PRINTED: 03/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 02/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 000	conduct a complaint Per CMS and manage additional information 1/31/19, 2/1/19, and Deficiencies was ame 607 and F609 were	tered the facility on 1/2/19 to a survey and exited on 1/4/19. It is survey and exited on 1/4/19. It is survey and exited on 1/30/19, and was obtained on 1/30/19, and 2/4/19. The Statement of sended on 2/13/19. Tag Fammended. Tag F 602 was the was changed to 2/4/19.	F 00	00	
F 565 SS=E	CFR(s): 483.10(f)(5) §483.10(f)(5) The re and participate in res (i) The facility must pure group, if one exists, reasonable steps, who make residents are upcoming meetings (ii) Staff, visitors, or resident group or far the respective group (iii) The facility must person who is approgroup and the facility providing assistance requests that result for (iv) The facility must resident or family groups concerning is in the facility. (A) The facility must response and rational (B) This should not be	sident has a right to organize sident groups in the facility. Provide a resident or family with private space; and take with the approval of the group, and family members aware of in a timely manner. Other guests may attend mily group meetings only at 's invitation. Provide a designated staff wed by the resident or family and who is responsible for and responding to written from group meetings. Consider the views of a pup and act promptly upon the ecommendations of such assues of resident care and life to be able to demonstrate their alle for such response. The construed to mean that the ent as recommended every	F 56	55	2/1/19
ABORATORY	L DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE	(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/28/2019

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	04/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2013	
	10115211 011 001 1 2.2.1				205 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER						
					PINEHURST, NC 28374		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 565	Continued From page	e 1	F 5	565				
	§483.10(f)(6) The res	ident has a right to						
	participate in family g							
	participate iii iairiiiy g	Toups.						
	§483.10(f)(7) The res	ident has a right to have other resident						
		et in the facility with the						
	families or resident re	presentative(s) of other						
	residents in the facilit	y.						
	This REQUIREMENT	is not met as evidenced						
	by:							
	Based on staff and resident interviews and				F 565			
	record review, the fac	cility failed to effectively						
	resolve Resident Coι	ıncil (RC) grievances for 3						
	(September, October	and November 2018) of 3			Address how corrective action will be			
	months reviewed for	RC grievances. The facility			accomplished for those residents found	d to		
	also failed to respond	I to RC grievances within 5			have been affected by the deficient			
	working days for 2 (S	eptember, and November			practice;			
		viewed for RC grievances.			The Administrator presented a resolution	on		
	The findings included				to the Resident Council President on			
					1/25/19 for the grievance of answering			
	Review of the facility'	s policy dated revised May			call lights timely to include monitoring of			
		s/Complaints, Filing read in			call lights on each unit, each shift 3 tim			
	part that upon receipt				a week for 4 weeks, to assure call light			
		review and investigate the			are answered timely. The resolution wa			
	allegations and subm	it a written report of the			accepted by the resident council			
	findings to the Admin				committee on 1/25/19. The Social			
	working days of recei	ving the grievances. The			Service Director (SSD) provided a writt	en		
	resident or person fili	ng the grievance will be			letter of follow up to the Resident Cour			
	informed on the findir	ngs of the investigation			President on 1/25/19 to be shared duri	ng		
	within 5 working days	of filing the grievance.			the next Resident Council meeting on			
	_ ,				1/25/19. The Administrator presented	a		
	Review of the Septen	nber RC minutes dated			resolution to the Resident Council			
		ievance dated 9/26/18			President on 1/25/19, for the grievance	e of		
	_	ot being answered in a timely			cold food to include monitoring food			
		on was to increase the			temperatures on the tray line for			
		tone of the call bells. The			breakfast, lunch and dinner 5 times a			
	grievance indicated w				week for 4 weeks and monitoring food			
		C members on 9/28/18.			temperature during meal pass in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(С
		345177	B. WING _			02/	04/2019
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE 655				20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST	REHAB & LIVING CENTER		P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 565	Continued From p	age 2	F 5	565			
	5				dining room and hallways, for breakfas	st,	
		tember RC minutes dated			lunch and dinner 5 times a week, to		
		grievance dated 9/26/18			assure food temperatures remain withi	n	
		d in the dining room and on the			acceptable temperature range of 125		
		on was staff education with			degrees or resident preference. The		
		as completed with the RC			resolution was accepted by the resider		
	members on 10/23	3/18 (17 days).			council committee. The SSD provided		
		. 50			written letter of follow up to the Reside	nt	
		ober RC minutes dated			Council President on 1/25/19, to be		
		a grievance dated 10/24/18			shared during the next resident council	İ	
		ing staff not passing the meal			meeting on 1/251/9.		
		ng in cold food. The resolution			A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
		completed on 10/25/18 to			Address how the facility will identify oth	ier	
		s trays not being passed out			residents having the potential to be		
		nce indicated follow up was			affected by the same deficient practice	;	
	completed with the	e RC members on 10/25/18.			Current facility residents have the potential to be affected by the same		
	Review of the Nov	rember RC minutes dated			deficient practice of the facility failure	to	
	11/28/18 included	a grievance dated 11/28/18			provide resolution and follow up to		
	regarding call bells	s not being answered in a timely			grievances voiced during resident cour	ncil	
	manner. The resol	lution was a new camera			meetings. The Administrator and/or th	е	
	system was install	ed. The grievance indicated			SSD reviewed grievances received fro	m	
	follow up was com	pleted with the RC members			the Resident Council group from		
	on 12/20/18 (16 da				September 2018 through December 20)18,	
					to validate that resolutions were initiate	: d	
	In an interview and	d observation on 1/3/19 at 8:45			or obtained, and the resident council		
	AM, Resident #21	confirmed she was the			group was given a follow up letter		
	Resident Council I	President. She stated long call			regarding the resolution. There were r	10	
	bell response time	and unappetizing food had			other grievances identified that were no	ot	
	been a problem fo	r a while and that the RC			investigated and followed up according	j to	
	member complete	d a grievance on several			facility protocol.		
	occasions with littl	e to no improvements.			Address what measures will be put into)	
					place or systemic changes made to		
	In an interview on	1/3/19 at 10:40 AM, the Social			ensure that the deficient practice will n	ot	
	Worker stated she	logged each grievance as to			recur;		
	when it was receive	ed and forwarded the			The Administrator provided education of	on	
	grievance to the d	epartment responsible for the			1/23/19, for the Interdisciplinary Team		
	investigation, reso	lution and written notice.			(IDT), which consists of the Director of		
					Nursing (DON), Assistant Director of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
		345177	B. WING			l	04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 565	Administrator stated grievance after the convestigation and resignity of the RC grievance was addressed with resid the RC grievance was addressed with resid The Administrator state that the grievance por followed for any resid that the grievance por followed for any resid that the grievance por followed for any resident that the grievance of the grieva	a/19 at 10:30 AM, the she reviewed each completion of any grievance olution to ensure the ssed and notice was pecified 5 working day. She in the root cause as to why ere not effectively and timely ent notice of the resolution. At the dit was her expectation of the dit was her expectation of the grievance. a/19 at 10:40 AM, the Dietary enable to provide any food ing completed after 9/8/18 bood was served at the proper ovided tray delivery times in 12/10/18 of the breakfast. a/19 at 12:43 PM, the DON) stated she was unable of call bell monitoring for RC grievance dated 9/26/18 eted on 10/13/18 on third completed 11/20/18 on first salso on first shift. The DON rovide any evidence of neals trays were being		565	Nursing (ADON), Social Service Direct (SSD), Dietary Manager (DM), Activitie Director (AD), Rehab Manager (RM) ar Maintenance director (MD), regarding response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Activities Director will document grievances received during resident council meetings on the approved Grievance form and will forward the grievance form to the SSD to be logged onto the Resident Council Grievance lot The SSD will then forward the grievance form to the Administrator, who will give the appropriate IDT member to investig and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to rev and approve, then the SSD will submit follow up letter to the Resident Council president and/or group within 5 days of the receipt of the grievance. A copy of follow up letter will be kept with the monthly resident council meeting minuted in the programment of the programment of the grievance to make sure that	d og. ce to gate c. n iew a f the tes.	
	passed out timely aft	er the 10/25/18 in-service.			solutions are sustained; The Administrator and/or the Director of Nursing will review resident council grievance log 5 x a week for 4 weeks then weekly for 5 months, to validate the grievances received from the resident council group were investigated, a resolution was initiated/completed and follow up letter was provided to the	nat	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING			l	0
	201/1252 02 01/221/52	345177	D. WING_			02/	04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D5 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as t furnished, the behavior	(4)		565	resident council president and/or reside group within 5 days of receiving the grievance. The Administrator and/or the Director or Nursing will review the audits to identify patterns/trends and will adjust the plan necessary. The Administrator will review the plan during the monthly QAPI meet and audits will continue at the discretion the QAPI committee. Indicate dates when corrective action who be completed; February 1, 2019	of / as ew ing n of	2/5/19
	facility must make pro resolve grievances th accordance with this	ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph. ility must make information					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING_			C 02/04/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		1210412013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 585	to the resident. §483.10(j)(4) The fact grievance policy to er of all grievances regared contained in this paraprovider must give a contained in the resident. The grinclude: (i) Notifying resident in postings in prominent facility of the right to formaning spoken) or grievances anonymous of the grievance officing can be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the continued pendent entities of the filed, that is, the pendent entities of the filed program or protection (ii) Identifying a Griev responsible for oversoreceiving and tracking conclusions; leading a by the facility; maintain information associate example, the identity grievances submitted written grievance decorrect.	lity must establish a sure the prompt resolution rading the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must andividually or through locations throughout the sile grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone is expected time frame for of the grievance; the right cision regarding his or her intact information of with whom grievances may entinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is beeing the grievance process, grievances through to their any necessary investigations in the confidentiality of all divith grievances, for of the resident for those anonymously, issuing isions to the resident; and eand federal agencies as	F5	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		، ا	С
		345177	B. WING			1	04/2019
NAME OF PROV	/IDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREENS	S AT PINFHLIRST RE	EHAB & LIVING CENTER		20	05 RATTLESNAKE TRAIL		
THE ORLLIN	JAI I INCHOROT RE	TIAD & LIVING SERVER		Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(ii printing in right	revent further pote ght while the allege exestigated; v) Consistent with a porting all alleged buse, including injund/or misapproprianyone furnishing servider, to the admissive required by State existence of the perfect of the perf	sking immediate action to ntial violations of any resident ed violation is being §483.12(c)(1), immediately violations involving neglect, uries of unknown source, tion of resident property, by ervices on behalf of the inistrator of the provider; and	F	585	F 585 Address how corrective action will be accomplished for those residents found		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345177	B. WING _			02/	04/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE ODE	-NO AT DINIFILLIDOT D	SELLAD O LINVINO OFNITED		20	5 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST R	EHAB & LIVING CENTER		PI	NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					BEHOLHOT		
F 585	grievances. The factories grievance regarding daily menus for 1 re	residents reviewed for cility failed to resolve a g the facility not following the esidents (Resident #6) of 4	F 5	585	practice; The facility provided a shower for Resident #9 on 1/4/19, following survey exit, and has received showers every	<i>'</i>	
	also failed to respo	for grievances. The facility nd within 5 working days of			_Tuesdays and Friday, per residents□ shower schedule. The Director of Nurs	sing	
		or 3 (Resident #9 and Resident			(DON) discussed the shower schedule	40	
	grievances. The fin	#6) of 4 residents reviewed for			and resolution with Resident #9 on 1/4/	19,	
	gnevances. The ini	alligs ilicidaea			as a resolution to the grievance documented 11/28/18, showers will be		
	2017 titled Grievan part that upon rece Grievance Officer vallegations and subfindings to the Adm working days of recresident or person informed on the fine within 5 working days	ty's policy dated revised May ces/Complaints, Filing read in ipt of a grievance, the will review and investigate the omit a written report of the inistrator within five (5) ceiving the grievances. The filing the grievance will be dings of the investigation by of filing the grievance.			offered and given by the certified nursing assistant (CNA) on the scheduled show days and documented on the shower sheet. The Licensed nurse will validate shower was given and document on the Medication administration record (MAR The facility provided a shower for Resident #13 on 1/5/19, following survey exit, and has received showers every _Wednesday and Saturday, per residents shower schedule. The DOI discussed the shower schedule and	ver e e .).	
		ses of Cerebral Vascular				20	
	Accident (CVA) with				resolution with Resident #13 on 1/4/19, a resolution to the grievance document on 11/28/18, showers will be offered ar	ed	
	she required staff a	ated electronic Kardex read assistance for showers every y on second shift and as			given by the CNA on the scheduled shower days and documented on the shower sheet. The Licensed nurse will validate shower was given and docume on the MAR.		
	she required staff a	plan last revised 7/28/18 read assistance for showers every y on second shift and as			The Dietary Manager (DM) met with Resident #6 on 1/25/19, to discuss the residents food preferences and update tray card on 1/25/19 to include Reside #6 s likes/dislikes. DM informed		
	grievance dated 11 was not getting her	ty grievance log revealed a /28/18 which read Resident #9 showers. The grievance read ovided on 12/20/18 (16 days)			Resident #6 that if she received a food item that she did not like or want, she could ask for an alternate. Resident #6 verbalized understanding and was	6	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	COMPLE	
		345177	B. WING			02/	04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE COE	NO AT DINELUIDOT DE	HAD S LIVING CENTED		2	05 RATTLESNAKE TRAIL		
INE GREE	ENS AI PINEHURSI REI	HAB & LIVING CENTER		P	PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 585	Continued From page	a 8		585			
1 000			-	303			
		nat new shower sheets were			pleased with the resolution to her	,	
		tation to include education			grievance that was received on 10/4/18	·-	
	was provided to nurs	es and aides.					
	Resident #9's quarte	rly Minimum Data Set (MDS)					
		ated she was cognitively			Address how the facility will identify oth	er	
		no behaviors. She was coded			residents having the potential to be		
	for total staff assistar				affected by the same deficient practice	:	
		G			Current facility residents have the	,	
	Review of the docum	entation from 11/1/18 to			potential to be affected by the same		
	1/4/19 indicated Resi	ident #9 only received one			deficient practice of the facility failure	to	
	shower on 12/21/18.	•			provide resolution and follow up to		
					grievances. The Administrator and/or t	he	
	In an interview on 1/3	3/19 at 10:40 AM, the Social			SSD reviewed grievances received from	om .	
	Worker stated she lo	gged each grievance as to			October 1, 2018 through January 17,		
	when it was received	and forwarded the			2019, to validate that resolutions were		
	grievance to the depart	artment responsible for the			initiated or obtained and the resident		
	investigation, resoluti	ion and written notice.			and/or resident representative was giv	en	
					a follow up letter regarding the resolution	on nc	
	In an interview and o	bservation on 1/3/19 at 1:40			with in 5 days of receiving the grievanc	e.	
	PM, Resident #9 stat	ed she had not been			There were (5) grievances documented	l in	
	receiving her schedu	led showers for some time.			December that were investigated but a		
	She stated she comp	leted a grievance but there			letter of follow up was sent later than th	ie	
	had been no improve	ement in receiving her			required 5 days. All other grievances		
	showers. Resident #9	9 appeared clean, absent of			were investigated and follow up letter s	ent	
	odors and dressed for	or season.			within 5 days.		
