PRINTED: 04/01/2021 FORM APPROVED OMB NO. 0938-0391

THE GREENS AT PINEHURST REHAB & LIVING CENTER X44 ID PREFIX TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DITENTIFY TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DITENTIFY TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DITENTIFY TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000 An unannounced recertification survey was conducted 3/8/21 through 3/11/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CYOP11. F 000 INITIAL COMMENTS F 000 A recertification and complaint investigation survey was conducted 3/8/21 to 3/11/21. Event ID# CYOP11. 2 of the 12 complaint allegations were substantiated resulting in deficiencies.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
THE GREENS AT PINEHURST REHAB & LIVING CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced recertification survey was conducted 3/8/21 through 3/11/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CYOP11. F 000 INITIAL COMMENTS A recertification and complaint investigation survey was conducted 3/8/21 to 3/11/21. Event ID# CYOP11. 2 of the 12 complaint allegations were substantiated resulting in deficiencies. F 550 SS=D CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.			345177	B. WING _			1	C 11/2021
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		substantiated resultir Resident Rights/Exer	ng in deficiencies. rcise of Rights	F 5	50			4/8/21
self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.		The resident has a right self-determination, an access to persons are outside the facility, in	ght to a dignified existence, nd communication with and nd services inside and					
§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.		with respect and digr resident in a manner promotes maintenand her quality of life, rec individuality. The faci	nity and care for each and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and					
§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		access to quality care severity of condition, must establish and m practices regarding to provision of services	e regardless of diagnosis, or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all					(X6) DATE

Electronically Signed 03/26/2021

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 (X		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 3/11/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		0/11/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	rights as a resident of or resident of the Un §483.10(b)(1) The faresident can exercise interference, coercio from the facility. §483.10(b)(2) The refree of interference, oreprisal from the facility and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on record revand resident interview promote dignity by fafor the urinary drainaresidents with an ind (Resident # 10) and doors or to ask permon for 3 of 3 reside (Residents # 1, #10 of Findings included: 1a. Resident # 10 was 9/12/17 with multiple retention. The quarte (MDS) assessment of the exercise of the United States of the United Sta	of Rights. right to exercise his or her if the facility and as a citizen ited States. cility must ensure that the e his or her rights without in, discrimination, or reprisal sident has the right to be coercion, discrimination, and lity in exercising his or her corted by the facility in the rights as required under this if is not met as evidenced riew, observation and staff ws, the facility failed to illing to provide privacy cover ge bag for 1 of 2 sampled welling urinary catheter failed to knock on resident's ission to enter on resident's ission to enter on resident's ents observed for privacy & # 3). as admitted to the facility on diagnoses including urinary erly Minimum Data Set lated 12/21/20 indicated that tion was intact, and she has	F 5	F550 Address how corrective action accomplished for those reside have been affected by the defi practice; The licensed nurse replaced the bag for resident #10 on 3/10/2 Residents number 1, 10 and 3 notified by the Director Of Nursidel 3/12/21 of the education that we provided to staff. Address how the facility will ideresidents having the potential affected by the same deficient A 100% audit of all residents we catheter was completed by the	nts found to icient he privacy 1. were sing on vould be entify other to be practice; vith a		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
			A. BOILDII	NG			С
		345177	B. WING			0.5	3/11/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03	0/11/2021
					5 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST	REHAB & LIVING CENTER			NEHURST, NC 28374		
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(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From p	F t	550				
	Resident #10 was	observed in bed on 3/8/21 at			other residents identified to be affecte	d by	
	9:30 AM and at 1:	30 PM. She has an indwelling			not having a dignity bag at that time.	Any	
	urinary catheter a	nd the drainage bag was not			resident with an indwelling catheter ha	as	
	covered. The cath	eter bag was facing the door			the potential to be affected by the defi	cient	
	and was visible to	her roommate. When			practice. The facility has ordered the		
		dent #10 stated that she would			catheter bags with the built-in privacy		
	feel much better v			cover and disposed of the drainage ba	ags		
	covered so her ur			without the covers.			
	others.				Resident #10 was identified as having		
	0 0/0/04 1 4 04	514 14 411 (814) #4			been impacted by the deficient practic		
		PM, Nurse Aide (NA) # 4 was			when staff failed to knock on her door		
		stated that she was assigned to			announce themselves prior to entering	-	
		A #4 observed the urinary stated that she didn't notice			room. No other residents were identifi		
		vered. NA #4 replied that she			as being impacted yet all facility resid- have the potential to be affected by th		
		age bag cover and would cover			deficient practice. Resident #10 was	C	
		reported that it was the NAs			informed that staff would be educated	on	
		sibility to make sure urinary			resident rights including her right to	•	
		ays has a privacy cover.			privacy and the requirement to knock	on	
					her door and announce themselves p		
	On 3/8/21 at 1:32	PM, Nurse # 2 was interviewed.			to entering her room		
	She stated that sh	ne was assigned to Resident					
		d that nurses and NAs were			Address what measures will be put in	iO	
	1	suring urinary drainage bag			place or systemic changes made to		
		rse #2 further stated that she			ensure that the deficient practice will r		
		he urinary drainage bag was not			recur; Central supply ordered bags wi	th	
		e administered her medications			built in privacy bags and the facility		
	this morning.				disposed of the old drainage bags on		
	On 2/40/24 at 2:5	C DM the Discretes of Nusscines			3/12/21. Every new admission or		
		5 PM, the Director of Nursing ewed. She stated that she			readmission from the hospital that has		
	, ,	drainage bag to be covered at			catheter in place, will have the cathete bag exchanged to the current system		
		y purposes. She added that the			built in privacy bags. The Assistant	WILLI	
		colored drainage bag which she			Director of Nursing provided education	n to	
		to use to ensure the contents			the nursing staff regarding Residents		
		t visible to the public.			Right to dignity.		
		,			The systemic change for resident right	nts	
					included re-educating staff about		
	1b. Resident # 10	was admitted to the facility on			resident's rights and the exercise of the	iose	

		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING_				C / 11/2021	
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	711/2021	
	101.52.1 0.1 00.1 2.2.1				05 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER			INEHURST, NC 28374			
()(1) ID	STIMMADA ST	ATEMENT OF DEFICIENCIES	ID.		<u> </u>		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 550	F 550 Continued From page 3		F 5	550				
	retention. The quarte (MDS) assessment d Resident #10's cognit				rights. On 3/19/21 the Assistant Direct of Nursing and the Human Resource Director provided an educational in-service on residents rights to dignity and privacy. The right to dignity focuse an applications are idented with paths to a providing residents with paths to a service of the contract of the c	, ed		
	On 3/10/21 at 8:18 AM, Housekeeper #1 was observed to enter Resident #10's room without knocking on the door or asking permission to enter. On 3/10/21 at 8:20 AM, Resident #10 was interviewed. She stated that she would like the staff to knock on her door before entering her room. She added that some staff did knock but others did not. On 3/10/21 at 8:19 AM, Housekeeper #1 was interviewed. She stated that she knocked when the doors were closed but she did not have to knock when the doors were open. On 3/11/21 at 3:55 PM, the Director of Nursing (DON) was interviewed. She stated that she expected all staff to knock on doors or to ask permission before entering a resident's room. The DON added that no matter if the door was open or closed, staff were expected to knock.				on providing residents with catheters a leaf drainage bag with a build in privac flap. The education on residents rights privacy focused on knocking on a resident s door, announcing oneself p	y to		
					to entering a residents room. Any staff present for education will be educated prior to returning to work.			
					Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing/ Assistant Director of Nurses will audit all new admissions with catheters and any	or		
					resident with a new order for a cathete ensure that the appropriate drainage b has been applied five times per week f four weeks then weekly for two months The Environmental services director, Social Worker, Human Resource Directions	ag or s.		
	was unsuccessful.	Housekeeping Director but			Medical records director and Activity Director will monitor the halls five times weekly for four week and then weekly t two months to ensure that staff are	;		
	8/9/19 with multiple d Congestive Heart Fai Fibrillation. The quar (MDS) assessment d	•			knocking and announcing themselves prior to entering the room. The Social Worker will interview 5 alert and orienteresidents weekly for 4 weeks and then monthly for two months to validate that employees are knocking and announcithemselves prior to entering rooms.	10 t		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 03/11/2021		
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2021	
				2	05 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REF	1AB & LIVING CENTER		F	PINEHURST, NC 28374			
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F 550	F 550 Continued From page 4		F 5	550				
	On 3/10/21 at 8:12 Al observed to enter Re knocking on the door enter.	M, Housekeeper #1 was sident #1's room without or asking permission to			The _Director of Nursing and Administrator will review the audits monthly to identify patterns/trends and adjust the plan as necessary to mainta compliance.			
	staff knocking so he we entering his room. He	ed that he would appreciate			The Administrator and Director of Nurs will review the plan during the monthly QAPI meeting and the audits will continuat the discretion of the QAPI committee	nue		
	On 3/10/21 at 8:19 AM, Housekeeper #1 was interviewed. She stated that she knocked when the doors were closed but she did not have to knock when the doors were open.				Indicate dates when corrective action v be completed; 4/8/21	vill		
	(DON) was interviewed expected all staff to ke permission before entranged that open or closed, staff of Attempted to call the	M, the Director of Nursing ed. She stated that she nock on doors or to ask tering a resident's room. no matter if the door was were expected to knock. Housekeeping Director but						
	11/20/20 with multiple schizophrenia. The c (MDS) assessment d Resident #3 had seve On 3/10/21 at 8:10 Al observed to enter Re	admitted to the facility on e diagnoses including quarterly Minimum Data Set ated 2/25/21 indicated that ere cognitive impairment. M, Housekeeper #1 was sident #3's room without or asking permission to						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 550	interviewed. She stathe doors were close knock when the doo On 3/11/21 at 3:55 F (DON) was interviewexpected all staff to permission before e The DON added that open or closed, staff Attempted to call the was unsuccessful.	AM, Housekeeper #1 was ted that she knocked when ed but she did not have to	F 55		
F 561 SS=D	promote and facilitat through support of renot limited to the right (1) through (11) of the \$483.10(f)(1) The reactivities, schedules waking times), healt care services consist assessments, and papplicable provisions \$483.10(f)(2) The rechoices about aspect facility that are significations \$483.10(f)(3) The rewith members of the	rmination. e right to and the facility must be resident self-determination esident choice, including but nts specified in paragraphs (f) nis section. sident has a right to choose (including sleeping and h care and providers of health tent with his or her interests, lan of care and other	F 56		4/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 03/11/2021
	PROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	· '	
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F 561	participate in other religious, and comn interfere with the rig facility. This REQUIREMEN by: Based on observatinterviews and recoprovide showers acpreference for 1 (Rereviewed for activitifindings included: Resident #43 was adiagnosis for Cereb Resident #43's qua (MDS) dated 1/18/2 cognitively intact, esbehaviors and requibathing. Resident #43 was adialy living (ADLs) shehavior symptoms hallucinating/paranaplanned for making (states staff does no shift). The care plar	esident has a right to activities, including social, nunity activities that do not ghts of other residents in the NT is not met as evidenced ion, staff and resident rd review, the facility failed to cording to resident's esident #43) of 1 residents es of daily living (ADLs). The admitted on 12/12/18 with a ral Vascular Accident (CVA). Acterly Minimum Data Set at indicated Resident #43 was exhibited rejection of care irred total assistance with the sare planned for activities of self-care performance deficit, such as refusal of care, bia, and yelling out and care false statements toward staff of come into room during in was revised on 2/8/21. #43's Physician orders for darch 2021 indicated she was showers on Tuesday's and t.	F 56	F561 Address how corrective action waccomplished for those resident have been affected by the deficipractice; Resident #43 had a shower on 3 The Director of Nursing was marthat resident #43 had a shower which was not her scheduled shas well. In review of resident showers on the following dates: 1,6,8,12,15,19,22,25,& 29 and ir on 2,5,9,12,16,19 and 23. Residented a shower on 2/26/21. Refused a shower on 2/26/21. Refused a shower on 3/12/21 discussed her preference for showers with the resident on 3/12/21 discussed her preference for showers. Address how the facility will idented the same deficient processed by the same deficient processed by the same deficient processed on 3/12/21 for all alert as the same deficient process	s found to ent 3/9/21. de aware on 3/6/21 ower days record it ent had January in February lent #43 esident eference of Nursing 21 and owers. ay with her hetify other be ractice; a ector of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 11/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2021	
				20	05 RATTLESNAKE TRAIL			
THE GREI	ENS AT PINEHURST RE	HAB & LIVING CENTER		P	INEHURST, NC 28374			
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F 561	Continued From pag	e 7	F t	561				
	3/10/21 indicated the received her showers on first shift. Review of the nursing from 2/9/21 to 3/10/2	rds (MAR) from 1/1/21 to e nurses documented she is every Tuesday and Friday g assistant's ADL charting 1 indicated she received a			oriented residents currently in house regarding their shower preference and their care plans and kardexes were updated to reflect their preferred schedule.			
	shower on 2/9/21, 2/23/21, 2/26/21, 3/1/21 and 3/5/21. Review of a grievance dated 3/2/21 read Resident #43 reported she was not getting her showers. The grievance read that Resident #43 understood it was a lot of work but she wanted to feel fresh. The grievance read that Resident #43 last received a shower and washed her hair on 2/27/21. In an observations and interview on 3/8/21 at 10:51 AM, Resident #43 was in bed. Her hair appeared disheveled. She was absent of odors and there was no evidence of lack of incontinence care. Resident #43 stated she was getting bed baths but she was not getting her showers according to her schedule and				Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur; The nursing department staff were educated on 3/19/21 by The Director o Nursing regarding the shower preferen and completing a shower sheet for each resident who is offered a shower. This education will be added to the orientatic process for new nursing department his Any nursing department staff not present for the education will be educated prior returning to work. The facility initiated shower sheets on 3/5/21 prior to the survey process. The Certified Nursing Assistants (CNAs) and fill out the shower sheets every time a resident is offered a shower and then to that into the nurse to verify that the	ot f ce h on res. nt to		
	getting her showers a in January 2021. In an observation and 8:20 AM, Resident # she got a shower and	preference. She stated she understood that the staff were really busy but she had not been getting her showers at scheduled since sometime in January 2021. In an observation and interview on 3/10/21 at 8:20 AM, Resident #43 was in bed. She stated she got a shower and had her hair washed yesterday. She appeared clean and her hair had			resident has had a shower or has refuse a shower. The nurse then turns these shower sheets into the Director of Nursing. These shower sheets will be utilized for all residents and monitored verified that showers are being given president preference. If the resident refuses a shower the nurse is to document that in the resident should be comment that are Alert and orient will have their shower preference discussed at admission and that	to er All		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ') MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 11/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 05 RATTLESNAKE TRAIL INEHURST, NC 28374	1 03/	11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Continued From pag	e 8	F t	561				
	by Resident #43. In an interview on 3/	ware of any shower refusals 10/21 at 11:00 AM, Unit ated he was not aware of Resident #43.			preference will be added to their care pand Kardex. Any resident without preference will be assigned showers 2 times per week and well as daily bed baths.			
