STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 07/23/2020. The facility was found incompliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart - B - Requirements for Long Term Care Facilities. Event ID # F08P11.	E 000		
F 000	INITIAL COMMENTS An unannounced Complaint Investigation and a COVID-19 Focused survey was conducted on 07/23/2020. Eleven (11) of the twelve (12) complaint allegations were unsubstantiated. Event ID # F08P11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		8/6/20

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

Electronically Signed | 08/15/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: F550 D Based on record review, interviews with family and staff, the facility failed to provide the resident representatives choices of COVID -19 facilities for facility-initiated resident transfers to another Long-Term Care Facility for 6 of 6 residents reviewed for choices (Resident #2, #4, #5, #6, #7, and #8). Findings included: A. Resident #2 was re-admitted to the facility on 7/8/19 and transferred to another Long-Term Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #2 also had the following diagnosis; bipolar disorder, hemiplegia, type 2 diabetes mellitus, major depressive disorder and epilepsy. The quarterly Minimum Data Set (MDS) dated	F 550	F550 Pine Ridge Nursing & Rehabilitation Center (the facility) acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge reserves the right to refute any of the deficiencies on this Statement of Deficiencies through	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 4-21-2020 coded the resident as being cognitively intact. Review of the facility progress note written by the social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 10:47 pm of the residents transfer to "Wilson Pines" to take place on 7-19-2020. There was no documentation in the record that choices of other COVID-19 facilities were offered to resident #2's representative. Resident #2's representative was interviewed on 7-22-2020 at 10:13 am by telephone. The representative stated she did receive a phone call from the facility at 10:45 pm on 7-18-2020 to inform her the resident was being moved to Wilson Pines the next day because of testing positive for COVID-19. The representative stated that she was not offered a choice of optional facilities. The resident state the facility did tell her once the resident tested negative on two occasion for COVID-19 the resident could be returned to Pine Ridge. B. Resident #4 was re-admitted to the facility on 5/16/17 and transferred to another Long-Term Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #2 also had the following diagnosis; schizophrenia, diabetes mellitus, depression malnutrition The quarterly Minimum Data Set (MDS) dated 6-8-2020 coded the resident as being cognitively intact. Review of the facility progress note written by the	F 550	Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The facility does ensure that each resident and/or representative is offered a choice in the event of a needed, involuntary transfer due to COVID-19. Residents #2 and #4 have returned to the facility. Resident #5 was discharged to their facility of choice on 7/19/20. Residents #6, #7 and #8 and/or resident representatives have been contacted regularly to provide health updates and discuss potential for return transfer to the facility. The facility has offered assistance as needed to find alternative placement as desired or requested. Residents who have tested positive for COVID-19 and have had a facility-initiated transfer have the potential to be affected. The director of nursing (DON) reviewed progress notes of like residents to validate that choices had been offered and documented. Any identified discrepancies were communicated for follow up to offer assistance in relocating and/or returning to the facility. Follow up documentation was documented appropriately. Pine Ridge has created a Special Care Unit to accommodate residents with COVID-19 related illnesses. The facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 11:25 pm of the residents transfer to "Wilson Pines" to take place on 7-19-2020. There was no documentation in the record that choices of other COVID-19 facilities were offered to resident #4's representative. Resident #4's representative was interviewed on 7-22-2020 at 11:16 am by telephone. The representative stated she did receive a phone call from the facility on 7-18-2020 around 12:30 am that resident #4 was being transferred to Wilson NC due to testing positive for COVID-19. The representative stated she was not given a choice of other facilities C. Resident #5 was admitted to the facility on 7/9/20 and transferred to another Long-Term Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #5 also had the following diagnosis; Displaced intertrochanteric fracture of left femur, congestive heart failure, dementia. The quarterly Minimum Data Set (MDS) dated 7/16/20 was in progress and revealed resident was severely cognitively impaired. Review of the facility progress note written by SW #2 dated 7-18-2020 revealed the resident's represented was notified by telephone at 9:14 pm of the residents positive COVID-19 test result and they will be provided with updates as the facility is made aware. An additional progress note written by SW#1 revealed a second call was made to the	F 550	also has created a list of facilities within a 100 mile radius that are currently accepting COVID related illnesses to ensure each resident or representative's choice is reasonably honored while ensuring safety of other residents within the facility. Follow up communication was documented accordingly. The DON, admissions director and social services director were educated on resident rights which includes the right to choices and the need to accommodate as is practicable for residents within the facility. Education also included documentation requirements. The DON will conduct chart reviews 2x a week over the next 60 days of residents who had a COVID-19 related, facility initiated transfer or discharge to ensure documentation reflects that choices were offered. Findings will be recorded in the Quality Assurance (QA) monitoring tool and results shared with the QA Committee for review. Based on results, QA will make recommendations as needed to ensure compliance is sustained. F550 Compliance Date – 8/6/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

