	F 804		

5. Resident #22 was most recently readmitted to the facility on 7/24/17. Her annual Minimum Data Set (MDS) assessment dated 10/2/18 indicated her cognition was fully intact.

An interview was conducted with Resident #22 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 84	F 804		

tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.

6. Resident #19 was most recently readmitted to the facility on 3/12/18. Her quarterly Minimum Data Set (MDS) assessment dated 10/3/18 indicated her cognition was intact.

An interview was conducted with Resident #19 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 85	F 804		

food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 86	F 804		

7. Resident #9 was most recently readmitted to the facility on 9/25/17. Her quarterly Minimum Data Set (MDS) assessment dated 9/18/18 indicated her cognition was moderately impaired.

An interview was conducted with Resident #9 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough.

An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 87	F 804		

new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.

8. Resident #27 was admitted to the facility on 11/21/17. Her annual Minimum Data Set (MDS) assessment dated 10/17/18 indicated her cognition was moderately impaired.

An interview was conducted with Resident #27 on 12/18/18 at 1:30 PM during the Resident Council meeting. She reported that "cold food" being served at meals continued to be an issue at the facility. She stated that this was primarily an issue for food served on the halls. She indicated that staff had told her that she could ask to have her food heated up, but that she got tired of always having to ask them to do this.

An interview was conducted with the Activities Director on 12/18/18 at 2:45 PM. She stated she facilitated the Resident Council meetings. She indicated she was aware that the temperature of food served on the halls had been a concern mentioned in the resident council meetings in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 88 past. She stated that the residents were reminded at every meeting that they could ask for staff to heat up their tray if it the food was not warm enough. An interview was conducted with the Administrator on 12/18/18 at 2:50 PM. He revealed he was aware that "cold food" was an issue since he began working at the facility in September of 2018. He reported that this issue was primarily concerning food served on the halls. He indicated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. He revealed that the current meal tray delivery system was not working well enough. The Administrator stated he was unsure when a new system was going to be implemented. An interview was conducted with the Dietary Manager (DM) on 12/20/18 at 8:30 AM. She stated that she had been working at the facility for 1 ½ years and revealed she was aware that "cold food" was an ongoing issue. She reported that this issue was primarily concerning food served on the halls. She stated that the residents have been told that they could ask for staff to heat up their tray or to receive an entirely new tray if their food was not warm enough. She confirmed the Administrators interview that the facility was looking into purchasing a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature.	F 804		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		1/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 89 §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 by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) to maintain implanted procedures and monitor interventions that the committee put into to place following the annual recertification survey dated 11/16/17. This was for two recited deficiencies in the areas of Accuracy of Assessments at F641-not accurately coding the Minimum Data Set in the areas of medications, hospice and prognosis previously cited on 11/16/17 and Bowel/Bladder Incontinence, Catheter/UTI at F690-not securing a urinary catheter previously cited 11/16/17. The findings included: This citation is cross referenced to: F641-Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses (Residents #31 and #73), bladder and bowel (Residents #40 and #73), medications (Residents #67 and #40), prognosis (Resident #40), hospice (Resident #86), activities of daily living (Resident #42), skin conditions (Resident #63), and therapies (Resident #54) for 8 of 17 residents reviewed. F690-Based on observation, record review and staff interview, the facility failed to provide catheter care by not securing and anchoring the catheter to prevent excessive tension and to	F 867	Based on observations, staff interviews, and record review, the facility's Quality Assurance and Performance Improvement Committee (QAPI Committee) failed to maintain implanted procedures and monitor interventions that the committee put into place following the annual recertification survey dated 11/16/17. This was for two recited deficiencies in the areas of Accuracy of Assessments at F641- not accurately coding the Minimum Data Set in the areas of medications, hospice and prognosis previously cited on 11/16/17 and Bowel/Bladder Incontinence, Catheter/ UTI at F690- not securing a urinary catheter previously cited 11/16/17. Members of the QAPI Committee met on 1/16/2019 to discuss repeat deficiencies at F641 and F690 to modify the facility's QAPI plan. The Corporate Director of Clinical Services was present at the meeting and completed an inservice on 01/16/2019 on the purpose of the QAPI Committee in insuring performance improvements are completed. An action plan was made and implemented by the members of the QAPI Committee(consisting of Administrator, Staff Development Coordinator, Clinical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 90 facilitate flow of urine for 3 of 3 sampled residents reviewed for indwelling urinary catheter (Residents #40, #45 and #135). In an interview on12/20/18 at 11:12 AM, the Administrator stated he had only been the Administrator at the facility for 3 months and he was in the process of revamping the QAA process. He stated he was uncertain why there were repeat citations and it could possibly be a personal issue, but he had to accept the responsibility.	F 867	Supervisor, Social Worker, Director of Nursing, Medical Records Director, Dietary Manager, Housekeeping Supervisor). The next meeting was scheduled for 1/30/2019 to review outcomes. The facility has determined that all residents have a potential to be affected. The Corporate Director of Clinical Services did an in-service with the licensed and unlicensed staff including part time and weekend staff regarding the facility's QAPI (Quality Assurance & Performance Improvement) plan on 01/24/2019. The Administrator will meet with all new hires during orientation to educate them on the facility's QAPI program. The QAPI Committee will meet monthly to discuss action plans related to the repeat deficiencies at F641 and F690 and all items on the QAPI agenda. The Medical Director will be physically present no less than quarterly at the meetings. Results of these meetings will be kept in the Administrator's office. This plan of correction will be continuously evaluated by the Administrator and the QAPI committee until such time as consistent substantial compliance is achieved. Completion Date 01/31/2019	