	Assistant (NA) #1 starefuse ADL assistant rooms on the skilled were out of order. If a they had to take the the facility. NA #1 stastarted completing sfloor nurse and the n in the computer. She shower sheets, she whaths.	ated Resident #43 does not be. She stated both shower hall and rehabilitation hall a resident was due a shower, resident to the other side of ated recently the aides shower sheets to give to the urse checked something off a stated when completing was really completing bed			Indicate how the facility plans to monitorits performance to make sure that solutions are sustained; The Director of nursing/Administrative nurse will interview 5 alert and oriented resident weekly for 4 weeks and then monthly for two months to ensure that showers are given per their preference. The Director of Nursing will review the audits monthly to identify patterns/trend and will adjust the plan as necessary to maintain compliance. The Director of Nursing and Administrative will review the plan during the monthly QAPI meeting and the audits will continuat the discretion of the QAPI committee.	ds o		
	stated the previous of but the new company using shower sheets restarted using the stago. She stated she refusal by Resident # room on the skilled h week. She stated it w fixed by maintenance	10/21 at 12:24 PM, NA #3 company used shower sheets by did not want the aides . NA #3 stated the facility hower sheets about a week was not aware of any shower #43. She stated the shower call was not working last was not draining but it was the last week. She stated the rehabilitation hall was still out the floor and ongoing			Indicate dates when corrective action v be completed: 4/8/21	vill		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 03/11/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 33/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 561	Continued From parenovations.	nge 9	F 561		
	Maintenance Direct that the skilled hall slow so he unclogg staff had been able room since last were stated because of the rehabilitation hall, the hall and caused state into the shower room that the shower room the shower room the shower room that the shower room the shower room that the shower room that the shower room the showe	8/10/21 at 12:30 PM, the tor stated he was made aware shower room was draining and drain last week. He stated to use the skilled hall shower ek. The Maintenance Director the remodeling on the he tile was removed from the aff difficulty wheeling residents am safely. He stated the hower room should be in week.			
	AM, the Director of facility reinstituted to beginning of March expectation of Corpshower sheets was showers were given always witness the shower sheets and	Nursing (DON) indicated the the shower sheets at the abecause it was the corate that the use of the a way to validate that in since the nurses may not shower. Aides filled out the gave them to the nurse to er were done or refused.			
	at 12:11 PM, the D expectation that sta showers as schedu She stated the staff as scheduled and p tended to refuse a scher shower on a no the staff obliged he	orrespondence dated 3/11/21 DON indicated that it was aff provide Resident #43's alled and per her preference. If were providing her showers preferred but Resident #43 shower and then request on on-scheduled day. She stated in due to her multiple refusals.			

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 3/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CREE	ENC AT DINEULIDET DEL	JAP 8 I IVING CENTER		205 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REI	AAB & 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	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 561	Continued From page	e 10	F 56	51			
	when she requested ensure she was getting	one so that the facility could ng her showers.					
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 64	41		4/8/21	
	resident's status. This REQUIREMENT by: Based on record rev and Registered Dietic failed to code the Min assessment accurate medications (Resider urinary catheter (Res (Resident #76), skin o smoking (Resident #* reviewed. The findings included 1) Resident #21 was facility on 7/5/16 with history of a pulmonar and cerebrovascular A review of the Medic (MAR) for Resident # revealed he received mouth twice a day for The quarterly Minimu assessment dated 2/ #21 had moderately i was not coded for an	is not met as evidenced iews, observation, and staff cian interviews the facility imum Data Set (MDS) ly in the areas of nts #1, #10, #21, #29, #235), ident #14), weight loss condition (Resident #78) and if for 8 of 20 residents coriginally admitted to the diagnoses that included a y embolism (a blood clot) disease. cation Administration Record 21 from 2/13/21 to 2/19/21 Eliquis 5 milligrams (mg) by an anticoagulant. m Data Set (MDS) 19/21 indicated Resident mpaired cognition and he		F 641 Address how corrective action will accomplished for those residents have been affected by the deficie practice; The residents identified having inaccurately coded assess had reviews and modifications matheir assessments by Minimum E (MDS) Nurse as follows: 1) The MDS nurse completed a modification of the 2/19/21 MDS assessment for Resident #21 on to include coding of an anticoagul 2) The MDS nurse completed a modification of the 2/9/21 MDS assessment for Resident #76 on to include coding of weight loss. 3) The MDS nurse completed a modification of the 2/11/21 MDS assessment for Resident #78 on to remove inaccurate coding of scondition. 4) a) The MDS nurse completed modification of the 8/27/20 MDS assessment for Resident #1 on 3 to include coding that resident did	found to nt as sments adde to Data Set 3/10/21, lant. 3/10/21, kin d a 8/18/21,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0	1		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	11/2021
TVAIVIL OF T	TOVIDER OR GOLT EIER				05 RATTLESNAKE TRAIL		
THE GREE	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			(X5) COMPLETION DATE	
F 641	Continued From page	e 11	F 6	641			
	for 7 days.				tobacco during the assessment period. b) The MDS nurse completed a modification of the 2/18/21 MDS assessment for Resident #1 on 3/10/2 to include coding of an anticoagulant. 5) The MDS nurse completed a		
	Director of Nursing in				modification of the 12/21/20 MDS assessment for Resident #10 on 3/10/21, to include coding of an anticoagulant.		
	2) Resident #76 was originally admitted to the facility on 4/23/19 with diagnoses that included end stage renal disease on hemodialysis, dysphagia (difficulty swallowing), diabetes, and schizophrenia.				6)a) The MDS nurse completed a modification of the 1/8/21 MDS assessment for Resident #29 on 3/10/2 to remove inaccurate coding of Gradu Dose Reduction (GDR) for an antipsychotic medication.		
	weights during the Mi period of August 2020 showed a weight loss	12/20 154.4 pounds (lbs.) 12/20 155.5 lbs. 1/22/20 156.2 lbs. 1/18/20 154.1 lbs. 1/15/20 155 lbs. 1/5/21 153.4 lbs. 1/21 120.7 lbs.			b) The MDS nurse completed a modification of the 2/16/21 MDS assessment for Resident #29 on 3/10/2 to include coding of a GDR for an antipsychotic medication. 7) The MDS nurse completed a modification of the 1/4/21 MDS assessment for Resident #14 on 3/10/2 to remove inaccurate coding of a urina catheter. 8) The MDS nurse completed a modification of the 2/25/21 MDS assessment for Resident #235 on	21,	
	indicated Resident #7 She was not coded for in the last month or a last 6 months. On 3/10/21 at 2:56 Pl conducted with the M Registered Dietician of	or weight loss of 5% or more loss of 10% or more in the loss of 5 Nurse #1 who stated the coded the nutritional section ent. She reviewed the			3/10/21, to include coding of an anticoagulant. All residents have the potential to be affected by inaccurate coding of assessments in the areas related to; anticoagulants, weight loss, skin condition, smoking, antipsychotic use, GDR and urinary catheter. The MDS nurses completed an audit o	n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	0.0			STREET ADDRESS, CITY, STATE, ZIP CODE	03	/11/2021	
NAIVIE OF FI	NOVIDER OR SUFFLIER				, , ,			
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL			
					PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	JMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 641	Continued From page	e 12	F	641				
	MDS should have bee	t data and confirmed the en coded with a weight loss.			3/19/21 of the last completed MDS assessments for residents receiving anticoagulants, weight loss, skin			
		n 3/10/21 at 4:56 PM, the			condition, smoking, antipsychotic			
	Director of Nursing in				medication, GDR of antipsychotics, an	d		
	expectation for the MI	DS to be coded accurately.			indwelling catheter, to validate that			
					assessments were coded accurately.			