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

representative at 11:09 pm that the resident will be moved to the facility Wilson Pines that she and will admit tomorrow. The note stated the resident's representative inquired about moving the resident back to Pruitt.

A review of a progress note written by the DON at 3:40 pm stated the representative was informed of the need to set up the transportation if the facility in Hight Point was her desire and was also informed this needed to be completed by 4:00 pm or the resident would need to leave on the next ambulance for Wilson Pines skilled nursing facility. The note stated the representative was very upset and did not understand why this transfer could not wait until Monday. The representative referenced they are not consenting to moving resident #5 to any facility except the Pruitt Health in High Point. The note stated the DON and the admissions representative explained this was a public health issue and that for the greater number of resident's safety, the transfer must be made today. The note stated that as of this writing the representative had not provided any information regarding the transfer to Pruitt Health in High Point, anticipate resident to be picked up and transported to Wilson Pines SNF at approximately 4:00 pm today. Daughter notified.
There was no documentation in the record that choices of other COVID-19 facilities were offered to resident #5's representative.

Resident #5's representative was interviewed on 7-22-2020 at 11:42 am by telephone. The representative stated the facility called at 8:00 or 9:00 pm on Saturday July 18, 2020 to inform him the resident was being moved to Wilson Pines the next day because of testing positive for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

COVID-19. The representative inquired as to why they were moving the resident to a facility three hours away and was told by the caller that they had three nursing homes and two of them are full so this is the only one the resident could go to. The representative stated he was not given a choice of other facilities. He stated he told the facility that they wanted the resident to go to a facility in High Point however the facility responded they would not have been able to have reached any other facilities until Monday. The representative stated another family member made several calls on Sunday and the resident did not go to Wilson Pines. The representative stated, "I think they told me she would be returning but I can't remember".

An interview was completed by telephone on 7-22-20 at 1:02 pm with residents #5's alternate contact representative. The representative stated she had called back to the facility at 8:00 am on Sunday 7-19-20 and was told the resident was moving to Wilson NC and was not presented the name of the facility. The representative told the facility that she did not give their consent to move resident #5 and would take legal action if she was moved. The representative was able to secure an admission to Pruitt Health in High Pont and contacted Pine Ridge to inform them of the move. The Representative stated the facility needed to know when the resident was going to be picked up and if she was not picked up by 4:00 pm she will be moved to Wilson Pines. The representative stated they did not say resident #5 would be coming back as they wanted her out of there.

D. Resident #6 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

1/25/20 and transferred to another Long-Term Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #6 also had the following diagnosis; vascular dementia, high blood pressure, Chronic obstructive pulmonary disorder, malnutrition, anxiety, depression and chronic pain.

The quarterly Minimum Data Set (MDS) dated 4/8/2020 coded resident as being cognitively intact.

Review of the facility progress note written by the social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 10:16 pm of the residents positive COVID-19 test result and that the resident was being moved to the isolation on 7-18-2020 and admitted to Wilson Pines tomorrow 7-19-2020.

There was no documentation in the record that choices of other COVID-19 facilities were offered to resident #6's representative.

Resident #6's legal representative was interviewed on 7-22-2020 at 12:12 pm by telephone. The representative stated she did receive a phone call from the social worker at 10:30 pm to inform her the resident was being moved to Wilson Pines in Wilson, NC on Sunday because of testing positive for COVID-19. The resident stated that the social worker did not give her a choice of optional COVID-19 facilities. The representative stated the facility told her the resident could return to Pine Ridge when she gets well.