	In an interview on 1/4	1/19 at 10:30 AM, the			Address what measures will be put into	,	
	Administrator stated	•			place or systemic changes made to		
		ompletion of any grievance			ensure that the deficient practice will no	ot	
	investigation and res				recur;		
	grievance was addre				The Administrator provided education of	n	
	_	pecified 5 working day. She			1/23/19, to the Interdisciplinary Team		
		the root cause as to why			(IDT), which consists of the Director of		
		evance was not effectively			Nursing (DON), Assistant Director of		
	_	y follow up within 5 working			Nursing (ADON), Social Service Director	or	
	days. The Administra				(SSD), Dietary Manager (DM), Activitie		
	expectation that the				Director (AD), Rehab Manager (RM) ar		
		d for any resident grievance.			Maintenance director (MD), regarding		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 04/2019
NAME OF PE	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2013
					05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST R	EHAB & LIVING CENTER			INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	Director of Nursing to provide documer compliance with Reshe She stated it was his be effectively resolve within 5 working da 2. Resident #13 wareadmitted 6/29/18 CVA, Diabetes and (CHF). Resident #13's quaindicated moderate behaviors. She was assistance with bat Resident #13's und she required staff a Wednesday and Saneeded. Resident #13's care read she required staff and she required she required staff and she required she required staff and she required she required staff and she required staff and she required staff	/4/19 at 12:43 PM, the (DON) stated she was unable ntation of monitoring for esident #9's shower schedule. Her expectation that grievances wed with written follow up ys. Is admitted on 1/15/18 and with cumulative diagnoses of Congestive Heart Failure Interly MDS dated 11/25/18 cognitive impairments with no is coded as requiring total staff	F 5	585	response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Administrator and/or the DON completed education on 1/25/19 for all nursing staff to include licensed nurses and certified nursing assistants, all shift all days including weekends and prn st regarding completion of grievance form when a grievance is voiced and process for reporting the grievance to the supervisor. Nursing staff will be educate regarding the Grievance policy and process during new hire orientation. When staff members receive a grievant from a resident and/or resident representative, they will assist the resident or representative as needed to writh the grievance on the grievance form at will forward the grievance form to the SSD will then forward the grievance for to the Administrator, who will give to the appropriate IDT member to investigate and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to revenue.	ted ce dent te nd sSD rm e	
	1/4/19 indicated Reshower on 12/12/18 12/26/18.	mentation from 11/1/18 to sident #13 only received a 3, 12/15/18, 12/22/18 and by grievance log revealed a /28/18 which read Resident			and approve, then the SSD will submit follow up letter to the resident and/or resident representative within 5 days of the receipt of the grievance. Indicate how the facility plans to monitority performance to make sure that solutions are sustained; The Administrator and/or the Director of	f or	
	read notification wa	her showers. The grievance is provided on 12/20/18 (16 in was that new shower sheets			Nursing will review the grievance log 5 week for 4 weeks then weekly for 2 months, to validate that grievances	ха	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2013
					05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page	e 10	F 5	585			
	were created for docu	umentation to include ed to nurses and aides.			received were investigated, a resolutio was initiated/completed, and a follow u		
	·	3/19 at 10:40 AM, the Social			letter was provided to the resident and resident representative within 5 days o	or	
		gged each grievance as to			receiving the grievance.		
	when it was received				The Administrator and/or the Director of	of	
		artment responsible for the			Nursing will review the audits to identify		
	investigation, resolution	on and written notice.			patterns/trends and will adjust the plan necessary. The Administrator will review		
	In an interview and ol	bservation on 1/3/19 at 4:50			the plan during the monthly QAPI meet		
	PM, Resident #13 stated she had not been and audits will continue at the dis		and audits will continue at the discretio	-			
	receiving her schedul	ed showers and she			the QAPI committee.		
		e with little improvement in					
	_	s. Resident #13 appeared					
	clean, absent of odor	s and dressed for season.			Indicate dates when corrective action v	vill	
					be completed;		
	In an interview on 1/4				February 1, 2019		
	Administrator stated s						
	_	ompletion of any grievance					
	investigation and reso						
	grievance was address	pecified 5 working day. She					
		n the root cause as to why					
		ievance was not effectively					
	_	follow up within 5 working					
	·	tor stated it was her					
	expectation that the						
		d for any resident grievance.					
	In an interview on 1/4						
		OON) stated she was unable					
	to provide documenta						
	•	dent #13's shower schedule.					
		expectation that grievances d with written follow up					
	•	•					
	within 5 working days	.					
		dmitted on 6/26/17 with s of Chronic Obstructive					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205	REET ADDRESS, CITY, STATE, ZIP CODE RATTLESNAKE TRAIL IEHURST, NC 28374	1 021	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page Pulmonary Disease at Resident #6's annual indicated she was cono behaviors. She with eating. Review of the facility grievance dated 10/4 meal tray did not mat The grievance read re 10/23/18 (13 days) at was to review the mean Review of the facility grievance dated 10/1 meal tray did not mat The grievance read re 10/23/18 (8 days) and education. In an interview on 1/2 Manager (DM) stated September 2018 throwas out, the Chef ow stated the Chef did ne process that resulted	e 11		585		ATE	DATE
	In an interview on 1/2 stated the facility gave menu, but they did not an ongoing problem to grievances about with #6 stated completing any resolutions, so sl	2/19 at 3:00 PM, Resident #6 e her a copy of the daily ot follow it. She stated it was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING		02/0	4/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 0210	7/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	Colostomy, there were eat. In an interview and o AM, Resident #6 was not feel well and was breakfast. Her breakfand grits. The tray ticher tray. In an interview on 1/3 Worker stated she low when it was received grievance to the depainvestigation, resolution. In an interview on 1/4 Administrator stated grievance after the convestigation and resignievance was addresprovided within the symptomic was unable to explain the Resident #6's grie addressed with timely days. The Administration a food committee back discuss the residents. She stated they met a voiced concerns relatifully following the menus. The Adexpectation that the general states are supported to out on leave. The Adexpectation that the general states are supported to the states are supported to out on leave. The Adexpectation that the general states are supported to the supported to the states are supported to the supported to the states are supported to the supported to th	bservation on 1/3/19 at 8:30 in bed. She stated she did not bothering to eat her fast tray included eggs, toast ket matched what was on and forwarded the fartment responsible for the on and written notice. 6/19 at 10:30 AM, the social great action of any grievance of and notice was becified 5 working day. She in the root cause as to why evance was not effectively a follow up within 5 working tor stated the facility started ck late summer if an effort to concerns with the food. The Administrator stated it was her later to stated	F 58	35		
F 602	Free from Misapprop		F 60	02	2	2/5/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 2/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 602 SS=D	neglect, misappropriand exploitation as a includes but is not li corporal punishmen any physical or cher treat the resident's right This REQUIREMEN by: Based on record resinterviews, and family 4) of three samples to address the relating a housekeeping aid car ownership and upermission. The find Record review reverses years of age, was 4/20/18. One of the a progressive neuron is known to affect but Record review reverses admission, the resign himself. A family me emergency contact, attorney for Resident Review of Resident	e right to be free from abuse, iation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to medical symptoms. IT is not met as evidenced view, resident interview, staff ly interview for one (Resident and residents, the facility failed conship with Resident # 4 and the concerning financial areas, use of resident items with his dings included: alled Resident # 4, who was a sadmitted to the facility on resident's diagnoses included degenerative disorder which that in activity. alled upon his 4/20/18 lent was responsible for the mber was listed as an There was no power of the that admission. # 4's admission minimum	F 6	F 602 Address how corrective action will accomplished for those residents have been affected by the deficie practice; The facility completed a 24-hour of 1/4/19, and 5-day investigation work completed on 1/9/19 for Resident regarding resident exploitation and misappropriation of resident fundapersonal belongings. This was at that occurred with Resident #4 while he was competent with a Biscore of 15. Employee #1 quit work the facility on 7/25/18. The Police APS were notified in September 2 when the resident had failed to make payment to the facility. Resident are requested his son be notified and allegations against employee #1.	report on ress t #4, and situation s consent IMS orking at e and 2018, make #4 I were		
	revealed the resider Brief Interview for M 10. (A cognitively in	essment, dated 4/27/18, and was assessed to have a dental Status (BIMS) score of tact score is considered 13 to as also assessed to have on the MDS.		made. The police and APS works informed the facility, following the investigations, that the resident woognitively intact and made his own decisions during the time when the and the car were made available	eir was wn ne funds		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NITIMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING			l	0.4/0040
NAME OF D	ROVIDER OR SUPPLIER	040117	1 2:		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2019
NAME OF PI	ROVIDER OR SUPPLIER						
THE GREE	ENS AT PINEHURST REI	AB & LIVING CENTER			05 RATTLESNAKE TRAIL		
				F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 602	Continued From page	e 14	F 6	602	employee #1. The facility became Rep)	
	upon "change of thera	ssessment was completed apy." The resident's BIMS to be 15, which indicated he			payee in October of 2018. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice. The Administrator and/or the Social	ier	
	renal failure. Hospital documentation the re memory disturbance admission date.	2/18 to 8/28/18 secondary to records included sident had delirium and upon his 8/22/18 hospital			Service Director (SSD) reviewed the grievance logs from July 2018- January 21, 2019, to identify concerns regarding resident exploitation and/or misappropriation, to validate that an investigation was completed and was reported to the state agency. There we no other concerns identified that had no	g ere	
	MDS assessment, Rehave a BIMS score of coded on this MDS adepression.	ed on a 10/21/18 quarterly esident # 4 was assessed to f 15. The resident was also ssessment to have signs of			been investigated and/or reported to the state agency. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Service director (S	e SD)	
	was interviewed on 1 business administrati following. Resident # when he was first adr 4/20/18. The residen he owed to the facility	administration employee /4/19 at 9:33 AM. The facility on employee reported the 4 had Medicaid approval mitted to the facility on t routinely paid any money / himself up until August,			completed interviews with current staff 1/25/19, regarding knowledge of reside abuse, exploitation and misappropriation that has not been previously reported. There were no other allegations identified that were not investigated.	ent on, ied	
	August, 2018. Upon It his September balanch had the money to pay business administrati Resident # 4's son the provided them with produced 8/31/18. Accordemployee the facility security payee follow.	en became involved and ower of attorney papers ding to the business			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator and/or the DON completed education on 1/25/19, for all facility staff, all shifts, all days including weekends and prn staff, regarding reporting and investigating allegations abuse. The education will be included new hire orientation. The staff will report immediately to the	ot I I	
	It was validated on 1/	31/19 with the facility			abuse officer any allegation of abuse to)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C	
	201/1252 02 01/221/152	345177	D. WING _	OTDEET ADDRESS SITV STATE TO SOR		2/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
THE GREE	NS AT PINEHURST RE	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL			
				PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 602	Continued From page	e 15	F 60	02			
	POA was notarized by validated on 2/4/19 who Deeds office that the file for Resident # 4. not registered in the presided.	e facility's copy of the son's ut had no seal on it. It was with the County Register of re was no registered POA on The son's 8/31/18 copy was county where the resident as interviewed on 1/3/19 at		include resident exploitation a misappropriation. The abuse submit the 24-hour report to the agency and an investigation withat time and within 5 days of allegation the abuse officer with 5-day investigative report to the agency.	officer will he state vill begin at the ill submit the		
	3:30 PM. The son state be appointed power of in the past several metallists. Price admission, Resident facility. During Reside former facility, an emphousekeeping aide, he and the other facility employee. When Rescurrent facility, the erequirement of the analysis of the employee took thouse from Resident # 4 him sign his car over of Motor Vehicles), a alcohol. During the telegraphs of the several metallic power of his became payee of his	ated he had taken action to of attorney for Resident # 4 onths. The son reported the or to his April 2018 facility # 4 had resided at another ent # 4's residency at the ployee, who was a nad "taken a liking to him," had terminated the sident # 4 moved to the enployee followed Resident # The son stated the ands of dollars of money hank accounts, arranged to have social security payee, had to her at the DMV (Division and would give him drugs and time that the employee social security check, she		Indicate how the facility plans its performance to make sure solutions are sustained; The Administrator, DON and/o will interview 5 staff members weeks then 10 staff members 2 months, to validate that alleadbuse were reported to the aband an investigation was initial reported to the state agency. The Administrator and/or the Nursing will review the grieval week for 4 weeks then weekly months, to validate that grieval missing items and/or care cor investigated and reported to the agency as required, if the item misappropriated or abuse situlidentified.	or the SSD weekly for 4 monthly for gations of buse officer ated and Director of nce log 5 x a y for 2 ances of ncerns were he State ns were		
	The son stated he re facility. The son could when all of this occur it, but stated the ever approximately the last named Employee # 1 who allegedly did the his concerns had also and APS (Adult Protests).	or which he was responsible. Corted his concerns to the dinot give definitive dates ared or when he had reported that had transpired in the six months. The son as the housekeeping aide se things. The son stated to been reported to the police ective Services) and "they about it." According to the		The Administrator and/or the Nursing will review the audits patterns/trends and will adjust necessary. The Administrator the plan during the monthly Q and audits will continue at the the QAPI committee.	to identify t the plan as r will review API meeting discretion of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				04/2019
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	0-4/2010
				20	05 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER			INEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page	e 16	F6	602			
	criminal activity deter	etermined there had been no mined, and the son provided egations against Employee			be completed; February 5, 2019		
	AM. Resident # 4 was whether an employee taken advantage of h head and stated, "I ju know." He would not 4's affect was observe	erviewed on 1/4/19 at 11:25 interviewed regarding had ever stolen from him or im. Resident # 4 shook his st don't know. I just don't expound further. Resident # ed to be flat and depressed. If, he looked away and ersation.					
	she was 29 years of a on the personnel file. competency form had The employee's term According to an intervon 1/4/19 at 11:10 AM 1 had worked for the The phone number list	# 1's personnel file revealed age. There was no hire date A new employee orientation been completed on 6/8/18. ination date was 7/25/18. view with the administrator A, this indicated Employee # facility for at least 48 days. Sted for Employee # 1 in the longer a working number.					
	administrator that the regarding the inciden on 9/11/18. On this da protective services we resident's family mem noted in the resident's facility documentation administrator she was responsible for invest had been made follow resignation. According	t was in the resident's record ate, the SW noted adult as notified on behalf of the ober. The reason was not so record or on any other of the solution and the solution and the solution are solution. According to the solution and the solution are solution.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С		
	345177	B. WING			02	2/04/2019		
ER				STREET ADDRESS, CITY, STATE, ZIP CODE				
T DE	HAR & LIVING CENTER			205 RATTLESNAKE TRAIL				
) I KE	HAB & LIVING CENTER			PINEHURST, NC 28374				
ICIENC	Y MUST BE PRECEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE		
n pag	e 17	F	602	2				
y evic	dence to validate							
sing a see, an report tated then she was ked he would not pay ed with how on the was all the was a for how e facil to ble to the were in taking the were in the stay the were in the stay the wears of the were in	n alternative family's number d an interview was obtained. Seed the following details. She had been trying to help the became involved with d not have a good family, and he still had a se still employed at the facility, for to help him go home while rather pay her to help him the nursing home. The th his requests by saying, for the road." Over a course talked to the resident to the ert and oriented, and not what he wanted to do. In felt he was alert to make a she felt it would be good for the than the nursing home sire. While she was ity, she met with the resident tak, and drew up a written im. The contract was was that the resident go back home full time with a care. She talked to the made them aware of the nagreement. She quit her g the resident home and here for interims.							