	Dietician on 3/11/21 athe MDS assessment	curred with the Registered at 9:25 AM. She reviewed dated 2/9/21 and Resident Indicated it should have			There were three other residents noted be affected and those MDS were modi on 3/19/21			
	been coded with a weight loss.				Address what measures will be put into)		
					place or systemic changes made to			
					ensure that the deficient practice will no	ot		
	3) Resident #78 was	originally admitted to the		recur;				
	facility on 8/24/20 with	n diagnoses that included			When an MDS assessment is complete	ed,		
	diabetes, and end sta	ge renal disease on			prior to locking, the second MDS nurse	;		
	hemodialysis.				will review and validate for accuracy of			
					coding. The MDS assessment is then			
	A review of the Febru	-			sent to a MDS scrubber (Scrubber is a			
	Administration Record				software tool utilized for improvement of			
		to Resident #78 for open			resident assessment data accuracy) th	at		
		surgical wound, burns or			will identify a potential inaccuracy with			
	skin tear. There was i				coding. The MDS will be corrected as			
		d (TAR) developed for			necessary, locked and submitted.	ad		
	February 2021.				The Director of Reimbursement provide			
	Paviou of a skilled au	ırsing progress note dated			education to the MDS nurses on 3/10/2 regarding accuracy of coding according			
		any skin condition concerns			the RAI manual and validation of accur			
	were present.	dry skin condition concerns			prior to locking and submitting the MDS	-		
	p. 223110				assessment.	=		
	The most recent guar	terly MDS assessment			Newly hired MDS nurses will be educa	ted		
	dated 2/11/21 indicate				during new hire orientation.			
		was coded with open						
	,	surgical wound, burns and			Indicate how the facility plans to monitor	or		
	skin tear. The area fo	r skin and ulcer treatments			its performance to make sure that			
	had pressure reducing	g device for bed marked			solutions are sustained;			
	only.				The Director of Nursing (DON) or the Administrator will audit 5 MDS			

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 11/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP CODE	03/	11/2021
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THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			IURST, NC 28374		
	OU MANA PLY OT	ATEMENT OF DEFICIENCIES		1	·		0.(7)
(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 641	Continued From page	e 13	F 6	641			
	lower leg, bruising to present and dialysis present and dialysis present and dialysis present at 2:45 Present	8 had a scab to the left her arms, a dialysis shunt port to the right chest. M, an interview was Nurse #1 who stated she ion section of the MDS f.		MI ac an co GI Th rev pa ne Th rev	sessments weekly for 4 weeks, then DS assessments monthly to validate curacy of coding related to ticoagulants, weight loss, skin ndition, smoking, antipsychotic use, DR and catheter. The DON and/or the Administrator will view the audits monthly to identify tterns/trends and will adjust the plan cessary to maintain compliance. The DON and/or the Administrator will view the plan during the monthly QA deting and the audits will continue at scretion of the QAPI committee.	as Pl	
	8/9/19 with multiple of Congestive Heart Fair Fibrillation. The annuassessment dated 8/2 Resident #1 did not us assessment period. Resident #1 had a snown completed on 5/28/20 able to smoke without smoker). The care plan that waincluded a problem the smoker". The nurse's note date that Resident #1 were occasionally.	alure (CHF) and Atrial ual Minimum Data Set (MDS) 27/20 indicated that use tobacco during the moking assessment and he was assessed as at supervision (unsupervised as initiated on 5/28/20 and "Resident #1 is a			dicate dates when corrective action value completed; 4/8/21	vill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 2/44/2024	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3/11/2021	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	641 Continued From page 14		F 6	41			
	he came to the facilit MDS Nurse # 1 was 2:50 PM. She stated completed the annual longer employed at t verified that Residen the assessment perio assessment and the the annual MDS date coded for tobacco us The Director of Nursi on 3/10/21 at 3:55 Pl expected the MDS a accurately. She add	interviewed on 3/10/21 at that the MDS Nurse who al MDS dated 8/27/20 was no he facility. MDS Nurse #1 t #1 had used tobacco during od based on the smoking care plan. She added that ed 8/27/20 should have been					
	8/9/19 with multiple of Congestive Heart Fa Fibrillation. The qual (MDS) assessment of Resident #1 had not medication during the Resident #1 had a demilligrams (mgs.) by Fibrillation on 8/10/19. The February 2021 Mecords (MARs) reviewed Eliquis twice assessment period.	s admitted to the facility on diagnoses including ilure (CHF) and Atrial reerly Minimum Data Set dated 2/18/21 indicated that received anticoagulant e assessment period. Doctor's order for Eliquis 5 mouth twice a day for Atrial 9. Medication Administration ealed that Resident #1 had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 03/11/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	'	33/11/2021	
(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 OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	Eliquis and had recassessment period that she did not know as anticoagulant m. The Director of Nuron 3/10/21 at 3:55 expected the MDS accurately. She accurately. She accurately. She accurately few m. 5. Resident #10 w. 9/12/17 with multip Pulmonary Embolis Minimum Data Set 12/21/20 indicated receive an anticoagussessment period. Resident #10 had a milligrams (mgs.) b of PE. The December 202 Records (MARs) received Eliquis du MDS Nurse #1 was 2:58 PM. She verit Eliquis and had recassessment period.	ied that Resident #1 was on reived Eliquis during the in February 2021. She stated ow that she had to code Eliquis edication. Ising (DON) was interviewed PM. The DON stated that she assessments to be coded ided that the facility had 2 oth nurses just started working onths ago. It is admitted to the facility on it is diagnoses including in (PE). The quarterly (MDS) assessment dated that Resident #10 did not gulant medication during the in diagnoses including the interviewed on 3/10/21 at field that Resident #10 was on reived Eliquis during the in December 2020. She not know that she had to code	F6	· · · · · · · · · · · · · · · · · · ·			
	on 3/10/21 at 3:55 expected the MDS	sing (DON) was interviewed PM. The DON stated that she assessments to be coded ided that the facility had 2					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 03/11/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	I	03/11/2021		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 641	at the facility few more 6. Resident #29 was 11/2/16 with multiple schizophrenia and de disturbance. A physician 's order Seroquel (antipsychology) once daily for R A review of the active 1/8/21 indicated Resiseroquel 50 mg (initiactive order. 1a. The quarterly Mirassessment dated 1/was rarely/never und administered routine 7 of 7 days. The merindicated Resident #2 Reduction (GDR) of a 1/15/21. This was 7 Assessment Referen medications section was coded by MDS N An interview was coron 3/10/21 at 2:30 Pt assessment dated 1/#29 had a GDR of he on 1/15/21 was revies She revealed this was this GDR should not 1/8/21 MDS as it occ.	h nurses just started working anths ago. admitted to the facility on diagnoses that included ementia without behavioral dated 4/5/20 indicated atic medication) 50 milligrams esident #29. a physician 's orders for dent #29 's order for ated on 4/5/20) remained an antipsychotic medication on dications section of the MDS 29 had a Gradual Dose antipsychotic medication on days after the 1/8/21 MDS ce Date (ARD). The of this MDS for Resident #29 Jurse #1. adducted with MDS Nurse #1 M. The quarterly MDS 8/21 that indicated Resident er antipsychotic medication wed with MDS Nurse #1. s an error. She stated that have been included on the	F 64	41				

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 /11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pag Nursing on 3/10/21 a she expected the ME 1b. A physician 's or Resident #29 had a 0 her dose from 50 mg daily. The quarterly Minimu assessment dated 2/ #29 's cognition was administered antipsy days and was noted medication. The me- for Resident #29 was An interview was cor on 3/10/21 at 2:30 Pl assessment dated 2/ Resident #29 had no medication was revie The physician 's ord indicated Resident # was reviewed with M this was an MDS erro that this 1/15/21 GDF	e 17 It 4:56 PM. She stated that DS to be coded accurately. Ider dated 1/15/21 indicated GDR of Seroquel decreasing once daily to 25 mg once Im Data Set (MDS) Indicated Resident severely impaired. She was chotic medication on 7 of 7 with no GDR of antipsychotic dications section of this MDS secoded by MDS Nurse #1. Inducted with MDS Nurse #1	F				
	Nursing on 3/10/21 a	nducted with the Director of it 4:56 PM. She stated that OS to be coded accurately.					