E. Resident #7 was admitted to the facility on 8/4/11 and transferred to another Long-Term

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7	F 550		

Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #7 also had the following diagnosis; Alzheimer's disease, Opioid dependency, heart failure, obesity, chronic obstructive pulmonary disorder, depression, mood disorder, hypothyroidism, bipolar.

The quarterly Minimum Data Set (MDS) dated 5/6/2020 specified the resident's cognition was severely impaired.

Review of the facility progress note written by the social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 11:18 pm of the residents positive COVID-19 test result and the resident was being admitted to Wilson Pines tomorrow 7-19-2020.

Review of the facility progress note written by the Licensed Practical Nurse dated 7-19-2020 at 2:01 pm stated the resident left on a stretcher via non-emergency transport to Wilson Pines. Medications and eye glasses sent with resident. Narcotic medications not sent with resident. There was no documentation in the record that choices of other COVID-19 facilities were offered to resident #7's representative.

The legal representative contacted the Stated Agency Director and reported she had been contacted on 7-18-2020 at 11:30 pm that resident #7 was positive for COVID-19. The next morning a voice mail was left on the representative's phone that they would be transferring her mother to another facility for covid positive patients and she was to call the facility back. She contacted the facility and asked them to check out Pruitt in Hight Point as she would like her mother transferred there as she did not want her mother

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8	F 550		

to go to Wilson Pines. The facility called her at 12:30 pm on 7-19-2020 and told her mother was on the van to Wilson Pines.
Review of the facility progress note written by the social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 11:18 pm of the residents positive COVID-19 test result and the resident was being admitted to Wilson Pines 7-19-2020.

F. Resident #8 was admitted to the facility on 8/4/11 and transferred to another Long-Term Care Facility on 7/19/2020 after testing positive for COVID-19. Resident #8 also had the following diagnosis; Alzheimer's disease, opioid dependency, heart failure, obesity, chronic obstructive pulmonary disorder, depression and bipolar.
The quarterly Minimum Data Set (MDS) dated 5/6/2020 specified the resident's cognition was severely impaired.

Review of the facility progress note written by the social worker dated 7-18-2020 revealed the resident's represented was notified by telephone at 10:52 pm of the residents positive COVID-19 test result and the resident was being admitted to Wilson Pines tomorrow 7-19-2020. The SW documented the family prefers Forsyth Hospital.

Review of the facility progress note written by the Licensed Practical Nurse dated 7-19-2020 at 3:46 pm stated the resident discharged from the facility on a stretcher via non-emergency transport to go to Wilson Pines. All medications sent with resident except narcotics.

There was no documentation in the record that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

choices of other COVID-19 facilities were offered to resident #8's representative.

Resident #8's representative was interviewed on 7-22-2020 at 12:31 pm by telephone. The representative stated she did receive a phone call from the facility at 10:53 pm on 7-18-2020 to Inform her the resident was being moved to Wilson Pines the next day because of testing positive for COVID-19. The representative explained she told the facility she would prefer the resident go to the hospital due to Wilson Pines being 4 ½ hours away. The facility stated the resident to the hospital stated they would not be able to move the resident to the hospital but would be moving the resident to Wilson Pines. She told the facility that she really did not want her going that far and asked if there was anything closer. The facility responded we have a facility in Greensboro but that is full. The representative stated that she was not offered a choice of optional COVID-19 facilities.

The facility's social worker was interviewed on 7-23-2020 at 11:01 am by telephone. The social worker stated she had contacted all resident representatives on the evening of 7-18-20 to inform them of the residents positive COVID -19 diagnosis and the resident transfer to Wilson Pines to take place on 7-19-2020. When the social worker was asked if they were given a choice of optional COVD-19 facilities, she stated, "we told them they were going to Wilson Pines, and we knew for a fact they had beds available as the other two sister facilities did not have beds available. We already had transportation set up". The Social Worker did not address why the representatives were not presented a choice of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 07/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10 optional COVID-19 facilities. An interview was completed with the Director of Nursing (DON), the Administrator and the Regional Vice President on 7/23/2020 at 2:46 pm via a conference telephone call. The DON stated the facility received the positive COVID-19 test results on Saturday July 18, 2020 at 6:30 pm. Corporate Leadership directed the DON to move all COVID-19 positive residents to Wilson Pines in Wilson, NC. The administrator and the DON did not address why the representatives were not presented a choice of optional COVID-19 facilities.	F 550		