	m page 4 drugs and a see, an a see, an a see, an a see, an a see and a see and a see and a see a see and a see a s	ST REHAB & LIVING CENTER LARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL BRY OR LSC IDENTIFYING INFORMATION) In page 17 If 4 drugs or alcohol and she was by evidence to validate on or exploitation. In page 17 If 4 drugs or alcohol and she was by evidence to validate on or exploitation. In page 17 If 4 drugs or alcohol and she was by evidence to validate on or exploitation. In page 17 If 4 drugs or alcohol and she was by evidence to validate on or exploitation. In page 17 If 4 drugs or alcohol and she was sing an alternative family's number even and an interview was obtained. If you have a good the following details. If you have a good the facility, we have a still employed at the facility, we have to help him go home while would rather pay her to help him on pay the nursing home. The led with his requests by saying, how on the road." Over a course of the was alert and oriented, and not ding what he wanted to do. In the felt he was alert to make so, and she felt it would be good for home than the nursing home has desire. While she was the facility, she met with the resident home than the nursing home has desire. While she was goal was that the resident ble to go back home full time with the for him. The contract was goal was that the resident ble to go back home full time with the for him. The contract was goal was that the resident ble to go back home full time with the for him. The contract was goal was that the resident ble to go back home full time with the for him. The contract was goal was that the resident ble to go back home full time with the resident home and stay there for interims. It taking the resident home and stay there for interims.	A. BUILDI 345177 B. WING ST REHAB & LIVING CENTER PRESTREHAB & LIVING CENTER ST REHAB & LIVING CENTER PRESTREHAB & LIVING CENTER PRESTR	A BUILDING 345177 B. WING ATTECHAB & LIVING CENTER ST REHAB & LIVING CENTER ID PREFIX TAG ID PREFIX TAG F 60: 15 AM Employee # 1 was sing an alternative family's number see, and an interview was obtained. reported the following details. stated she had been trying to help shen she became involved with # 4 did not have a good she his family, and he still had a see was still employed at the facility, ked her to help him go home while would rather pay her to help him so pay the nursing home. The sed with his requests by saying, show on the road." Over a course she talked to the resident to vas alert and oriented, and not ding what he wanted to do. In she felt he was alert to make ss, and she felt it would be good for home than the nursing home sis desire. While she was e facility, she met with the resident h break, and drew up a written k for him. The contract was goal was that the resident ble to go back home full time with 4 hour care. She talked to the y and made them aware of the were in agreement. She quit her d taking the resident home and stay there for interims. Casions she assisted him to go to request where he "moved money	A BUILDING 345177 BY STREHAB & LIVING CENTER STREHAB & LIVING CENTER TARY STATEMENT OF DEFICIENCIES ICIDENCY MUST BE PRECEDED BY FULL RRY OR LSC IDENTIFYING INFORMATION) TAG TAG TAG TAG TAG TAG TAG TA	STREAT STREAMS LIVING CENTER STREAMS & LIVING CENTER STREAM & LIVING CENTER STREAMS & LIVING CENTER PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345177	B. WING		02/04/201	10		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	02/04/201	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPI	K5) LETION ATE		
F 602	Administration Office got there that she be payee. They were to social security admin recognized that she chelp the resident. Enthe exact date on wh Social Security Administrator (Aformer facility, where and to which the fam where Employee # 1 interviewed on 1/31/2 interviewed on 1/31/2	him to the Social Security, and he insisted when they made his social security gether at the time, and the istration employee [Employee # 1) was trying to aployee # 1 could not recall ich they had gone to the inistration Office. Sked her to take him to the Vehicles (DMV) one day to tion of his car. Once at the sisted that her name be a According to Employee # 1 com the resident nor had she im. According to the resident's idea to drink in she took him home. Exported that prior to Resident pay his nursing home bill, and he also Employee # 1 stated the an envelope within his made sure the wallet was in	F 60	02				

OLIVILIY	OT OIL WILDIO, WE G	WEDIO/ ND CEITTICE				CIVID ITC	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		,	С
		345177	B. WING			1	04/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE COE	ENS AT PINEHURST REI	HAR & LIVING CENTER		2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHUNST KEI	HAB & LIVING CENTER		F	PINEHURST, NC 28374		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG		,	1,10		DEFICIENCY)		
F 602	Continued From page	e 19	F	602			
	resided "off and on" v	with them from 12/7/16 to					
	3/21/18. While Resid	ent # 4 resided at their					
		oriented, and responsible for					
		is own facility bill. The					
	-	y of not paying his bill and					
		a 30 day discharge notice on					
		nuse of his refusal to pay.					
	The resident also had a history of offering money to facility staff to buy him things and "carrying wads of cash." The resident also reported money						
	was being taken from						
	_	e period during which only					
	his son had access to	the resident's financial					
	account and Employe	ee # 1 was not an employee					
	-	ing to the former facility's					
		1 had been at Administrator					
		1/18 to 5/14/18. According to					
	Administrator # 2, En						
	•	ident # 4 of which he was it recall personnel problems					
		hile she worked at the former					
		s validated that Employee # 1					
		ated as the family member of					
		because of her involvement					
	with Resident # 4; rat	ther she quit work on her					
	own accord. Also ac	ccording to Administrator # 2,					
		for Medicaid during the					
	resident's residency a						
		trator # 2, there had been					
	-	ent # 4's family cooperating					
		plication to assure Resident many valued items to qualify					
		sident had not had his					
		efore his final discharge on					
	3/21/18.	o.o.o mo mar albonargo on					
	Interview with the pol	lice on 1/31/19 at 2:10 PM					
		been no criminal activity					
	substantiated in their	investigation into the son's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _		1	04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,,	<u> </u>
THE ODE	- 10 47 BINELIUBOT BEI	IAD A LIVING GENTED		205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	that Employee # 1 ha that she was being m Security Representation provided evidence that on Resident # 4's car vehicle. According to records showing the According to the police had been deemed ale police investigation. Temployee # 1 had as work for Resident # 4 Interview with an Adu employee on 1/31/19 had no evidence of bate Employee # 1 had sto According to the APS referral on 9/10/18, and no 9/11/18. She admided Mental Status Exam (he had the highest povery alert and orienter him, Resident # 4 told of a social worker's with then changed his had taken his money, of and he did not need She saw him again or administered the SPM highest score. At that	at # 4's money was at Resident # 4 was did provide records showing d been notified on 8/16/18 ade Resident # 4's Social we Payee. The police also at Employee # 1 was placed title as a joint owner of his the police there were car value was \$4500.00. The interview, Resident # 4 The police also stated that signed and legal contract to at 10:07 AM revealed they tank records validating then to see Resident # 4 The worker, she received then the went to see Resident # 4 The sistered a Short Portable The specific point is date, and the sistered a Short Portable The specific point is date, and the sistered a Short Portable The specific point is money to the statement to say, someone but it had been taken care d the APS worker's help. The specific point is money The sident told the time, the resident his money	F 6	,		
	permission to drive th money and car. He la	e car, but not to take the ter stated he had made her /ee under the influence of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 02/04/2019		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		12/04/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 602	she validated from the Employee # 1 was Frepresentative payer in determining the complex Employee # 1 had fasafety and well-being to make sure Resident was paid. According not aware Resident paying his own bill coresiding at another formade regarding Emstated it was also do not need APS service became the residen Representative after according to the APs registered Power of of 1/31/19. The APS son had informed the Power of Attorney do through. Resident # 4 was in 10:00 AM with the faccording to Resident with Emploogly Home at times to "had did it for free. The regive Employee # 1 rough. The regive Employee # 1 rough with him. The regive Employee # 1 rough with him. The regive Employee from him took money from him.	According to the APS worker, alking to the police that Resident # 4's social security e in August, 2018. Therefore ase, APS validated that ailed to assure Resident # 4's g when Employee # 1 failed ent # 4's nursing home bill to the APS worker, she was # 4 had a history of not en multiple occasions while acility when this decision was ployee # 1. The APS worker etermined that the resident did ses because the facility	F6	02				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 RA	T ADDRESS, CITY, STATE, ZIP CODE ATTLESNAKE TRAIL IURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	the car was still jointing Employee # 1. According to the intervalidated that the restatements contrary and/or contrary to other esident, he had agreed to pay Employee # 1 to wor to the resident, Employee was on the title as joo According to the police was on the title as joo According to the police was on the title as joo According to the police was on the title as joo According to the police was on the title as joo According to the police was on the title as joo According to the police was on the title as joo According to the contrary to what Employee # 1, she at the bank so he con "move money around Also according to the inconsistent in the definition in the definition of the police worker, they stated to worker, they stated to # 1 was driving his contract.	dent, he was not aware that y owned by him and rview with the resident it was sident made different to evidence the police had her interviews. According to not signed any contract or oyee # 1, but according to the gned and legal contract for k for Resident # 4. According oyee # 1 had taken his car to the DMV title, which was be, the resident's name still int owner of the car. In the value of the car was \$ d have been in excess of the a Medicaid nursing home to the resident, Employee # oank with him, but this is ployee # 1 stated. According the went to assist the resident was betails of what he conveyed to the interviews, the resident was betails of what he conveyed to the interviews with the cility administrator and social the resident denied Employee ar or doing anything wrong	F	602	DEFICIENCY)		
	with the resident driv interviews, the reside claim that the Emplo money. Also, accord interview, the residen	pached him about problems ing his car. According to ent then changed this to yee had taken his car and ing to the APS worker's nt initially told her it was not a less who he had given his					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
				_		(
		345177	B. WING			02/	04/2019
	ROVIDER OR SUPPLIER ENS AT PINEHURST REI	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 602	indicate his money had according to the intervalidated that the sor contrary to informatic administration. During the son alleged that it terminated because or resident at a previous Administrator # 2 on no personnel problem relationship between According to the interval the resident had missis son had access to his was validated with the 10:07 AM that during reportedly the son had APS had validated mad a Direct TV bill and gone account, although the home, not in need of he had money missing was no record with the that there was any reconsidered alert and interview with the AP AM, the resident had incompetent. According representative payed be assured to be paid	changed what he said to ad been stolen. Tryiew with the son it was a had made statements on presented by facility ag the interview with the son, Employee # 1 had been of her relationship with the safacility. The interview with 1/31/19 at 9:38 AM, revealed ans with Employee # 1 or her and Resident # 4. Tryiew with Administrator # 2, sing money when only the sabank accounts in 2017. It the APS worker on 1/31/19 at this time in 2017, in which ad access to the account, soney had being used to pay asoline from the resident's the resident was in the nursing these items, and claiming and the safety of Deeds office and the registered POA on file for ing to interviews with the rorker, the resident was oriented. According to the S worker on 1/31/19 at 10:07	F	602			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		345177	B. WING _			C 02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	, ZIP CODE	02/04/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATI CIENCY)	(X5) COMPLETION DATE	
F 607 F 607 SS=D	Continued From particles of the particle	ility must develop and policies and procedures that: ibit and prevent abuse, tation of residents and resident property, blish policies and procedures such allegations, and de training as required at a resident interview, staff willy interview for one (Resident ed residents, the facility failed policy regarding investigating and exploitation when a resident ed by a family member byee's involvement with the ags included:	F	DEFI	re action will be e residents found to the deficient a 24-hour report of estigation was or Resident #4, ploitation and	2/5/19	
	interview, staff inter one (Resident # 4) the facility failed to Resident # 4 and a concerning financia use of resident iten findings included:	n record review, resident rviews, and family interview for of three sampled residents, address the relationship with housekeeping aide al areas, car ownership and ns with his permission. The		personal belongings. that occurred with Res while he was compete score of 15. Employe the facility on 7/25/18. APS were notified in S when the resident had payment to the facility requested his son be r allegations against em	This was a situation sident #4 s consein the with a BIMS are #1 quit working at the Police and September 2018, I failed to make a Resident #4 notified and	nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 02/04/2019	
NAME OF PE	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE	02/04/2019	
TO UNIC OF TH	TO VIDEIX OIX OOF TELEIX			205 RATTLESNAKE TRAIL		
THE GREE	NS AT PINEHURST REF	IAB & LIVING CENTER				
				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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 607	7 Continued From page 25		F 60	07		
F 607	last revised on 9/24/1 information was noted does not condone resincluding staff members who are not employed misappropriation and resident abuse. Exploit the facility's policy as resident for personal manipulation, intimided According to the policy responsibility to appoinvestigate incidents and the investigation the person making the members, staff, and to the policy, allegation exploitation would be agency. On 1/4/19 at 1:45 PM interviewed. It was conditionally member regard exploitation and misal did not implement the an investigation nor siday report to the state administrator she was responsible for investigation to the state dealt with alleged events.	8, revealed the following d in the policy. The facility sident abuse by anyone; ers and other individuals es. According to the policy, exploitation were forms of sitation was defined within "taking advantage of a gain through use of attion, threats, or coercion." by it is the Administrator's int a staff member to of alleged misappropriation is to include interviews with the report, witnesses, family the resident. Also according ons of misappropriation and reported to the state. The administrator was confirmed with the allt protective services was a behalf of Resident # 4's ding an allegation of propriation, but the facility in abuse policy and conduct tubmit a 24 hour report or 5 agency. According to the senot aware she was igating and reporting the agency since the allegation ents the administrator felt alleged perpetrator's	F 60	made. The police and APS worker informed the facility, following their investigations, that the resident wa cognitively intact and made his own decisions during the time when the and the car were made available to employee #1. The facility became I payee in October of 2018. Address how the facility will identify residents having the potential to be affected by the same deficient pract. The Administrator and/or the Social Service Director (SSD) reviewed the grievance logs from July 2018- Janu 21, 2019, to identify concerns regar resident exploitation and/or misappropriation, to validate that an investigation was completed and we reported to the state agency. There no other concerns identified that ha been investigated and/or reported to state agency. The Administrator, Director of Nursin (ADON) and Social Service director completed interviews with current social service director director director director director director direct	funds Rep other tice; e uary ding n as e were d not o the ng g f (SSD) taff on sident iation, ed. ntified	
				The Administrator and/or the DON completed education on 1/25/19, fo facility staff, all shifts, all days include		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 2/04/2019		
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE .	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 607	Continued From pag	e 26	F6	weekends and prn staff, reporting and investigation abuse. The education where the staff will report immabuse officer any allegal include resident exploits misappropriation. The asubmit the 24-hour repolagency and an investigation the abuse officer any allegation the abuse officer and within 5 day investigative repolagency. Indicate how the facility its performance to make solutions are sustained; The Administrator, DON will interview 5 staff mer weeks then 10 staff mer 2 months, to validate the abuse were reported to and an investigation was reported to the state age. The Administrator and/or Nursing will review the gweek for 4 weeks then whom the staff and reported agency as required, if the misappropriated or abusing the staff and will necessary. The Administrator and will necessary.	ing allegations of will be included in lediately to the station of abuse to ation and abuse officer will bort to the state ation will begin at any of the licer will submit the ort to the state. I and/or the SSD mbers weekly for 4 mbers monthly for at allegations of the abuse officer initiated and ency. For the Director of grievance log 5 x a weekly for 2 grievances of the State are items were se situations were set to the Director of audits to identify adjust the plan as			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345177	B. WING _				04/2019
	ROVIDER OR SUPPLIER	I		20	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RATTLESNAKE TRAIL INEHURST, NC 28374	027	04/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	e 27	F6	607	the plan during the monthly QAPI meet and audits will continue at the discretio the QAPI committee.		