		admitted to the facility on es that included diabetes liabetic neuropathy.					
	The annual Minimum	n Data Set (MDS)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345177	B. WING_			C 3/11/2021		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		5/11/2021		
(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 OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 641	's cognition was sever coded for an indwellic coded for occasional The catheter and incommoded MDS was coded by I with Resident #14 or Resident #14 was obtained the state of the catheter and he cat	erely impaired (07). He was ng catheter and was also incontinence of bladder. ontinence section of the MDS Nurse #1. servation were conducted a 3/8/21 at 12:35 PM. oserved with no urinary ed that he never had a anducted with Nursing 3/10/21 at 9:05 AM. She samiliar with Resident #14. The worked at the facility since since that time Resident #14 ter. Inducted with MDS Nurse #1 M. The annual MDS (4/21 that indicated Resident theter was reviewed with the revealed this was an error. The must have clicked the wrong 1:14 had no urinary catheter. Inducted with the Director of 1:156 PM. She stated that DS to be coded accurately.	F6	541				
	8. Resident #235 wa diagnosis of Atrial Fil	as admitted on 2/24/21 with a prillation (A. Fib).						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 03/11/2021	
	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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 658 SS=E	included an order for milligrams in the mor A.Fib. Review of Resident & Data Set (MDS) date the use of Eliquis (and An interview was cor PM with MDS Nurse #235's admission ME for the use of an antioversight. An interview was cor PM with the Director stated it was her expadmission MDS be a use of an anticoagula Services Provided M CFR(s): 483.21(b)(3) \$483.21(b)(3) Compit The services provide as outlined by the comustication of the professional This REQUIREMENT by: Based on record reversions of the profession of the professional This REQUIREMENT by: Based on record reversions of the profession of	rission orders dated 2/24/21 Eliquis (anticoagulant) 5 rining and at bedtime for #235's admission Minimum rid 2/25/21 was not coded for riticoagulant). riducted on 3/10/21 at 2:49 #1. She stated Resident OS should have been coded roagulant and it was an riducted on 3/10/21 at 5:00 rof Nursing (DON). She rectation that Resident #235's recurate and coded for the riticoagulant and it was an riducted on 3/10/21 at 5:00 reference and coded for the right and right	F 64	F658	4/8/21	
	resulting in a duplica			Address how corrective action will be accomplished for those residents foun have been affected by the deficient practice; The licensed nurse discontinued the duplicate order for resident #41 on	d to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 11/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2021	
					05 RATTLESNAKE TRAIL			
THE GREE	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	e 20	F 6	358				
	The findings included	! :			3/10/21. An audit of the medical record showed no evidence that the medication			
	10/31/18 with multiple	mitted to the facility on e diagnoses that included th hemiparesis (muscle			had been given twice at any time.	···		
		on one side of the body)			Address how the facility will identify oth residents having the potential to be affected by the same deficient practice	;		
	9/25/19 indicated Ultr	order for Resident #41 dated ed Ultram (opioid pain medication) mg) as needed for pain greater).			A 100 % audit of all current residents w completed on 3/17/21 by the DON and there were no other resident affected.			
	A physician 's order for Resident #41 dated 6/12/20 indicated Ultram 50 mg as needed for pain greater than 5 out of 10. The previous order for as needed Ultram 50 mg that was initiated on 9/25/19 for Resident #41 remained an active order.				Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur; Licensed nurses were educated on 3/19/21 on the importance of discontinuing the previous order prior to	ot		
	#41 's cognition was received PRN (as ne- routine pain medication frequently at a rating	14/21 indicated Resident moderately impaired. She eded) pain medications, no ons, and reported pain of 02 out of 10. Resident			placing another order into the system. nurses not present will be educated pri to returning to work. This education wil added to the orientation process for all newly hired nurses.	All or I be		
	days.	d opioid medication on 2 of 7			Indicate how the facility plans to monitorits performance to make sure that	or		
	6/12/20 through 3/8/2 the Pharmacy Consu recommendations on to the duplicate Ultral recommendations inc Administration Recor orders for Ultram 50 instructions. The Pharmacy Consultram 50 instructions.	12/2/20 and 3/3/21 related m 50 mg PRN orders. Both dicated the Medication d (MAR) showed 2 active			solutions are sustained; The Director of Nurses/ ADONS will review all orders during the daily clinical meeting to validate no duplicate orders are present. This review and audit will done five times per week for four week and then twice weekly for three months. The Director of Nurses will review the audits monthly to identify patterns/trend and will adjust the plan as necessary to	be s s.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245477	B WING				С	
		345177	B. WING _			03/	/11/2021	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GREE	ENS AT PINEHURST REH	IAR & LIVING CENTER			05 RATTLESNAKE TRAIL			
THE GIVE	INS AT FINEHOUST KEI	IAB & LIVING CENTER		P	INEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page one of these orders fr		F 6	558	maintain compliance.			
	focus area of pain. The part, evaluating the elinterventions, review symptoms, dosing soli satisfaction with result ability, and impact on the Areview of Resident orders was conducted.	for compliance, alleviation of hedules, resident ts, impact on functional cognition. #41 's active physician 's to on 3/8/21 and revealed 2			The Director of Nursing and Administra will review the plan during the monthly QAPI meeting and the audits will continuate the discretion of the QAPI committee. Indicate dates when corrective action when completed; 4/8/21	nue e.		
	same instructions for was initiated on 9/25/initiated on 6/12/20. A review of the MARs	-						
	3/10/21 at 11:30 AM. regularly assigned to 's active physician 's active orders for PRN reviewed with Nurse anot noticed this before going to speak with the (PA) and would have discontinued. Nurse of the same orders in Resident #41 could be 50 mg twice during the	#6. She revealed she had e. She indicated she was ne Physician 's Assistant one of the orders #6 acknowledged that with 2 place, there was a risk that e administered PRN Ultram e same time period.						
		s conducted with the on 3/10/21 at 3:25 PM. e physician ' s orders that						

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 03/11/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	<u> </u>	03/11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 658	revealed 2 active order was reviewed with the The Pharmacy Constructions to PRN Ultram 50 mg or recommendations has the reported that have place created a risk for administered both PR during the same time. An interview was con Nursing (DON) on 3/2 #41's active physicial active orders for PRN reviewed with the DO one of these PRN Ultrave been discontinuated the place created a risk for administered both PR same time period. Shorders for PRN Ultrar would be discontinue	ers for PRN Ultram 50 mg e Pharmacy Consultant. ultant stated that she made 2 discontinue one of these rders, but her d not been responded to. ving a duplicate order in or Resident #41 being RN Ultram 50 mg orders period. ducted with the Director of 10/21 at 1:20 PM. Resident an's orders that revealed 2 I Ultram 50 mg was N. The DON stated that ram 50 mg orders should ed. She explained that she scussed in a morning nager #1 and Unit Manager cy Consultant wrote the tion and she thought one of intinued at that time. The aving a duplicate order in or Resident #41 being RN Ultram orders during the ne stated that one of the in 50 mg for Resident #41 id.	F6			
F 686 SS=D	CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives	rity re ulcers. hensive assessment of a	F€	86		4/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING			03/2	11/2021	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2021	
					5 RATTLESNAKE TRAIL			
THE GREI	ENS AT PINEHURST RE	HAB & LIVING CENTER		PI	NEHURST, 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 686	ulcers unless the ind demonstrates that the (ii) A resident with pronecessary treatment with professional star promote healing, prenew ulcers from deverthis REQUIREMENT by: Based on record restraction facility failed to obtain pressure ulcers were residents reviewed for #85). The findings included Resident #85 was as 11/25/20 with multiple dementia, atrial fibril disease and muscle diagnosed with COV. The admission Minimassessment dated 11 #85 had severe cogrequired extensive a mobility, was inconting and was at risk for pressure ulcers or other skin of the pressure ulcer of summary dated 12/1	does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to event infection and prevent eloping. T is not met as evidenced view, and staff interviews, the n a treatment order when e first identified for 1 of 4 or pressure ulcers (Resident diation, coronary artery weakness. He was ID-19 on 12/1/20. The mum Data Set (MDS) 2/1/20 indicated Resident nitive impairment. He esistance from staff for bed ment of bowel and bladder, ressure ulcers. The evealed he had no pressure	F	686	F 686 At the time of survey the facility did not have a treatment nurse. The Director of Nursing was receiving the communication/reviewing the documentation for skin issues. On 3/16 a new treatment nurse was in place. The resident affected by the deficient practice #85 was sent to the hospital of 2/11/21 due to respiratory distress and not return to the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice current facility residents are at risk to be affected. A 100% audit of all current residents was completed on 2/25/21 by the Director Of Nursing and there were other resident noted to be affected.	of 6/21 on did ner ; All ne		
		ure ulcer development ed mobility, weakness, and			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur;			

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		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/11/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/11/2021
TO UNIC OF T	TO VIDER OIL OIL OIL I EIER			205 RATTLESNAKE TRAIL	
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORR		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 686	Continued From pag	ne 24	F 680	3	
		note dated 1/28/21 indicated		The Director of Nursing/Assistant Director	rector
	Resident #85 was fo	und with an open area to the		of Nursing completed education on	
	right and left heel wit	th clear drainage and the size		2/26/21 for the licensed nurses and	
	of a quarter. The wo	und nurse was notified, the		nursing assistants, regarding the wo	
		l, and a dry dressing was		protocol. Nursing staff were not pern	
	=	eas. Resident #85's spouse		to work until the education had been	
	was notified of the w	ound areas.		received. When a resident is admitted	, l
				readmitted or if a skin injury is identif	· ·
	•	esident #85 was reviewed and		the licensed will assess the resident	
	-	ssure ulcers was initiated on		skin and notify the physician to obtai	
		part, "actual pressure ulcer		treatment orders. The licensed nurse	
		eral heels. Is at risk for er development related to		complete weekly skin assessments i Point Click Care (PCC) electronic me	
	impaired bed mobility			record on current facility residents a	
		nterventions included:		notify physician and residents or the	
		nts as ordered and monitor		Responsible Party (RP) regarding ar	
	for effectiveness.	nie de cracied and meriner		new skin issues and initiate treatmer	-
		nitor wound healing weekly		orders. The licensed nurse will docu	
	and as needed.	3 ,		the injury in the wound communication	on
	- Monitor nutritional s	status. Serve diet as ordered,		book as well as the medical record a	
	monitor intake and re	ecord.		will complete a Braden risk assessm	ent.
	- Alternating pressur	e mattress to bed due to		The nursing assistants will complete	а
		turning and repositioning was		shower sheet that will be used to ide	entify
	initiated on 2/8/21.			any areas to the resident⊡s skin. Th	
				sheets will be turned into the license	
		ician orders, Medication		nurse who will initiate the protocol ar	
		rd (MAR) and Treatment		then place these sheets in the woun	
		rd (TAR) for January 2021		communication book for follow up by	the
		here was no order or		wound nurse. He wound nurse will	
		ed for the right or left heel		monitor the communication book dai	-
	pressure ulcers.			during the work week and will compl follow up assessment of wounds that	
	A review of a wound	evaluation flowsheet dated		identified. The wound nurse will review	
	2/2/21 indicated the			treatment orders with the physician.	
		able pressure ulcer acquired		wound nurse will completed the wou	
		3/21, measured 4 by 3		evaluation assessment in PCC week	
		1% necrotic tissue, scant		and update the wound log at that tim	
	serosanguinous drai			The wound nurse along with the	
		ble pressure ulcer acquired in		Interdisciplinary Team (IDT) will revie	ew

Facility ID: 923320

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 _			0	3/11/2021
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				20	5 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST	REHAB & LIVING CENTER		PI	NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 686	Continued From p	page 25	F	686			
	the facility 1/28/21	I, measured 2.4 by 2 cm, 50%			wounds weekly and will make		
		ulation, scant serosanguinous			suggestions/changes as needed to		
	drainage, and no				promote wound healing. The Registere	∍d	
		d the doctor and family were			Dietician will be updated weekly by the		
		atment order of calcium alginate			DON/wound nurse on the condition of		
	and protective boo	ots was obtained.			current wounds and any new wounds		
					identified. The wound nurse/MDS will		
	A review of the Fe	ebruary 2021 physician orders,			update the resident□s care plan.		
	and TAR, revealed	d orders dated 2/2/21 to cleanse					
		neel with wound cleanser, pat					
		alginate to the wound bed and					
	cover with a dry d	ressing every day.			Indicate how the facility plans to monit	or	
					its performance to make sure that		
		s note dated 2/5/21 indicated			solutions are sustained;		
		found to have two small open			The DON/ADON will review and comp		
		cks. The first was centrally			shower sheets, skin assessments and		
		crum and the second smaller			progress notes 5 times per week for 4	_	
		uttock. No drainage was present			weeks and then 3 times per week for 2		
		by Resident #85. Both areas			months to validate that treatment orde		
		ry dressings applied, and the			are in place, the Physician and RP have	/e	
	wound care nurse	e was noulled.			been notified and the wound		
	A review of a way	nd evaluation flowsheet dated			documentation is complete.		