F 609 SS=D	Reporting of Alleged CFR(s): 483.12(c)(1)(F 6	609	Indicate dates when corrective action was be completed; February 5, 2019		2/5/19
		se to allegations of abuse, or mistreatment, the facility					
	involving abuse, neglimistreatment, includir source and misappro are reported immedia hours after the allegathat cause the allegative serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the state state law provides term care facilities) in the law through established					
	designated represent accordance with State Survey Agency, within	the results of all administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING			02/04/2019	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	DE	02.0 1.20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		
F 609	This REQUIREMENT by: Based on record revinterviews, and family # 4) of three sampled to submit a 24 hour a state agency regardir exploitation and misa funds and personal bincluded: This tag is cross reference. This tag is cross reference. February 602: Based on reinterview, staff intervione (Resident # 4) of the facility failed to ack Resident # 4 and a heconcerning financial acconcerning financial acconcern	e action must be taken. Is not met as evidenced iew, resident interview, staff interview for one (Resident residents, the facility failed and five day report to the ag an allegation of resident ppropriation of resident's elongings. The findings Tred to: ecord review, resident ews, and family interview for three sampled residents, dress the relationship with busekeeping aide areas, car ownership and with his permission. The If the administrator was onfirmed with the all protective services was a behalf of Resident # 4's ding an allegation of ppropriation, but the facility our report or 5 day report to cording to the administrator he was responsible for orting the allegation to the e allegation dealt with iministrator felt transpired perpetrator's resignation of	F 60	Address how corrective action accomplished for those residn have been affected by the depractice; The facility completed a 24-h 1/4/19, and 5-day investigation completed on 1/9/19 for Resiregarding resident exploitation misappropriation of resident personal belongings. This withat occurred with Resident while he was competent with score of 15. Employee #1 quithe facility on 7/25/18. The FAPS were notified in Septem when the resident had failed payment to the facility. Residing requested his son be notified allegations against employee made. The police and APS winformed the facility, following investigations, that the residing cognitively intact and made he decisions during the time who and the car were made avails employee #1. The facility be payee in October of 2018. Address how the facility will i residents having the potential affected by the same deficier The Administrator and/or the Service Director (SSD) review grievance logs from July 201	dents found eficient nour report of on was ident #4, on and funds and ras a situation #4 set on a BIMS uit working Police and other 2018, to make dent #4 de and effect worker getheir lent was nis own en the fundable to ecame Report for the fundable fundable for the fundable fun	on on ent at	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 609	Continued From pag	e 29	F	21, 2019, to identify concersident exploitation and/or misappropriation, to validate investigation was completed reported to the state agent no other concerns identificate been investigated and/or state agency. The Administrator, Director (DON), Assistant Director (ADON) and Social Service completed interviews with 1/25/19, regarding knowled abuse, exploitation and must that has not been previous. There were no other alleged that were not investigated. Address what measures we place or systemic change ensure that the deficient precur; The Administrator and/or completed education on 1 facility staff, all shifts, all of weekends and prin staff, reporting and investigating abuse. The education will new hire orientation. The staff will report immediates officer any allegation include resident exploitation misappropriation. The absubmit the 24-hour report agency and an investigating that time and within 5 day allegation the abuse officer 5-day investigative report agency.	ate that an ated and was acy. There wered that had not reported to the proof Nursing of Nursing at director (SS) a current staff of edge of resident alisappropriations identified. Will be put into some actice will not the DON 1/25/19, for all days including regarding gregarding to the state on will begin at sof the er will submit the state on will submit the grey will submit the grey will submit the grey grey grey grey grey grey grey gre	D) n t n, d

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 02/04/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	02/04/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 677 SS=E	ADL Care Provided for CFR(s): 483.24(a)(2)	r Dependent Residents	F 67	Indicate how the facility plans to monitority performance to make sure that solutions are sustained; The Administrator, DON and/or the SSI will interview 5 staff members weekly for weeks then 10 staff members monthly 2 months, to validate that allegations or abuse were reported to the abuse officiand an investigation was initiated and reported to the state agency. The Administrator and/or the Director of Nursing will review the grievance log 5 week for 4 weeks then weekly for 2 months, to validate that grievances of missing items and/or care concerns we investigated and reported to the State agency as required, if the items were misappropriated or abuse situations we identified. The Administrator and/or the Director of Nursing will review the audits to identify patterns/trends and will adjust the plan necessary. The Administrator will reviet the plan during the monthly QAPI meet and audits will continue at the discretion the QAPI committee. Indicate dates when corrective action we be completed; February 5, 2019	D D D O T 4 for f er f x a ere f / as ew ing n of
		ent who is unable to carry ving receives the necessary			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE S COMPL	ETED
		345177	B. WING _			02/0	;)4/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE		
				205 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 677 Continued From page 31		e 31	F 6	77			
F 677	services to maintain of personal and oral hydrogen the personal hydro	good nutrition, grooming, and giene; is not met as evidenced on, staff and resident direview, the facility failed to echeduled for activities of bendent residents for 3 and #13 and Resident #21) of for ADLs. The findings dmitted on 7/6/08 with so d Cerebral Vascular	F 6	F 677 Address how corrective accomplished for those in have been affected by the practice; The facility provided a she Resident #9 on1/4/19, for exit, and has received she Tuesday and Friday pershower schedule. The E (DON) discussed the she and resolution with Resinas a resolution to the gridocumented 11/28/18, soffered and given by the assistant (CNA) on the sidays and documented on sheet. The Licensed nu	residents found the deficient whower for collowing survey howers every er residents Director of Nurscower schedule dent #9 on 1/4/ devance schowers will be a certified nursing scheduled shower the shower	sing (19, ng ver	
		on second shift and as		shower was given and d Medication administratio The facility provided a sl	locument on the on record (MAR	е	
	-	grievance log revealed a 8/18 which read Resident #9 howers.		Resident #13 on 1/5/19, exit, and has received sh Wednesday and Saturda shower schedule. The D	howers every ay per residents	S 🗆	
	dated 12/15/18 indica intact and exhibited r for total staff assistan Review of the docum	entation from 11/1/18 to		the shower schedule and Resident #13 on 1/4/19, the grievance document showers will be offered a CNA on the scheduled s documented on the show	as a resolution ted on 11/28/18 and given by the shower days and wer sheet. The	n to d e	
	present indicated Reshower on 12/21/18.	sident #9 received one		Licensed nurse will valid given and document on The facility provided a sl	the MAR.	S	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER	2.2	 	S	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2019
	10115211 011 001 1 2.2.1				5 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	AB & LIVING CENTER			INEHURST, NC 28374		
	OLIMAN DV OT	ATEMENT OF DEFICIENCIES		-			217
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION	
F 677	F 677 Continued From page 32 Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #9 was still not getting her showers. In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time.		F 6	677			
					Resident #21 on 1/5/19, following surversexit, and has received showers every Saturdays on first shift and Wednesday on second shit per residents□ shower	-	
					schedule. The DON discussed the shower schedule and resolution with Resident #21 on 1/4/19, as a resolution	n to	
	She stated she comp there had been no im			the grievance documented on 12/27/18 showers will be offered and given by the			
	showers. Resident #9			CNA on the scheduled shower days ar			
	odors and dressed fo			documented on the shower sheet. The Licensed nurse will validate shower wa	,		
	In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues				given and document on the MAR.		
		nment and completing her			Address how the facility will identify oth	er	
	assigned showers du	· · · · · · · · · · · · · · · · · · ·			residents having the potential to be affected by the same deficient practice		
	In an interview on 1/3	/19 at 3:45 PM, NA #2			Current facility residents have the		
		n several occasions she was			potential to be affected by the same		
	unable to complete a to staffing issues.	Il her assigned showers due			deficient practice of not receiving show as scheduled.	ers	
	_	:/19 at 5:00 PM, NA #7			The DON and ADON s completed an		
		often understaffed. She			audit on 1/21/19, of shower documentation for current facility		
		get her showers done on her			residents, to identify residents that had	not	
		ated there were three aides			received a shower as scheduled. Ther		
	working on all floors a				were 3 residents identified. Those		
	3				residents were offered a shower on		
	In an interview on 1/3	/19 at 5:05 PM, NA #5			1/21/19 and will be offered showers go	ing	
	stated she worked on	an as needed basis on			forward according to shower schedule.		
		. NA #5 stated it was difficult					
	to answer call bells, to						
	bathroom and comple	ete her assigned showers.			Address what measures will be put into)	
					place or systemic changes made to		
		/19 at 6:35 AM, NA #3			ensure that the deficient practice will no	ot	
	,	been short staff for about 1			recur;		
	-	had difficulty answering call			The DON and/or ADON s provided		
	bells and completing staffing.	her ADL rounds due to short			education beginning on 1/22/19, for th licensed nurses and CNA□s , all shifts		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 02/04/2019	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2013	
					5 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER			NEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTIVE ACTION SHOULD BE COM NCED TO THE APPROPRIATE		
F 677	Director of Nursing (I resident's not receiving was not a personnel issue on second and the facility recently his second and third shift been utilizing a lot of holes in the schedule expectation that the inshowers as schedule 2. Resident #13 was readmitted 6/29/18 w CVA, Diabetes and C (CHF). Resident #13's quart indicated moderate of behaviors. She was assistance with bathin Resident #13's undar she required staff assi Wednesday and Satuneeded. Resident #13's care read she required staff assi wednesday and satuneeded. Review of the documpresent indicated R	A/19 at 12:43 PM, the DON) stated she felt that the ng their scheduled showers issue that rather a staffing third shift. The DON stated ared several aides for both as needed staff to fill staffing as needed it was her residents receive their and as needed. admitted on 1/15/18 and with cumulative diagnoses of congestive Heart Failure erly MDS dated 11/25/18 and option of the condet as requiring total staff	F	677	days, including weekends and prn staff regarding providing showers to resident according to the shower schedule, with documentation by the CNA on the show sheet, and the licensed nurse will valid shower was given and document on the residents MAR. When a resident refuse a shower, the CNA will report to the licensed nurse and the licensed nurse follow up with the resident and docume refusal or acceptance of the shower on the MAR. The education will be provided to newly hired staff during new hire orientation. Indicate how the facility plans to monitorits performance to make sure that solutions are sustained; The DON and/or the ADON swill audit shower sheets and MARS 5 times a week for 4 weeks then 3 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or observe 10 residents weekly for 4 weeks then 20 residents monthly for 5 months, to validate that showers are given as scheduled, as evidenced by alert and oriented resider voicing confirmation, and/ or observing cognitively impaired residents during shower. The Director of Nursing will review the audits to identify patterns/trends and we adjust the plan as necessary. The DOI will review the plan during the monthly QAPI meeting and audits will continue the discretion of the QAPI committee.	ets wer ate e es will ent y or it eek		
	Review of the facility grievance log revealed a				Indicate dates when corrective action v	vill		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING _				C 04/2019	
	ROVIDER OR SUPPLIER	IAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D5 RATTLESNAKE TRAIL INEHURST, NC 28374	1 02/	04/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	EFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 677	7 Continued From page 34 grievance dated 12/28/18 which read Resident #13 was not getting her showers.		F 6	677				
					be completed; February 1, 2019			
	Assistant (NA) #1 sta	nment and completing her						
	stated there had beer	/19 at 3:45 PM, NA #2 n several occasions she was I her assigned showers due						
	PM, Resident #13 stareceiving her schedul She stated she comp had been no improve	ed showers for some time. leted a grievance but there ment in receiving her 3 appeared clean, absent of						
	stated the facility was stated she could not o	/19 at 5:00 PM, NA #7 often understaffed. She get her showers done on her ated there were three aides at present.						
	stated she worked on second and third shift to answer call bells, ta	/19 at 5:05 PM, NA #5 an as needed basis on . NA #5 stated it was difficult ake residents to the ete her assigned showers.						
	stated the facility has year. She stated she	/19 at 6:35 AM, NA #3 been short staff for about 1 had difficulty answering call her ADL rounds due to short						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		02/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Director of Nursing resident's not received was not a personner issue on second and the facility recently second and third shoeen utilizing a lot of holes in the schedulex expectation that the showers as scheduled 3. Resident #21 was cumulative diagnos and Diabetes. Resident #21's quaindicated she was cono behaviors. She was aff assistance with Resident #21's under the sident #21's unde	/4/19 at 12:43 PM, the (DON) stated she felt that the ving their scheduled showers of issue that rather a staffing district the driving their scheduled showers of the driving their scheduled showers of the driving the driving that the driving several aides for both drift. She stated the facility has of as needed staff to fill staffing le. The DON stated it was here residents receive their led and as needed. It is admitted on 1/6/12 with less of Coronary Artery Disease of Coronary Artery Disease of Coronary and exhibited was coded as requiring total in bathing.	F6	577		
	Wednesday and Saneeded. Resident #21's care read she required severy Wednesday and as needed. Review of the facilit grievance dated 12. #21 was not getting. Review of the document of the document indicated Review Rev	e plan last revised on 12/24/18 taff assistance with showers and Saturday on second shift y grievance log revealed a /27/18 which read Resident her showers. mentation from 11/1/18 to esident #21 only received a /3, 12/19/18, 12/22/18 and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION		LETED
		345177	B. WING _				04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 F	EET ADDRESS, CITY, STATE, ZIP CODE RATTLESNAKE TRAIL EHURST, NC 28374	1 02/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	e 36	F	677			
	AM, Resident #21 co Resident Council Pre not been receiving he some time. She state grievance and broug Resident Council me improvement in recei #21 appeared clean, for season. In an interview on 1/3 Assistant (NA) #1 state completing her assig assigned showers du In an interview on 1/3 stated there had bee	esident. She stated she had er scheduled showers for ed she completed a ht the lack of showers in eetings but there had been no eiving her showers. Resident absent of odors and dressed 3/19 at 11:47 AM, Nursing eted she had issues nment and completing her					
	stated the facility was stated she could not	3/19 at 5:00 PM, NA #7 s often understaffed. She get her showers done on her tated there were three aides at present.					
	stated she worked or second and third shift to answer call bells, t	3/19 at 5:05 PM, NA #5 n an as needed basis on ft. NA #5 stated it was difficult take residents to the ete her assigned showers.					