					The _Director of Nurses will review the audits monthly to identify patterns/tren		
	2/8/21 indicated the	ulcer acquired in facility on			and will adjust the plan as necessary to		
		4 cm in width, 1 cm in length			maintain compliance.	J	
		oth, 100% granulation, and			maintain compliance.		
		nguinous drainage.			The Director of Nurse/ Administrator w	rill	
		essure ulcer acquired in facility			review the plan during the monthly QA		
		red 2 cm in width, 1 cm in			meeting and the audits will continue at		
		in depth, 100% granulation,			discretion of the QAPI committee.		
		nguinous drainage, and no odor.					
		d the doctor and family were					
		atment order of a dry protective					
	dressing was obta	* ·			Indicate dates when corrective action v	will	
					be completed; 4/8/21		
	A nursing progres	s note dated 2/8/21 by the			•		
		e nurse stated a dry dressing					
		sacrum and buttock until the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345177	B. WING		0.5	C 3/11/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03	0/11/2021	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page		F 68	36			
	care physician.	er assessed by the wound					
	Resident #85 was sephysician on 2/9/21.	en by the facility wound care					
	and TAR, indicated the treatment documented ulcer prior to 2/10/21, present to cleanse the wounds with normal states.	d to the sacral pressure On 2/10/21 an order was e sacral and left buttock					
	with Nurse #4 who way on 2/5/21. Nurse #4 sopen areas on Reside were 2 small, superfixed alerting the former way pressure areas, clear dressing to the sacratareas. Nurse #4 state and obtained orders to state why there way	M, an interview occurred as assigned to Resident #85 stated when he observed the ent #85's buttocks there cial openings. He recalled ound care nurse to the new using, and applying a dry I and buttock pressure ed he notified the physician for treatment but was unable is no treatment orders acral and buttock wounds					
	left with the consulting	AM a phone message was g wound physician. There eived during the time of the					
	on 3/11/21 at 11:00 A Resident #85 on 1/28 1/28/21 she assessed	us conducted with Nurse #3 M, who was assigned to 5/21. She explained on d pink areas to both heels rainage, reported this to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			
		345177	B. WING			C / 11/2021
	VIDER OR SUPPLIER S AT PINEHURST REF	IAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03	711/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
for a s d u T b wh ti n S o M ict the trope B S S = D S S rea a m c n S irr c e (i irr	and applied a dry drestate why there was relocumented for the learntil 2/2/21. The Director of Nursir by phone on 3/11/21 and awas aware Resident was aware Resident was aware and buttocks are the stated the former obtain and place the confidence of the wounds was aware to the amount of the nurse who identified. The DON to the nurse who identified areatment order by followord or calling the Bowel/Bladder Inconting CFR(s): 483.25(e)(1)-6483.25(e)(1) The face sident who is continually and the condition is or become and the continence of the continence, based of the continence of the continence of the continence of the continence, based of the continence of the	arse, cleansed the areas asing. She was unable to no treatment orders aft and right heel wounds arg (DON) was interviewed at 12:07 PM and stated she at 12:07 PM and stated she at 15 had pressure areas to as. She further stated at the informed the wound care when they were identified. It wound care nurse failed to orders for treatments on the ele wounds were first further stated she expected and the open area to obtain a llowing the facility's wound physician. In the continence, Catheter, UTI (3) area. Sillity must ensure that the ent of bladder and bowel on the ervices and assistance to an ervices and assistance to an ervices and assistance is such that continence is sain.	F6			4/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	COMPLETED		
		345177	B. WING _			C 03/11/2021
	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	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 690	indwelling catheter of is assessed for remoral as possible unless the demonstrates that cannot (iii) A resident who is receives appropriate prevent urinary tract continence to the extra continence to the extra continence, based comprehensive assed ensure that a resider receives appropriate restore as much normal possible. This REQUIREMENT by: Based on record revinterview, the facility orders for the use of catheter care, and four inary catheter for 1 urinary catheters (Ref. The findings included Resident #40 was ac 11/14/19 and most rewith multiple diagnosts Disease. A review of the nursi assessment dated 1.	r subsequently receives one val of the catheter as soon e resident's clinical condition atheterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. resident with fecal on the resident's ssment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as It is not met as evidenced riew, observation, and staff failed to have physician's a urinary catheter, for urinary resident #40).	F	F 690 Address how corrective action accomplished for those resider have been affected by the defipractice; Resident # 40 has an order that written on 1/26/21 for PRN cat every 8 hours if no voiding. Rehas not required continuous cat has not required continuous cat affected by the same deficient Current facility residents with in urinary catheter are at risk of the deficient practice of failing to his physicians order to support the	nts found to cient at was herization esident #40 atheter use. entify other to be practice; ndwelling he alleged ave a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345177	B. WING _			C 03/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			INEHURST, NC 28374		
(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 690	A nursing note dated #8 indicated Residen urinary catheter in plate The significant change assessment dated 1/ #40 's cognition was had indwelling urinary. The Urinary Incontine (CAA) related to the MDS assessment incindwelling urinary catelimination. An observation of Resident 1/7/21 at 9:00 All no indwelling urinary. A review of Resident 1/7/21 through 3/10/2 orders for the use of catheter, the care/tre catheter, and no discurinary catheter. An interview was con 3/10/21 at 9:05 AM. #40 had an indwelling was readmitted from 2021, but the catheter She was unable to resident.	1/7/21 completed by Nurse t #40 had an indwelling ace. In Minimum Data Set (MDS) 13/21 indicated Resident severely impaired and she y catheter. In Care Area Assessment 1/13/21 significant change licated Resident #40 had an heter in place for urinary In She was observed with catheter in place. #40's medical record from the revealed no physician's an indwelling urinary atment of the urinary ontinuation order for the ducted with NA #6 on She stated that Resident g urinary catheter when she the hospital in January r had since been removed. call when the indwelling removed. She reported that		590		ent to des e, er.	
	when the urinary cath	needed for Resident #40 neter was in use. ducted with Nurse #6 on			educated during new hire orientation. Indicate how the facility plans to monitorits performance to make sure that	or	

OLIVILIV	O T OIT WILDIO TITLE O	· · · · · · · · · · · · · · · · · · ·					0.0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	` '	E SURVEY IPLETED
							С
		345177	B. WING			03	3/11/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST REF	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	3/10/21 at 11:30 AM. regularly assigned to confirmed NA #6 's in had an indwelling urin readmitted from the had the catheter had since was asked when the was removed and shoreview the medical remedical record that in orders for the use of catheter, no urinary corders, and no discordinary catheter was Nurse #6 confirmed to orders related to Resurinary catheter that streadmitted from the harvealed that because orders related to this she was unable to tel was discontinued. Since he was unable to tel was discontinued. Since he recollection Residurinary catheter was January 2021. She was certain catheter was certain	She indicated that she was Resident #40. She interview that Resident #40 mary catheter when she was inospital in January 2021, but the been removed. Nurse #6 indwelling urinary catheter the indicated she needed to cord. Resident #40 's included no physician 's included no physician 's included no physician 's included no physician 's indicated with Nurse #6. The reviewed with Nurse #6. There were no physician 's indent #40 's indwelling she had when she was inospital on 1/7/21. Nurse #6 there were no physician indwelling urinary catheter at the exact date of when it the stated that to the best of the stated that to the best of the stated that to the best of the stated that was normally done in the stated the was normally done in the stated the control of the stated that t	F	690	solutions are sustained; The DON and/or the ADON will audit/observe new admissions/readmissions and residents identified with a change of condition 5 aweek for 4 weeks then weekly for 2 months to determine if the resident has an indwelling urinary catheter and will validate that a physicians order has be obtained and input into the residents electronic medical record. The DON and/or ADON will review the audits for patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action where the completed; 4/8/21	s en st the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00/11/2021
(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 SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 695 SS=E	facility from the hosp indwelling urinary cat there were no physic #40 's medical recor urinary catheter. The reviewed Resident #40 based on the notes the was removed in the IShe reported that the readmission (Nurse #40 was removed in the IShe reported that the readmission (Nurse #40 was removed so orders for the soldent #40 was removed should have orders. The DON state expectation for a physic for the use of a urinal care/treatment of the discontinuation of the Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheal succare, consistent with practice, the compression of the season of the succare plan, the resides and 483.65 of this succare plan, the resides and 483.65 of this succare interviews and record administer oxygen as succared interviews and record administer oxygen as succared interviews and record administer oxygen as successive medical succare interviews and record administer oxygen as successive medical successive medi	int #40 was readmitted to the ital on 1/7/21 with an otheter. She verified that itan 's orders in Resident do related to this indwelling a DON reported that she indwelling urinary catheter atter half of January 2021. In increase who completed the increase who increase who increase when increase who increase w	F 69		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
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NAME OF B		345177	D. WING _		DEET ADDRESS SITV STATE ZID SODE	03/	11/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			5 RATTLESNAKE TRAIL		
				PIN	NEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 695	Continued From page 32		F 6	695			
	findings included	r respiratory care. The			have been affected by the deficient practice; 1) On 3/10/21, the licensed nurse		
	1. Resident #69 was diagnosis of Chronic Disease (COPD).			adjusted the oxygen rate to 2 liters per minute according to the physicians ord for Resident #69. 2) On 3/10/21, the licensed nurse			
	Resident #69's admis (MDS) dated 1/31/21 was not assessed an behaviors. She was of assistance with bed r			adjusted the oxygen rate to 2 liters per minute according to the physicians ord for Resident # 43. 3) On 3/10/21, the licensed nurse obtained a physicians order for continu	er ous		
		re planned for altered e to COPD. There was for oxygen.			oxygen at 2 liters per minute for Reside #82 and set the rate to 2 liters minute.		