	stated the facility has year. She stated she	4/19 at 6:35 AM, NA #3 s been short staff for about 1 had difficulty answering call her ADL rounds due to short					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		245477					С
NAME OF D	ROVIDER OR SUPPLIER	345177	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2019
	ENS AT PINEHURST REI	HAB & LIVING CENTER		2	205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	resident's not receiving was not a personnel issue on second and the facility recently his second and third shift been utilizing a lot of holes in the schedule		F	677			
F 725 SS=E	showers as schedule Sufficient Nursing Sta CFR(s): 483.35(a)(1)	d and as needed. aff (2)	F	725			2/5/19
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care					
	by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			02/0) 04/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	DE	02/0	J-1/2010
				205 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 725	Continued From page	e 38	F 7	725			
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation interviews and record provide sufficient staff (Resident #, Resident residents who requires showers and failed to 1 resident (Resident trequired assistance wincluded: 1. Resident #9 was a cumulative diagnoses Accident (CVA) with I Resident #9's undates she required staff assing Tuesday and Friday oneeded. Resident #9's care pleshe required staff assing Tuesday and Friday oneeded. Review of the facility grievance dated 11/2 was not getting her serice dated 12/15/18 indicated 12/15/18 indicated 12/15/18 indicated 11/15/18 indica	section, the facility must nurse to serve as a charge of duty. T is not met as evidenced ons, resident and staff of review, the facility failed to offing to provide showers for 3 to 13 and Resident #21) of 6 ed staff assistance with of answer call bells timely for each of 1 resident who with toileting. The findings of Cerebral Vascular Hemiplegia. Indeed electronic Kardex read sistance for showers every on second shift and as an last revised 7/28/18 read sistance for showers every on second shift and as grievance log revealed a 8/18 which read Resident #9 howers. In Minimum Data Set (MDS) ated she was cognitively to behaviors. She was coded		F 725 Address how corrective actic accomplished for those resid have been affected by the depractice; The facility provided a shower Resident #9 on 1/4/19, follow exit, and has received shower Tuesday and Friday per resid shower schedule. The Direct (DON) discussed the shower and resolution with Resident as a resolution to the grievar documented 11/28/18, shower offered and given by the cert assistant (CNA) on the schedules and documented on the sheet. The Licensed nurse with shower was given and documented the shower was given and documented in the shower was given and documented as shower Resident #13 on 1/5/19, followexit, and has received shower Wednesday and Saturday per shower schedule. The DON the shower schedule and resident #13 on 1/4/19, as at the grievance documented on showers will be offered and goon the scheduled showed documented on the showers.	dents found efficient er for ving survey ers every dents □ tor of Nurs r schedule #9 on 1/4/nce ers will be eiffied nursir duled shower will validate ment on the cord (MAR er for owing survey er residents discussed solution with a resolution in 11/28/18 given by the er days an	sing /19, ng ver e e th n to 3, ie id	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345177	B. WING _		_	C 02/04/2019
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	02/04/2013
				205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 725	present indicated Re shower on 12/21/18. Review of the facility grievance dated 12/2 was still not getting he in an interview and op PM, Resident #9 state receiving her schedu. She stated she compathere had been no im showers. Resident #9 odors and dressed for in an interview on 1/3 Assistant (NA) #1 state completing her assigned showers during the interview on 1/3 stated there had been unable to complete a to staffing issues.	grievance log revealed a 18/18 which read Resident #9 er showers. bservation on 1/3/19 at 1:40 ed she had not been led showers for some time. Pleted multiple grievances but aprovement in receiving her en appeared clean, absent of or season. 8/19 at 11:47 AM, Nursing sted she had issues and the short staffing. 8/19 at 3:45 PM, NA #2 an several occasions she was lil her assigned showers due.	F 7	Licensed nurse will given and documer The facility provider Resident #21 on 1/ exit, and has received Wednesday and Sa shower schedule. The shower schedule Resident #21 on 1/ the grievance documented on the Licensed nurse will given and documer Resident #4 require toileting. The Directin service education nursing staff regard lights timely to incluoff until resident new Address how the faresidents having the affected by the sam Current facility residents assistance with AD have the potential the deficient practice.	I validate shower want on the MAR. d a shower for 5/19, following surveyed showers every aturday per residents. The DON discussed ale and resolution wit 4/19, as a resolution immented on 12/27/18 ared and given by the clared and given by the led shower days and shower sheet. The law are shower sheet. The law are sassistance with ctor of Nursing provious on 1/22/19, for the ding answering call and not to turn call lighteds are met.	h to ded ght er
	stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers.			received a shower were 3 residents id residents were offe 1/21/19 and will be	current facility fy residents that had as scheduled. There lentified. Those	e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345177	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	02/04/2019
NAME OF T	NOVIDEN ON 3011 LIEN				_	
THE GRE	ENS AT PINEHURST R	EHAB & LIVING CENTER		205 RATTLESNAKE TRAIL		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 40	F 7	25		
	stated the facility had year. She stated she bells and completin staffing. In an interview on 1 Director of Nursing resident's not received was not a personner issue on second and the facility recently second and third sheen utilizing a lot of holes in the schedulexpectation that the showers as schedulexpects.	/4/19 at 6:35 AM, NA #3 as been short staff for about 1 e had difficulty answering call g her ADL rounds due to short /4/19 at 12:43 PM, the (DON) stated she felt that the ving their scheduled showers el issue that rather a staffing d third shift. The DON stated hired several aides for both ift. She stated the facility has of as needed staff to fill staffing le. The DON stated it was her er residents receive their led and as needed and the ate staffing on all three shifts.		Address what measures will be place or systemic changes may ensure that the deficient practiceur; The DON and/or ADON spreeducation beginning on 1/22/licensed nurses and CNA spreeducation beginning on 1/22/licensed nurses and country including weekends and regarding providing showers that according to the shower scheed documentation by the CNA or sheet, and the licensed nurse shower was given and documentation when a residents MAR. When a residents MAR. When a resident and the licensed nurse and the license follow up with the resident and refusal or acceptance of the state of the st	ade to tice will not ovided 19, for the all shifts, all prn staff, to residents dule, with the shower will validate thent on the dent refuses to the ed nurse will d document	
	readmitted 6/29/18 CVA, Diabetes and (CHF). Resident #13's qua indicated moderate behaviors. She was assistance with batl Resident #13's und she required staff a	a was admitted on 1/15/18 and 1/18 with cumulative diagnoses of and Congestive Heart Failure quarterly MDS dated 11/25/18 rate cognitive impairments with no was coded as requiring total staff bathing. undated electronic Kardex read aff assistance for showers every d Saturday on second shift and as		the MAR. This education will to newly hired nursing staff du hire orientation. The Director of Nursing provious service education on 1/22/19, nursing staff all shifts, all days weekends and prn staff, regal answering call lights timely to to turn call light off until reside met. This education will be provided in the nursing staff during orientation. The Administrator and/or the nursing staff to fill open position occur in order to provide sufficients.	ded in for the sincluding include not ent needs are rovided to ng new hire DON will hire ons as they	
	read she required s	e plan last revised on 11/27/18 taff assistance with showers and Saturday on second shift		meet resident care needs. Indicate how the facility plans its performance to make sure solutions are sustained;	to monitor	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		, ,	E SURVEY MPLETED
	345177	B. WING		0:	C 2/ 04/2019
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	270-172010
			205 RATTLESNAKE TRAIL		
ENS AT PINEHURST R	EHAB & LIVING CENTER		PINEHURST, NC 28374		
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
Continued From pa	ge 41	F 72	25		
Review of the docu present indicated R	mentation from 11/1/18 to tesident #13 only received a		shower sheets and MARS 5 tir for 4 weeks then 3 times a wee	mes a week ek for 5	
Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing.			interview and/or observe 10 rewweekly for 4 weeks then 20 res	sidents sidents	
			showers are given as schedule evidenced by alert and oriented voicing confirmation, and/ or of cognitively impaired residents	ed, as d resident bserving	
stated there had be unable to complete to staffing issues.	een several occasions she was all her assigned showers due		The DON and/or ADON□s will answering of call lights for all s week for 4 weeks then 3 times 2 months, to validate call lights answered timely to meet reside	hifts 5 x a a week for are being	
PM, Resident #13 s receiving her sched Resident #13 appe	stated she had not been duled showers for some time. ared clean, absent of odors	servation on 1/3/19 at 4:50 ted she had not been ed showers for some time. ed clean, absent of odors on.		ks then 20 s, to ng	
stated the facility w stated she could no assignment. NA #7	as often understaffed. She of get her showers done on her stated there were three aides		needs. The Administrator and/or the I monitor staffing needs daily to	OON will validate	
stated she worked second and third sh to answer call bells bathroom and com	on an as needed basis on hift. NA #5 stated it was difficult, take residents to the plete her assigned showers.		audits/monitors/interviews to id patterns/trends and will adjust necessary. The DON will revie during the monthly QAPI meeti	lentify the plan as ew the plan ing and	
1	ROVIDER OR SUPPLIER SUMMARY (EACH DEFICIENT REGULATORY OF The Property of The	ROVIDER OR SUPPLIER ENS AT PINEHURST REHAB & LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 Review of the documentation from 11/1/18 to present indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/26/18. Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview and observation on 1/3/19 at 4:50 PM, Resident #13 stated she had not been receiving her scheduled showers for some time. Resident #13 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 6:35 AM, NA #3	ROVIDER OR SUPPLIER ENS AT PINEHURST REHAB & LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 Review of the documentation from 11/1/18 to present indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/26/18. Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and completing her assigned showers due to short staffing. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview and observation on 1/3/19 at 4:50 PM, Resident #13 stated she had not been receiving her scheduled showers for some time. Resident #13 appeared clean, absent of odors and dressed for season. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers.	ROYIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY PULL RESOLATORY OR LISC IDENTIFITING INFORMATION) Continued From page 41 Review of the documentation from 11/1/18 to present indicated Resident #13 only received a shower on 12/12/18, 12/15/18, 12/22/18 and 12/28/18. Review of the facility grievance log revealed a grievance dated 12/28/18 which read Resident #13 was not getting her showers. In an interview on 1/3/19 at 11:47 AM, Nursing Assistant (NA) #1 stated she had issues completing her assignment and complete give and staffing issues. In an interview on 1/3/19 at 3:45 PM, NA #2 stated there had been several occasions she was unable to complete all her assigned showers due to staffing issues. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there whomers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there showers done on her assignment. NA #7 stated there serve three aides working on all floors at present. In an interview on 1/3/19 at 5:05 PM, NA #5 stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the necessary. The DON will review during the monthly QAPI meet audits will continue at the discreption of 1/4/19 at 6:35 AM, NA #3 In an interview on 1/4/19 at 6:35 AM, NA #3 In an interview on 1/4/19 at 6:35 AM, NA #3 Assistant (NA) #1 steep the precipient of the proving	A BUILDING 345177 3. WIND 4. WIND 5. WIND 5. WIND 5. WIND 5. WIND 6. WIND 6

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING_				04/2019
NAME OF PE	ROVIDER OR SUPPLIER	0.0	1	S-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2019
TVAINE OF TH	TO VIDER OR OUT FEEL				05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			INEHURST, NC 28374		
				•	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	2 42	F 7	725			
	year. She stated she had difficulty answering call bells and completing her ADL rounds due to short staffing.				Indicate dates when corrective action vibe completed; February 1, 2019	vill	
	resident's not receivir was not a personnel i issue on second and the facility recently his second and third shift been utilizing a lot of holes in the schedule expectation that the reshowers as schedule facility have adequate 3. Resident #21 was a cumulative diagnoses and Diabetes. Resident #21's quarte indicated she was con behaviors. She was staff assistance with the Resident #21's undata she required staff assistance staff assistance with the second person and the second per	pON) stated she felt that the grighter scheduled showers assue that rather a staffing third shift. The DON stated red several aides for both a she stated the facility has as needed staff to fill staffing and as needed it was her esidents receive their d and as needed and the estaffing on all three shifts. Admitted on 1/6/12 with a for Coronary Artery Disease or Coronary Artery Disease or Coronary interest and exhibited as coded as requiring total			rebluary 1, 2019		
	read she required sta	olan last revised on 12/24/18 ff assistance with showers d Saturday on second shift					
	_	grievance log revealed a 7/18 which read Resident er showers.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		22.0-11.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 43	F 7	25		
	present indicated R	mentation from 11/1/18 to esident #21 only received a 3, 12/19/18, 12/22/18 and				
	AM, Resident #21 of Resident Council P not been receiving some time. She sta grievance and brou Resident Council m improvement in rec	observation on 1/3/19 at 8:45 confirmed she was the resident. She stated she had her scheduled showers for ted she completed a ght the lack of showers in leetings but there had been no eiving her showers. Resident h, absent of odors and dressed				
	Assistant (NA) #1 s completing her assi	/3/19 at 11:47 AM, Nursing tated she had issues gnment and completing her due to short staffing.				
	stated there had be	/3/19 at 3:45 PM, NA #2 en several occasions she was all her assigned showers due				
	stated the facility was stated she could no	/3/19 at 5:00 PM, NA #7 as often understaffed. She at get her showers done on her stated there were three aides at present.				
	stated she worked of second and third sh to answer call bells	/3/19 at 5:05 PM, NA #5 on an as needed basis on afficult. NA #5 stated it was difficult take residents to the olete her assigned showers.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C)2/04/2019
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		2104/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From p	_	F 7	725		
	stated the facility hyear. She stated s	1/4/19 at 6:35 AM, NA #3 has been short staff for about 1 he had difficulty answering call ng her ADL rounds due to short				
	Director of Nursing resident's not rece was not a personn issue on second at the facility recently second and third's been utilizing a lot holes in the sched expectation that the showers as sched facility have adequal 4. Resident #4 was cumulative diagnorand Parkinson's Director Resident #4's quaindicated he was cono behaviors. He	rterly MDS dated 10/21/18 cognitively intact and exhibited was coded for extensive staff				
	assistance with his	care planned for staff s ADLs.				
		on 1/3/19 at 4:40 PM, Resident observed lite to signify he stance.				
	was observed self the hall outside the	at 1/3/19 4:50 PM, Resident #4 -propelling his wheelchair into e doorway of his room. He sistance going to the bathroom				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345177	B. WING _			C 02/04/2019
	NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 45 and his call bell had been ringing for over 10 minutes. Resident #4 stated he had difficulty getting timely assistance with his ADLs. In an interview on 1/3/19 at 5:00 PM, NA #7 stated the facility was often understaffed. She stated she could not get her showers done on her assignment. NA #7 stated there were three aides working on all floors at present. In an observation a 1/3/19 at 5:05 PM, NA #5 retrieved the mechanical lift and proceeded to assist Resident #4. She stated she worked on an as needed basis on second and third shift. NA #5 stated it was difficult to answer call bells, take residents to the bathroom and complete her assigned showers. In an interview on 1/4/19 at 12:43 PM, the Director of Nursing (DON) stated she felt that the resident's not receiving their scheduled showers was not a personnel issue that rather a staffing issue on second and third shift. The DON stated the facility recently hired several aides for both second and third shift. She stated the facility has been utilizing a lot of as needed staff to fill staffing holes in the schedule. The DON stated it was her expectation that the residents receive their showers as scheduled and as needed and the facility have adequate staffing on all three shifts. Nutritive Value/Appear, Palatable/Prefer Temp		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	<u> </u>	02/04/2010	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725			F 7	25		
	minutes. Resident #	4 stated he had difficulty				
	stated the facility wa stated she could not assignment. NA #7	is often understaffed. She get her showers done on her stated there were three aides				
	retrieved the mecha assist Resident #4. S as needed basis on stated it was difficult residents to the bath	nical lift and proceeded to She stated she worked on an second and third shift. NA #5 to answer call bells, take				
	Director of Nursing (resident's not receiv was not a personnel issue on second and the facility recently h second and third shi been utilizing a lot o holes in the schedul expectation that the showers as schedul facility have adequa	DON) stated she felt that the ing their scheduled showers issue that rather a staffing dithird shift. The DON stated hired several aides for both ift. She stated the facility has f as needed staff to fill staffing e. The DON stated it was her residents receive their ed and as needed and the te staffing on all three shifts.	F 8	004		2/1/19
	§483.60(d)(1) Food	d drink ves and the facility provides- prepared by methods that alue, flavor, and appearance;				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
		345177	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	I DE	02/04/2019
				205 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 804	Continued From p	age 46	F 8	804		
	attractive, and at a temperature. This REQUIREME by:	d and drink that is palatable, a safe and appetizing				
	staff interviews an failed to ensure th and served at an a (Resident #9, Res Resident #22 and	ations, resident interviews and d record review, the facility e food served was palatable appetizing temperature for 5 ident #10, Resident #21, Resident #24) of 5 dents reviewed for palatable included:		Address how corrective active accomplished for those residence have been affected by the dipractice; The Administrator presented to the Resident Council Presented to the Reside	dents found to eficient d a resolution sident on of cold food to	
	Review of the September 2018 Resident Council (RC) minutes dated 9/26/18 included a grievance dated 9/26/18 regarding cold food in the dining room and on the halls. The resolution was staff education. Review of the October 2018 RC minutes dated 10/24/18 included a grievance dated 10/24/18 regarding the nursing staff not passing the meal trays timely resulting in cold food. The resolution was an in-service completed on 10/25/18 to address the meals trays not being passed out			the tray line for breakfast, ludinner 5 times a week for 4 monitoring food temperature pass in the dining room and breakfast, lunch and dinner week, to assure food temperemain within acceptable terrange at the point of service degrees or resident preferer resolution was accepted by council on 1/25/19. The Administrator and/or the	nch and weeks and e during meal hallways, for 5 times a ratures mperature of 125 nce. The the resident	
	cumulative diagno Accident (CVA) wi Resident #9's qua dated 12/15/18 ind intact and exhibite	rterly Minimum Data Set (MDS) dicated she was cognitively		Nursing (DON)and Dietary Met with Residents # 9, 10, individually on 1/25/19, to prove the new process for monitor temperatures in the dining routhe hallways. These residenthe new process. The Administrator, DON and interview Residents 9, 10, 2 weekly for 4 weeks, to validation items were received at an acceptance with the new process.	21,22, and 24 resent to them ing food oom and on its accepted d/or DM will 1, 22 and 24, ate that food	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _			,
		345177	B. WING				ر 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE ODE	- 10 47 DINELUIDOT 6	DELLAR & LIVING OFNITER		20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST F	REHAB & LIVING CENTER		P	INEHURST, NC 28374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	,	DR LSC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROPRIA		DATE
F 804	Continued From pa	age 47	F	804			
	Manager (DM) stat	ted the facility was under new			temperature.		
		July 2018 and there had been					
		he menu. She stated the new			Address how the facility will identify oth	er	
		ot offer an "alternate" to what			residents having the potential to be		
	_	nenu but rather have a "Always			affected by the same deficient practice	;	
		AAM). The DM stated the items			Current facility residents that receive m		
	,	ed: grilled cheese sandwiches,			trays have the potential to be affected I		
	soup, chef salad, g			the same deficient practice.	-		
	and deli sandwiche			Address what measures will be put into	,		
	residents ordered	from the AAM but did not think			place or systemic changes made to		
	it was because the	food on the menu was not			ensure that the deficient practice will no	ot	
	palatable. The DM	stated she was out on leave			recur;		
	from September 20	018 to 10/29/18 and in her			The Director of Nursing provided in		
	absence, the Chef	was in charge. She stated the			service education on 1/22/19, for the		
	Chef did not "catch	on" to the ordering process			nursing staff, all days all shifts including	j	
	that resulted in the	facility running out of food.			weekends and prn staff, regarding		
	The DM stated she	was aware that the menus			passing of meal trays timely to keep for	od	
	were not being foll	owed so she ordered the food			at the point of resident service within th	ie	
	remotely while on I	eave. She stated she was			acceptable temperature range of 125		
	aware of the comp	lains of cold food. The DM			degrees or resident preference. This		
	stated a new menu	u cycle was scheduled to start			education will be provided to newly hire	∌d	
	on 1/7/19 and hope	ed the residents would be			nursing staff during new hire orientation	١.	
	happy with the nev	v menu cycle.			The Dietary Manager completed		
					education on 1/25/19, for the dietary st		
		l observation on 1/2/19 at			all days, all shifts, including weekends	and	
		nt #9 was observed eating			prn staff , regarding maintaining		
	_	room. She was served beef			acceptable food temperatures of 140		
	_	odles. Resident #9 stated the			degrees or greater on the tray line.		
	food was often ser	ved cold.			The Dietary Manager orders food week	-	
					for the upcoming weekly menu and the		
		1/3/19 at 9:30 AM, the			always available menu. The DM and/o		
		ed there was some "tweaking"			the cook will validate daily that food ite		
		months back and that			are available for the following days me		
	_	ot realize it would put the			and the Always Available menu. The D)M	
		t over budget. She stated the			is responsible for ordering food items		
		arge while the DM was on			and/or adjusting the menu with		
		s oversight provided by the			alternatives of equal nutritive value as		
		Services (DDS). The			necessary to accommodate resident		
	Administrator state	ed the DDS was at the facility			preferences and to meet the nutritional		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				04/2040
NAME OF P	ROVIDER OR SUPPLIER	0.0		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2019
TVAINE OF T	TOVIDER OR OUT FEER				05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST R	EHAB & LIVING CENTER					
					PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pa	age 48	F 8	804			
	maybe every 2 wee	eks. She stated the facility was			guidelines as determined by the Dietici	an.	
		and that the Chef was not			The facility provides an Always Availab		
	_	how to order food based on			Menu or Alternate menu, if the resident		
	the food count or m	nenu. The Administrator she			chooses not to want the food on the da	ily	
	was currently awar	e of concerns in the dietary			menu.		
	department and the	e unhappiness of residents.			The DON and/or ADON's will assign		
					nursing staff to the dining area and		
	In an interview on 1	1/3/19 at 9:50 AM, Nursing			hallways during meal times to assure		
		stated she was aware that the			meal trays are passed timely when the	y	
	residents were unhappy with the food served at				are sent from the kitchen.		
		ted the residents complained					
		getting what was on the menu					
		n would run out of food. NA #6					
		noticed any improvements or			Indicate how the facility plans to monito	r	
	worsening since the	e DM returned from leave.			its performance to make sure that		
	In a talanhana inta	rview on 1/3/19 at 9:55 AM, the			solutions are sustained; The DM, the cook and/or the		
	-	s no longer employed at the			Administrator will monitor food		
		ie was aware the dietary staff			temperatures on the tray line for		
	•	the menus and that residents			breakfast, lunch and dinner 5 times a		
	_	out cold food. He stated he			week for 4 weeks, then 3 times a week	for	
	•	ained on the facility's ordering			5 months to include weekends. Standa		
		chen frequently ran out of food.			of practice is at each meal, ensuring		
		e DDS came to the facility			foods are held at a temperature of above	ve	
	every few weeks to	assist him.			140 degrees F.		
					The DM, the cook and/or the		
		of the lunch meal in the main			Administrator will monitor food		
	_	/19 at 12:10 PM, the menu			temperature during meal pass in the		
		and no reports of cold food			dining room and hallways, for breakfas	st,	
	from the sampled r	esidents.			lunch and dinner 5 times a week for 4		
	In an interview on 1/3/18 at 11:35 AM, NA #4				weeks then 3 times a week for 5 month	iS	
					to include evenings and weekends, to		
	_	d residents often complained			assure food temperatures at point of	ĺ	
		epartment regarding cold food, enus and the taste of the food.			service remain within acceptable		
	_	quently had to reheat food.			temperature range of 125 degrees or resident preference.	ĺ	
	one stated site liet	quentry flau to refleat 1000.			The DON and/or the ADON's will monit	or	
	In an interview on 1	1/3/19 at 1:40 PM, Resident #9			the dining area and hallways during me		
		I at the facility was "horrible".			times 5 times a week for 4 weeks, then		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3)) DATE SURVEY COMPLETED
		345177	B. WING			C 02/04/2019
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	IP CODE	02/04/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 804	In an interview on stated food was a stated her assigned the taste and temporal in a telephone into DDS stated while. Chef and the Admidaily operations of the Chef was adected food using the facting proving to be unstable DM to order the Decause the Chefinventory and the items. He stated he complains about of the stated food the stated here.	1/3/19 at 2:45 PM, NA #2 problem at the facility. She ad residents were vocal about perature of the food. erview on 1/3/19 at 3:10 PM, the the DM was out of leave, the inistrator were charge of the the kitchen. The DDS stated quately training on how to order lity's system, but it was uccessful." He stated he asked the food while she was on leave was not completing the facility was not getting certain the was not aware of the old food.	F8	times a week for 5 mont evenings and weekends staff are present in the dhallways and passing trathe Administrator, DON manager will interview 5 for 4 weeks then 10 resists months, to validate the delivered at an acceptable according to resident pretthe Administrator, Dieta and/or the Director of Nuaudits/monitors and interpatterns and trends and plan as necessary. The Administrator/Dietar will review the plan during meeting and will continue discretion of the QAPI continuation.	s, to validate that lining area and ays timely. and/or the dietary residents weekly dents monthly for at food was ble temperature eference. Bury Manager cursing will review rviews to identify will adjust the gry manager/DON and monthly QAPIU the plan at the formittee.	
	stated her assigned complained about the food. She state from the AAM become the menu was "so In an interview on Administrator state the food served from palatable and services of the further stated menus be followed. In an interview on was unable to promonitoring complete.	1/4/19 at 10:30 AM, The ed it was her expectation that om the dietary department be red at the proper temperature. it was her expectation that the		Indicate dates when combe completed; February 1, 2019	rective action will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING _			1	04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	,	
THE GREI	ENS AT PINEHURST RE	HAB & LIVING CENTER			5 RATTLESNAKE TRAIL NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pag	e 50	F 8	304			
		She provided tray delivery inning 12/10/18 of the meals.					
		admitted on 2/9/18 with s of Diabetes and Coronary					
	grievance dated 9/18 #10. The grievance r because she did not menu. The resolution	grievance logs revealed a k/18 completed by Resident ead she was unhappy get what was listed on the read the dietary department ted on the daily menu.					
	(MDS) dated 11/13/1	erly Minimum Data Set 8 indicated she was exhibited no behaviors.					
	stated the facility was since July 2018 and changes to the menumanagement did not was on the main mer Available Menu" (AA on the AAM included soup, chef salad, gar and deli sandwiches residents ordered froit was because the forpalatable. The DM st from September 201 absence, the Chef will Chef did not "catch of that resulted in the fat The DM stated she will were not being follow.	2/19 at 11:20 AM, the DM is under new management there had been some it. She stated the new offer an "alternate" to what in u but rather have a "Always M). The DM stated the items it grilled cheese sandwiches, it den salad, hot dog, chips is She stated a lot of the imit the AAM but did not think and on the menu was not eated she was out on leave it to the ordering process incility running out of food. Was aware that the menus are so she ordered the food are. She stated she was					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		345177	B. WING _			C 02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	2/04/2019	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 804	stated a new menu on 1/7/19 and hoped happy with the new In an interview on 1/Administrator stated of the menus a few management did no dietary department of Chef was left in challeave but there was Director of Dining Sc Administrator stated maybe every 2 weel running out of food a properly trained on the food count or me was currently aware department and the In an interview on 1/stated she was awa unhappy with the foot stated the residents not getting what was kitchen would run output the property of the stated training out of the stated the residents not getting what was kitchen would run output the property of the stated training out of the stated the residents not getting what was kitchen would run output the property of the stated training output the stated training of the stated training output training output the stated training output train	cins of cold food. The DM cycle was scheduled to start of the residents would be menu cycle. 3/19 at 9:30 AM, the there was some "tweaking" months ago and that it realize it would put the over budget. She stated the roge while the DM was on oversight provided by the ervices (DDS). The the DDS was at the facility was and that the Chef was not now to order food based on enu. The Administrator she of concerns in the dietary unhappiness of residents. 3/19 at 9:50 AM, NA #6 re that the residents were od served at the facility. She complained that they were so on the menu and that the ut of food. NA #6 stated she improvements or worsening	F8	,			
	Chef stated he was facility. He stated he were not following the had complained about was not properly transystem and the kitch	view on 1/3/19 at 9:55 AM, the no longer employed at the was aware the dietary staff ne menus and that residents but cold food. He stated he ined on the facility's ordering nen frequently ran out of food. DDS came to the facility assist him.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		LETED
		345177	B. WING			1	04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205 R	ET ADDRESS, CITY, STATE, ZIP CODE ATTLESNAKE TRAIL HURST, NC 28374	<u> </u>	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pag	e 52	F	304			
	stated her assigned about the dietary der following the menus. She stated she frequent in an interview on 1/stated the facility officiated on the posted for her. In an observation of dining room on 1/3/1 was being followed a from the sampled results from the sampled from t	d another interview on 1/3/19 Int #10 received soup and a vich. She stated it was what the "Always Available Menu" not like what was being meal choice. She stated cluded soup and grilled salads and hot dog. she frequently ordered from bod was "so bad". //3/19 at 2:45 PM, NA #2 oblem at the facility. She residents were vocal about					
	Chef and the Admini daily operations of the the Chef was adequate	strator were charge of the ne kitchen. The DDS stated ately training on how to order stem, but it was "proving to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	IAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		210-12013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 804	order the food while so the Chef was not come the facility was not gestated he was not away cold food. In an interview on 1/3 stated her assigned recomplained about the the food. She stated a from the AAM because the menu was "so bade in an interview on 1/4 Administrator stated in the food served from palatable and served She further stated it was unable to provide monitoring completed which indicated the form the food served from palatable and served she further stated it was unable to provide monitoring completed which indicated the form the food served from palatable and served she further stated it was unable to provide monitoring completed which indicated the form the food served from the food served from palatable and served she was unable to provide which indicated the food food from the food fr	stated he asked the DM to he was on leave because apleting the inventory and titing certain items. He are of the complains about /19 at 5:05 PM, NA #5 esidents frequently taste and temperature of a lot of the residents ordered e they stated the food on d.". /19 at 10:30 AM, The twas her expectation that the dietary department be at the proper temperature. // as her expectation that the dietary department department be at the proper temperature. // as her expectation that the dietary department depar	F8	304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(0
		345177	B. WING			02/	04/2019
	ROVIDER OR SUPPLIER ENS AT PINEHURST REI	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D5 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	was on the main mer Available Menu" (AAI on the AAM included soup, chef salad, gar and deli sandwiches. residents ordered fro it was because the for palatable. The DM st from September 2018 absence, the Chef was Chef did not "catch of that resulted in the fat The DM stated she was were not being follow remotely while on lead aware of the complain stated a new menus on 1/7/19 and hoped happy with the new not ha	chere had been some . She stated the new offer an "alternate" to what the but rather have a "Always M). The DM stated the items is grilled cheese sandwiches, den salad, hot dog, chips She stated a lot of the in the AAM but did not think and on the menu was not lated she was out on leave as to 10/29/18 and in her las in charge. She stated the in" to the ordering process cility running out of food. It is a sware that the menus led so she ordered the food live. She stated she was line of cold food. The DM lycle was scheduled to start lithe residents would be lithere was some "tweaking"	F	804			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	· /	ATE SURVEY DMPLETED
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	,	02/04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 804	AM, Resident #21 co Resident Council Premembers had completed about the food. She is RC members that with Manger, the food worthere was not much it In an interview on 1/3 stated she was award unhappy with the food stated the residents of not getting what was kitchen would run out had not noticed any if since the DM returned In a telephone intervity. The stated he was not properly train system and the kitcher The Chef stated the levery few weeks to a In an interview on 1/3 stated her assigned if about the dietary deprollowing the menus as She stated she frequent In an observation of the dining room on 1/3/15	bservation on 1/3/19 at 8:45 infirmed she was the seident. She stated the RC eted several grievances stated it was the hope of the th return on the Dietary uld improve but to date, improvement. 8/19 at 9:50 AM, NA #6 ethat the residents were discreted at the facility. She complained that they were on the menu and that the tof food. NA #6 stated she improvements or worsening diffrom leave. sew on 1/3/19 at 9:55 AM, the inclonger employed at the was aware the dietary staff ethe menus and that residents at cold food. He stated he inclonded the facility is ordering en frequently ran out of food. DDS came to the facility issist him. 8/18 at 11:35 AM, NA #4 residents often complained bartment, cold food, not and the taste of the food. ently had to reheat food.	F 8	04		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED
		345177	B. WING			C)2/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		2104/2019
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 804	stated food was a prestated her assigned the taste and temper. In a telephone interved DDS stated while the Chef and the Adminited daily operations of the Chef was adequated using the facility's sybe unsuccessful." He order the food while the Chef was not contract the facility was not go stated he was not avecold food. In an interview on 1/2 stated her assigned complained about the food. She stated from the AAM becaute the menu was "so batches and served the food served from palatable and served.	oblem at the facility. She residents were vocal about rature of the food. iew on 1/3/19 at 3:10 PM, the e DM was out of leave, the strator were charge of the ne kitchen. The DDS stated ately training on how to order stem, but it was "proving to e stated he asked the DM to she was on leave because mpleting the inventory and etting certain items. He ware of the complains about 3/19 at 5:05 PM, NA #5 residents frequently e taste and temperature of a lot of the residents ordered se they stated the food on	F8	,		
	was unable to provid monitoring complete which indicated the f proper temperature.	4/19 at 10:40 AM, the DM le any food temperature d after 9/8/18 RC grievance food was not served at the She provided tray delivery ginning 12/10/18 of the meals.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345177	B. WING _			C 2/04/2019
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	210412013
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 804	Continued From բ	page 57	F 8	804		
	cumulative diagno Accident and Dial Resident #22's ar	vas admitted 12/27/17 with oses of Cerebral Vascular petes. nnual MDS dated 12/7/18 os cognitive intact and exhibited				
	stated the facility since July 2018 a changes to the m management did was on the main Available Menu" (on the AAM inclusion, chef salad, and deli sandwich residents ordered it was because the palatable. The DM from September 2 absence, the Chef did not "cate that resulted in the The DM stated she were not being for remotely while on aware of the comstated a new mer	a 1/2/19 at 11:20 AM, the DM was under new management nd there had been some enu. She stated the new not offer an "alternate" to what menu but rather have a "Always AAM). The DM stated the items ded: grilled cheese sandwiches, garden salad, hot dog, chips nes. She stated a lot of the from the AAM but did not think e food on the menu was not all stated she was out on leave 2018 to 10/29/18 and in her off was in charge. She stated the ch on" to the ordering process to facility running out of food. The was aware that the menus allowed so she ordered the food leave. She stated she was plains of cold food. The DM to cycle was scheduled to start order the residents would be the menu cycle.				
	Administrator state of the menus a fe management did	1/3/19 at 9:30 AM, the sed there was some "tweaking" w months ago and that not realize it would put the nt over budget. She stated the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345177	B. WING	B. WING		C
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		02/04/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 804	leave but there was Director of Dining S Administrator stated maybe every 2 weer running out of food properly trained on the food count or mas currently award department and the In an interview on 1 stated she was awa unhappy with the fostated the residents not getting what was kitchen would run of had not noticed any since the DM return. In a telephone inter Chef stated he was facility. He stated he was facility. He stated he was not properly trasystem and the kitch The Chef stated the every few weeks to In an interview on 1 stated her assigned about the dietary defollowing the menus She stated she frequency from the composition of dining room on 1/3/	rige while the DM was on oversight provided by the ervices (DDS). The if the DDS was at the facility is. She stated the facility was and that the Chef was not how to order food based on enu. The Administrator she is of concerns in the dietary unhappiness of residents. If a 19:50 AM, NA #6 is that the residents were od served at the facility. She is complained that they were is on the menu and that the int of food. NA #6 stated she improvements or worsening it from leave. If a 19:55 AM, the included in the included in the dietary staff the menus and that residents out cold food. He stated he inned on the facility's ordering then frequently ran out of food. DDS came to the facility	F 8	04		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	. ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		02/04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 804	#22 stated she regul meetings and the food stated management resident's disliked the the facility was "territ frequently ordered food on the menu was In an interview on 1/3 stated food was a prostated her assigned the taste and temper In a telephone interview DDS stated while the Chef and the Adminically operations of the Chef was adequated using the facility's sybe unsuccessful." He order the food while the Chef was not control to the facility was not greated he was not avoid food. In an interview on 1/3 stated her assigned complained about the food. She stated from the AAM becaumenu was "so bad".	sidents. 3/19 at 1:50 PM, Resident arly attended the RC od committee meetings. She was aware of that the e food and stated the food at ole." Resident #22 stated she om the AAM because the as not palatable. 3/19 at 2:45 PM, NA #2 oblem at the facility. She residents were vocal about ature of the food. iew on 1/3/19 at 3:10 PM, the e DM was out of leave, the strator were charge of the le kitchen. The DDS stated ately training on how to order stem, but it was "proving to e stated he asked the DM to she was on leave because empleting the inventory and etting certain items. He ware of the complains about 3/19 at 5:05 PM, NA #5 residents frequently e taste and temperature of a lot of the residents ordered se they state the food on the	F8	04		
	Administrator stated	it was her expectation that the dietary department be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				04/2019
	ROVIDER OR SUPPLIER ENS AT PINEHURST REF	HAB & LIVING CENTER		205	RATTLESNAKE TRAIL EHURST, NC 28374	, <u>v-</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 804		e 60 at the proper temperature. was her expectation that the	F	304			
	In an interview on 1/4 was unable to provide monitoring completed which indicated the formation for the proper temperature. Stimes monitoring beg breakfast and lunch rows. Stimes and lunch rows. Resident #24 was Chronic Renal Disease Resident #24's annual provides and the provi	admitted 11/28/17 with se and Diabetes.					
	stated the facility was since July 2018 and to changes to the menu management did not was on the main men Available Menu" (AAI on the AAM included: soup, chef salad, gar and deli sandwiches. residents ordered from it was because the forpalatable. The DM staffrom September 2018 absence, the Chef was Chef did not "catch of that resulted in the father DM stated she was were not being follow."						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 02/04/2019		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•			
(X4) ID PREFIX TAG			ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 804	Continued From page	_	F	804				
	stated a new menu	ains of cold food. The DM cycle was scheduled to start d the residents would be menu cycle.						
	Administrator stated of the menus a few management did not dietary department. Chef was left in challeave but there was Director of Dining S Administrator stated maybe every 2 weerunning out of food properly trained on the food count or m was currently award department and the In an interview on 1 stated she was awa unhappy with the foot stated the residents not getting what wa kitchen would run o	/3/19 at 9:30 AM, the If there was some "tweaking" months ago and that of realize it would put the over budget. She stated the rge while the DM was on oversight provided by the ervices (DDS). The If the DDS was at the facility ks. She stated the facility was and that the Chef was not show to order food based on enu. The Administrator she of concerns in the dietary unhappiness of residents. /3/19 at 9:50 AM, NA #6 re that the residents were od served at the facility. She complained that they were s on the menu and that the ut of food. NA #6 stated she improvements or worsening						
	Chef stated he was facility. He stated he were not following to had complained about was not properly transystem and the kitch	view on 1/3/19 at 9:55 AM, the no longer employed at the e was aware the dietary staff he menus and that residents out cold food. He stated he ined on the facility's ordering hen frequently ran out of food.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING				04/2019	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CIT 205 RATTLESNAKE TR PINEHURST, NC 28	RAIL	, , , , ,		
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH COI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 804	Continued From pag	e 62	F	304				
	stated her assigned in about the dietary dep following the menus. She stated she frequently an an observation of dining room on 1/3/1 was being followed a from the sampled result in an interview on 1/3 #24 stated management resident's disliked of at the facility was "tenshe frequently ordered food on the menu was a prostated her assigned in the taste and temper. In a telephone interview on 1/3 stated her assigned in the taste and temper. In a telephone interview on 1/3 stated her assigned in the taste and temper. In a telephone interview on 1/3 stated her assigned in the taste and temper. In a telephone interview of the facility is systematically operations of the Chef was adequated using the facility's systematically was not continuous facility was not go stated he was not awould food.	3/19 at 1:45 PM, Resident then the food and stated the food arrible." Resident #24 stated and from the AAM because the is not palatable. 3/19 at 2:45 PM, NA #2 oblem at the facility. She residents were vocal about ature of the food. 3/19 at 3:10 PM, the residents were charge of the extrator was "proving to extrated he asked the DM to she was on leave because inpleting the inventory and extring certain items. He ware of the complains about						
	In an interview on 1/3 stated her assigned i	3/19 at 5:05 PM, NA #5 residents frequently						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _		02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION	
F 867 SS=E	the food. She stated from the AAM becamenu was "so bad". In an interview on 1 Administrator stated the food served from palatable and serve She further stated it menus be followed. In another interview DM was unable to proper temperature times monitoring complete which indicated the proper temperature times monitoring be breakfast and lunch QAPI/QAA Improve CFR(s): 483.75(g)(2) \$483.75(g) Quality a \$483.75(g)(2) The cassurance committed (ii) Develop and impaction to correct idea This REQUIREMENT by: Based on observatinterviews and recondates.	de taste and temperature of de a lot of the residents ordered duse they state the food on the delay at 10:30 AM, the lit was her expectation that in the dietary department be de at the proper temperature. Was her expectation that the mon 1/4/19 at 10:40 AM, the provide any food temperature and after 9/8/18 RC grievance food was not served at the list of the meals. The meals of the meals of the meals of the meals of the most: See must: See mus	F 8	F 867 Address how corrective action will be		
	interventions that the following a complain was for three recited	procedures and monitor e committee put into to place nt survey dated 6/15/18. This d deficiencies in the areas of 565-not effectively resolve		accomplished for those residents for have been affected by the deficient practice; cross reference to the following: F 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			0.2	C 2/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/04/2019
					5 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER			NEHURST, NC 28374		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 867	Continued From p	page 64	F 8	867			
	grievances of the	Resident Council with timely			The Administrator presented a resoluti	on	
	response, Quality	of Life at F677-not providing			to the Resident Council President on		
	showers as sched	duled, and Food and Nutrition			1/25/19 for the grievance of answering	I	
	Services at F804-	not serving food at a palatable			call lights timely to include monitoring	of	
	temperature. Th	e findings included:			call lights on each unit, each shift 3 times		
					a week for 4 weeks, to assure call ligh		
	This citation is cro	oss referenced to:			are answered timely. The resolution w	as	
					accepted by the resident council		
					committee. The Social Service Directo		
	FECE Decedes	staff and resident interviews and			(SSD) provided a written letter of follow	w up	
		e facility failed to effectively			to the Resident Council President on 1/25/19 to be shared during the next		
					Resident Council meeting on 1/25/19.		
	resolve Resident Council (RC) grievances for 3 (September, October and November 2018) of 3				The Administrator presented a resoluti	on	
		for RC grievances.			to the Resident Council President on	• • • • • • • • • • • • • • • • • • • •	
		S .			1/25/19, for the grievance of cold food	l to	
					include monitoring food temperatures		
					the tray line for breakfast, lunch and		
		bservation, staff and resident			dinner 5 times a week for 4 weeks and		
		cord review, the facility failed to			monitoring food temperature during me		
	•	as scheduled for activities of			pass in the dining room and hallways,	for	
		dependent residents for 3			breakfast, lunch and dinner 5 times a		
	(Resident #9, Res	sident #13 and Resident #21) of			week, to assure food temperatures		
	o residents reviev	ved for ADEs.			remain within acceptable temperature range of 125 degrees or resident		
					preference. The resolution was accept	ed	
	F804- Based on o	observations, resident interviews			by the resident council committee. Th		
		vs and record review, the facility			SSD provided a written letter of follow		
		ne food served an appetizing			to the Resident Council President on	•	
	temperature for 5	(Resident #9, Resident #10,			1/25/19, to be shared during the next		
	Resident #21, Re	sident #22 and Resident #24) of			resident council meeting on 1/251/9.		
	5 interviewable re	sidents reviewed for palatable			F 677		
	food.				The facility provided a shower for		
		4/4/40 4 40 00 455 **			Resident #9 on1/4/19, following survey	/	
		1/4/19 at 10:30 AM, the			exit, and has received showers every		
		s unable to explain the repeated			_Tuesday and Friday per residents'	-i	
		eas of grievances and showers.			shower schedule. The Director of Nur	•	
		stated there had been some ary department while the Dietary			(DON) discussed the shower schedule and resolution with Resident #9 on 1/4		
	, 133003 III IIIC UICI	ary acparament wille are Dictary	1	- 1	ana resolution with Nesident #3 011 1/4	7 I J ,	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIAT ICIENCY)	
F 867	Continued From page	ge 65	F 8	367			
	Manager was on lea	ave, but she was working with food committee meetings to		as a resolution to the documented 11/28/18 offered and given by the assistant (CNA) on the days and documented sheet. The Licensed shower was given and Medication administration The facility provided at Resident #13 on 1/5/1 exit, and has received Wednesday and Sature shower schedule. The the shower schedule at Resident #13 on 1/4/1 the grievance documented on the showers will be offere CNA on the scheduled documented on the ship Licensed nurse will variety and has received Saturdays on first shift on second shit per resistend schedule. The DON of shower schedule and Resident #21 on 1/5/1 exit, and has received Saturdays on first shift on second shit per resistendule. The DON of shower schedule and Resident #21 on 1/4/1 the grievance documented on the showers will be offere CNA on the scheduled documented on the shucensed nurse will variety and document of the Resident Council F804.	in, showers will be the certified nursing e scheduled showed on the shower nurse will validate didocument on the ation record (MAR) is shower for 19, following surveying per residents to EDON discussed and resolution with 19, as a resolution ented on 11/28/18, did and given by the dishower sheet. The alidate shower was not the MAR. Is shower for 19, following surveying and Wednesday sidents' shower discussed the resolution with 19, as a resolution ented on 12/27/18, did and given by the dishower days and nower sheet. The alidate shower was not the MAR.	er	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 02/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	02/04/2019	
				205 RATTLESNAKE TRAIL			
THE GREENS AT PINEHURST REHAB & LIVING CENTER			PINEHURST, NC 28374				
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DATE		
F 867	Continued From page	÷ 66	F&	1/25/19, for the grievance of include monitoring food temper the tray line for breakfast, lund dinner 5 times a week for 4 w monitoring food temperature of pass in the dining room and his breakfast, lunch and dinner 5 week, to assure food temperature of degrees or resident preference resolution was accepted by the council. The Administrator and/or the Nursing (DON) and Dietary Mamet with Residents # 9, 10, 2 individually on 1/25/19, to prethe new process for monitoring temperatures in the dining roof the hallways. These residents the new process. The Administrator, DON and/of interview Residents 9, 10, 21, weekly for 4 weeks, to validate items were received at an accepted by the same deficient cross referenced to the follow F 565. Current facility residents have potential to be affected by the	eratures of ch and reeks and during mean allways, if times a satures perature of 125 ce. The ne resident of 1,22, and 2 ce that food or DM will a 22 and 2 ce that food ceptable dentify other to be t practice; ring:	n al for t f M) 24 em l 4,	
				deficient practice of the facility provide resolution and follow grievances voiced during resi	up to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA' CIENCY)	
F 867	Continued From page	ge 67	F	meetings. The Adminis SSD reviewed grievand the Resident Council g September 2018 through to validate that resolution or obtained, and the regroup was given a follow regarding the resolution F 677 Current facility resident potential to be affected deficient practice of not as scheduled. The DON and ADON's audit on 1/21/19, of she documentation for curresidents, to identify residents, to identify residents were 3 residents identification residents were offered 1/21/19 and will be offerward according to she F 804 Current facility resident trays have the potentia the same deficient practice.	ces received from roup from gh December 20 ons were initiated sident council ow up letter in. Its have the leady the same to receiving shower ent facility sidents that had scheduled. Therefied. Those a shower on ered showers goin nower schedule. Its that receive me it to be affected by the same tower ent facility sidents that had scheduled. Therefied the scheduled the scheduled the scheduled the scheduled the scheduled to be affected by the schedule the	n 18, d ers not e eal	
				Address what measure place or systemic chan ensure that the deficier recur; cross referenced to the F 565 The Administrator prov 1/23/19, for the Interdis (IDT), which consists o	nges made to the practice will no electric following: ded education of sciplinary Team	ot	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345177 B. WING			C 02/04/2019					
NAME OF D	ROVIDER OR SUPPLIER	343177	5: 1:::10	etd.	REET ADDRESS, CITY, STATE, ZIP CODE	02/	04/2019	
NAME OF F	ROVIDER OR SUFFLIER							
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER			RATTLESNAKE TRAIL IEHURST, NC 28374			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				·		0/5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 867	Continued From page	e 68	F		Nursing (DON), Assistant Director of Nursing (ADON), Social Service Direct (SSD), Dietary Manager (DM), Activitie Director (AD), Rehab Manager (RM) and Maintenance director (MD), regarding response with resolution to grievances and follow up letter within 5 days of receiving the grievance. The Activities Director will document grievances received during resident council meetings on the approved Grievance form and will forward the grievance form to the SSD to be logger onto the Resident Council Grievance form to the Administrator, who will give the appropriate IDT member to investig and provide resolution to the grievance. The Grievance form, along with the investigation information and resolution will be given to the Administrator to revand approve, then the SSD will submit follow up letter to the Resident Council president and/or group within 5 days of the receipt of the grievance. A copy of follow up letter will be kept with the monthly resident council meeting minus F 677 The DON and/or ADON's provided education beginning on 1/22/19, for the licensed nurses and CNA's regarding providing showers to residents according to the shower schedule, with documentation by the CNA on the show sheet, and the licensed nurse will valid shower was given and document on the residents MAR. When a resident refuse a shower, the CNA will report to the licensed nurse and the licensed nurse and the licensed nurse.	d oge to gate iew a the tes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	02/04/2019	
TVAIVIL OF T	KOVIDER OR OUT FEEK			205 RATTLESNAKE TRAIL	OODL		
THE GREENS AT PINEHURST REHAB & LIVING CENTER				PINEHURST, NC 28374			
(V4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		ID	PROVIDER'S PLAN C	NE COPPECTION	(X5)	
PREFIX				CTION SHOULD BE THE APPROPRIA	COMPLETION		
F 867	Continued From page				at and docume the shower on vided to newly e orientation. Trovided in 2/19, for the assing of mea at the point of e acceptable degrees or seducation wid nursing staff on 1/25/1 ceptable food rees or greater ers food week menu and the The DM and/o y that food item wing days mer menu. The D g food items u with tive value as ate resident the nutritional	nt / I II f 9, r rity r ms nu	
				The facility provides an A Menu or Alternate menu, chooses not to want the f menu. The DON and/or ADON's nursing staff to the dining hallways during meal time	if the resident ood on the da will assign area and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 02/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/04/2019	
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 867	Continued From pag	e 70	F 86	meal trays are passed timely when the are sent from the kitchen. The facility failed to follow the QAPI process for identifying, planning and implementing quality plans for improvement and did not continue ongoing monitoring to assure continuation compliance in areas identified. The Regional Director of Clinical Service provided education on 1/23/19, to the Interdisciplinary team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Assistant Director, Activities Director, Dietary Manager, Maintenance Direct and Housekeeping supervisor, regard the QAPI process to include how to identify, plan and implement a quality for improvement and ongoing monitor to assure compliance. The Administrator is the QA coordinate the facility and will hold monthly QAI meetings to review and update plans have been implemented to assure continued compliance. Members of the QAPI committee will consist of at least Administrator, Director of Nursing, Medical Director, Social Service Director, Activities Director, Infection Control Nurse, Care plan coordinator, Dietary Manager, Maintenance Director and Housekeeping supervisor. A member the direct care staff will also be invited participate. Active Quality Plans will be reviewed weekly by the Administrator the department managers to validate audits/monitors are being completed adjust plans as necessary for continual compliance.	ed vices e or ling plan ring or at Pl that the est the est or, or of d to one and and	

· · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING		C 02/04/2019		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 867	Continued From pag	e 71	F 86	Indicate how the facility plans to monitits performance to make sure that solutions are sustained; cross referenced to the following: F 565 The Administrator and/or the Director Nursing will review resident council grievance log 5 x a week for 4 weeks then weekly for 5 months, to validate to grievances received from the resident council group were investigated, a resolution was initiated/completed and follow up letter was provided to the resident council president and/or resident council president and/or resident group within 5 days of receiving the grievance. The Administrator and/or the Director Nursing will review the audits to identify patterns/trends and will adjust the plan necessary. The Administrator will review the plan during the monthly QAPI meet and audits will continue at the discretic the QAPI committee. F 677 The DON and/or the ADON's will audit shower sheets and MARS 5 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or the ADON's will inter 10 residents weekly for 4 weeks then residents monthly for 5 months, to validate that showers are given as scheduled. The Director of Nursing will review the audits to identify patterns/trends and valjust the plan as necessary. The DO will review the plan during the monthly	of hat d a lent of fy n as lew letting on of t veek view 20		

			(3) DATE SURVEY COMPLETED			
		345177	B. WING _			C 02/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	P CODE	02/04/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 867	Continued From pag	e 72	F 8		s will continue at PI committee. If the refood I line for the set of the rest at each the held at a set of the he	or I at
				audits/monitors and inter patterns and trends and	views to identify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 04/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	04/2013	
THE GREENS AT PINEHURST REHAB & LIVING CENTER					05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	÷73	F	867	plan as necessary. The Administrator/Dietary manager/DC will review the plan during monthly QAI meeting and will continue the plan at the discretion of the QAPI committee.	PI		
					Indicate dates when corrective action v be completed; February 1, 2019	vill		
F 925 SS=D	program so that the farodents. This REQUIREMENT by: Based on observatio interviews, and record	n an effective pest control acility is free of pests and is not met as evidenced in, resident and staff d review, the facility failed to pest control program on one (100 Hall).		925	F 925 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; Resident #11's room 113 was treated of		2/1/19	
	AM with Resident #11 the facility indicated F oriented. During the stated his room was F resident also reported with roaches." The recockroach last night croom. He also recalled something crawling obed. He stated it was	ducted on 1/2/19 at 10:50 I. Information provided by Resident #11 was alert and Interview, Resident #11 kept clean. However, the I there was a "bad problem esident reported he saw one on the privacy curtain in his ed that last week he felt in him when he was lying in a cockroach. When asked about the problem with			12/12/18, 12/27/18 and 1/15/19. Room 111 was treated on 12/12/18, 12 and 1/15/19. Room 124 was treated on 12/12/18, 12/27/18 and 1/15/19. Room 127 was treated on 12/27/18. Visitors bathroom near lobby was treat 12/12/18, 12/27/18 and 1/15/19. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice	ed ner		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
				_			С
		345177	B. WING _			02/	/04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	05 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER		Р	INEHURST, NC 28374		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 925	Continued From p	age 74	F 9	925			
	· '	d he did when he was first			The Maintenance director completed a		
	admitted to the fac	cility. However, he reported he			100% audit of the facility on 1/4/19, to		
		ng to anyone about the			identify areas of pest infestation. Focu		
		week or last night because the			areas identified are Kitchen, service ha	ıll,	
		aware of this problem from his			Long term care (LTC) med room, LTC		
		Additionally, Resident #11			nursing station, LTC locker room, LTC		
		staff has talked about			main hallway, rooms 113, 123 and 124	-	
	cockroaches being			A -1-1	_		
	rooms as well.				Address what measures will be put into)	
	A ravious of Booids	ent #11 's medical record			place or systemic changes made to	o.t	
	revealed the resid			ensure that the deficient practice will no recur;	JL		
	on 9/4/18 from a h			The Maintenance director, Administrate	or		
		it quarterly Minimum Data Set			and/or the Director of Nursing (DON)	וכ	
		nt dated 12/12/18 revealed the			completed education on 1/25/19 for all		
	· ·	ssed to have moderately			staff, all days, all shifts including week		
		status for daily decision			and prn staff, regarding process for		
	making.	•			reporting when pest is observed, to		
					include a Pest Control log book located	d at	
	An interview was	conducted on 1/2/19 at 3:35 PM			each nurse's station. Staff will docume	∍nt	
	with the facility 's	Assistant Director of Nursing			on the log, where the pest were observ	⁄ed	
		ng Term Care unit, which			and type of pest.		
		#11 's hall. Upon inquiry, the			The Maintenance director, Housekeep		
	_	esident #11 was alert and			supervisor and/or manager on duty will	Į	
		ted Resident #11 could answer			monitor the logs daily and provide		
	questions appropr	iately and reliably.			appropriate treatments or notify pest		
		1 1 1 1 1/0/40 1 44 00			control company.		
		conducted on 1/2/19 at 11:30			The facility obtained a contract with a r		
		Housekeeper #2. At the time ousekeeper #2 was working on			pest control company on 12/12/18. Th company will treat facility at least twice		
		all. Housekeeper #2 reported			month and/or as needed. The compar		
		ne on 1st shift. Upon inquiry,			has treated the facility and focus areas	•	
		stated she last saw a dead			the following dates: 12/12/18, 12/27/18		
		ther hall last week. She			and 1/15/19.		
		nes typically came out of a night,			The facility has provided written notice	to	
		she would find would likely be			current residents and/or resident		
		per #2 stated she thought the			representatives to store food items in		
		roaches might be a little better			closed containers. The facility will prov	/ide	
	than it had previou				containers as needed. Facility protoco		

C R WING	
345177 B. WING 02/04/2	2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
205 RATTLESNAKE TRAIL	
THE GREENS AT PINEHURST REHAB & LIVING CENTER PINEHURST, NC 28374	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
An observation was made on 1/3/19 at 8:35 AM of a small (approximately 1/2 inch long), dead black bug in the comen of a restroom adjacent to the common hallway near the facility 's lobby. Housekeeper #1 was observed to be working near the bathroom at the time of the observation. Upon request, Housekeeper #1 doserved the dead insect and stated it was a dead cockroach. At that time, she reported there have been cockroaches in the facility. An interview was conducted on 1/3/19 at 11:35 AM with the facility's Director of Housekeeping. The Director reported there has been a problem with cockroaches in the facility. Upon inquiry, the Director reported there has been a problem with cockroaches in the facility but noted, "For the last 2-3 months we have been really crunching down on it." He stated a lot of the problems termmed from the residents ' families bringing in outside food without placing the food items in sealed containers. The Director reported the facility has been talking about buying some type of container to store food items in the residents' rooms. The Director recalled an insect spray and deep clean was recently done due in Room #111 due to cockroaches having been reported in that room (a room on Resident #11's hallway). An interview was conducted on 1/3/19 at 11:44 PM with the facility's Director of Maintenance. The Director reported the started at the facility in Coclober, 2018. When he started his position, he was told bugs were being seen in the facility. The contracted pest control company was coming out monthy at that time. The Director stated he has asked staff to keep him informed of any pest	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C)2/04/2019		
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 925	crumbs. The Director continued to receive cockroaches from state control service to connew pest control company and the pest control company individuals provided; no special the invoice. On 10/4/18, a month was provided; no special the invoice. On 11/1/18, a month was provided; no special the invoice. On 11/1/18, a month was provided; no special the invoice. On 12/12/18, an invoice control company individuals provided. On 12/27/18, an invoint control company individuals provided and the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview, the NA representation of the perfect control company individuals provided assigned to care for interview.	p the rooms cleaned from or reported when he complaints about aff, he asked a new pest me out to the facility. The npany came out to do a 12/18. On 12/27/18, the new y come back to target Room the dining room, kitchen, vice hall. To date, the nece stated the facility had not Assurance and Performance or plan to present at the QAPI	F9	25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			02/0	04/2019	
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	CODE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 925	"They are all over the the last 3 weeks." The months ago when shoretrieve something for roommate, a cockroad stated she did report. An interview was conwith NA #6. NA #6 reshift. Upon inquiry, the live cockroaches climin Room #124 this manda accompanied sur NA was observed as the wall located betwourtain and the bathrabrown bug briefly appunder the corner gual was a live cockroach told anyone about the told the Assistant Hotof Maintenance three roaches in the room. report seeing the cockroach they had already been seen to the surface of the seeing the cockroach told anyone about the told the Assistant Hotof Maintenance three roaches in the room.	is in his room, the NA stated, is place, but it 's gotten better he NA reported about 2-3 is went into a drawer to resident #11 's che ran up her arm. The NA the incident. ducted on 1/3/19 at 3:00 PM is ported she worked on 1st he NA stated she saw three bing on the privacy curtain bring. Upon request, the everyor to Room #124. The she hit the corner guard on it is privacy from. At that time, a live, beared before crawling back ord. The NA confirmed this is when asked if she had it roach, the NA stated she is exekeeper and the Director days ago when she saw the NA stated she did not kroaches today because in told about the problem.	FS	DEFICIEN 925	CY)			
	with the Director of Minterview, the Director told about any conce #124. He stated he his Director went to Room cockroach was obserwall just to the right or resident 's room. The was a cockroach. With Maintenance reporter	ducted on 1/3/19 at 3:10 PM laintenance. During the r was asked if he had been rns of cockroaches in Room had not. Upon request, the m #124. At that time, a live ved to be climbing on the f the bathroom door in the e Director confirmed this hen asked, the Director of d there were generally three hting pest control problems						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				04/2019	
NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	DE	02.	0-11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE	
F 925	concerns could be sh brought up in the dail submitted electronical. An interview was conwith NA #8. When as cockroaches today, to one live roach runnin Room #127 earlier to told anyone, she state or not she did. Howe normally she would reither maintenance of stated, "I've seen the just not as much as be A follow-up interview, was recently told staft cockroaches in the red Director of Housekee Room #111 (which had deep cleaned), he had were seen residents weeks. A follow-up interview 11:20 AM with the Director control company had him when they last careported he was told structural repairs until eradicated. When as Maintenance stated to	es to him. He stated any lared verbally with him, y stand-up meeting, or ally as a work order. ducted on 1/3/19 at 3:15 PM ked if she had seen any he NA stated she did see g across the baseboard in day. When asked if she had ed she was not sure whether ever, the NA reported that eport something like this to r housekeeping. The NA em pretty much everywhere, refore." was conducted on 1/4/19 at ector of Housekeeping. The ping reported that other than ad been re-sprayed and d not been told cockroaches rooms within the last two was conducted on 1/4/19 at rector of Maintenance. At r was asked if the pest provided any instructions to ame to the facility. He not to do any cosmetic or I the cockroaches were	FS	025				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 02/04/2019	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	ODE	0=0 ==0	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 925	PM with the Assistatinquiry, the housek had reported a conwithin the last two was been told about a phis supervisor. An interview was conwith the facility 's A interview, the concept the facility were disstated the facility which a new pest convaluation address the problem involvement), the A not done a QAPI pladministrator states staff to notify either	onducted on 1/4/19 at 12:30 ant Housekeeper. Upon eeper stated no staff members cern to him about cockroaches weeks. He reported if he had roblem, he would have notified onducted on 1/3/19 at 3:17 PM administrator. During the erns regarding cockroaches in cussed. The Administrator as currently on a 2-week cycle atrol company. When asked if had been formulated to	FS	DEFICIENCE OF THE PROPERTY OF	OY)		