	Resident #69 was shi saturation of 78% on cannula (NC) at 3 lite increased to 4 liters to Resident #69 calmed decreased to 3 liters. Review of a Physicial Resident #69 was or NC continuously for C	w of a nursing note dated 2/18/21 read ent #69 was short of breath with an oxygen tion of 78% on room air. Oxygen via nasal la (NC) at 3 liters was administered and sed to 4 liters to increase saturation. Once ent #69 calmed down, the oxygen was ased to 3 liters. The Physician was notified. W of a Physician order dated 2/24/21 read ent #69 was ordered oxygen at 2 liters via intinuously for COPD.			Address how the facility will identify oth residents having the potential to be affected by the same deficient practice. Current facility residents that receive oxygen is at risk for the alleged deficient practice of failing to administer oxygen ordered. The DON, ADON and licensed nurses completed an audit on 3/22/21, of currefacility residents with oxygen to validate that oxygen was administered according to the physician orders. All residents identified were receiving oxygen as ordered.	; nt as ent	
	was deemed alert and concentrator was run Resident #69 did not stated she thought he at 4 liters. She stated times. Observation on 3/8/2	d interview, Resident #69 d oriented. Her oxygen ning a 3.5 liters via NC. appear short of breath and er oxygen should be running she wore her oxygen at all 1 at 2:28 PM, revealed en concentrator was running			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur; The DON and ADON completed education on 3/19/21, for nursing staff regarding following physician orders fo	ot	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2021
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(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 695	Continued From page 33		F6	395			
F 695	at 3.5 liters via NC. Review of a nursing read Resident #69 was oxygen running at 2 literated Resident #69 was oxygen was running of NC. In an observation and 8:15 AM, Resident #69 was running at 3.5 literated Resident #69 was running at 3.5 literated Resident #69 was good because tho oxygen rate. In an interview on 3/1 stated Resident #69 was running at 3.5 literated Resident #69 was good because tho oxygen rate. In an interview on 3/1 Manager (UM) #1 stated Resident #69 was running at 3/1 Manager (UM) #1 stated Resident #69 was running at 3/1 Manager (UM) #1 stated Resident #69 was running at 3/1 Manager (UM) #1 stated Resident #60 observed self-adjusting In an interview on 3/1 Assistant (NA) #1 stated remove her oxygen. Sobserved Resident #60 oxygen concentrator. In an observation on a state of the state	note dated 3/8/21 at 5:43 PM as alert and oriented with laters via NC. note dated 3/9/21 at 6:37 AM as alert and oriented and her continuously at 2 liters via d interview on 3/10/21 at 6:9's oxygen concentrator ers. She stated she required and she felt everything ey never adjusted her 0/21 at 8:30 AM, Nurse #1 was very compliant and was ust her oxygen concentrator. 0/21 at 11:00 AM, Unit ted Resident #69 was very very complaint with wearing d Resident #69 had not been and her oxygen concentrator. 0/21 at 11:15 AM, Nursing ted does not refuse or She stated she had never 69 attempting to adjust her	F	395	administration of oxygen. Newly hired nursing staff will be educated during new hire orientation. When an order is obtained for oxygen ilicensed nurse will implement the order and will place a sticker on the concentrator to indicate the amount of oxygen flow for the resident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or ADON will observe 10 residents weekly for 4 weeks then 20 residents monthly to validate that oxyg is administered as ordered. The DON or the ADON will review the audits monthly to identify patterns/trend and will adjust the plan as necessary to maintain compliance. The DON or the ADON will review the plan during the monthly QAPI and will continue the audits at the discretion of QAPI committee. Indicate dates when corrective action where the completed; 4/8/21	the for or en ds o	
	In an observation on	3/10/21 at 11:45 AM,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	00/11/2021	
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F 695	F 695 Continued From page 34		F 6	95			
		on 3/10/21 at 1:34 PM, gen concentrator was running					
		on 3/10/21 at 3:20 PM, gen concentrator was running					
	stated she had not attempting to adjus	3/10/21 at 4:00 PM, NA #5 observed Resident #69 it her oxygen concentrator and would because she was very					
		on 3/10/21 at 4:10 PM, gen concentrator was running					
	Director of Nursing expectation that Re	3/10/21 at 5:00 PM, the (DON) stated it was her esident #69's oxygen be dered at 2 liters continuously					
		as admitted on 12/12/18 with a ral Vascular Accident.					
	included an order o	t #43's Physician orders lated 2/19/20 for oxygen at 2 nula (NC) continuously.					
	(MDS) dated 1/18/2 cognitively intact, e	arterly Minimum Data Set 21 indicated she was exhibited rejection of care ed for the use of oxygen.					
		ised care plan dated 2/8/21 k for respiratory distress due					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER ENS AT PINEHURST R	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		00/11/2021	
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	Continued From pa	ge 35	F 6	95			
	to sleep apnea. Ox interventions.	ygen was not included in any					
		g note dated 2/17/21 read alert and oriented and on at 2 liters.					
	10:51 AM, Residen	nd interview on 3/8/21 at t #43's oxygen concentrator ers. She stated she wore her					
	Resident #43's oxy at 3 liters. Resident observed staff adju	n 3/10/21 at 8:20 AM, gen concentrator was running : #43 stated she had not sting her oxygen rate but d her saturation rate					
	stated Resident #4	3/10/21 at 8:30 AM, Nurse #1 3 was on continuous oxygen at she was not able to self-adjust					
	Manager (UM) #1 s	3/10/21 at 11:00 AM, Unit stated Resident #43 was o self-adjusted her oxygen					
		8/10/21 at 11:15 AM, Nursing tated Resident #43 could not concentrator.					
		3/10/21 at 11:50 AM, NA #1 3 could not adjust her oxygen					
		n 3/10/21 at 12:20 PM, gen concentrator was running					

		ATE SURVEY DMPLETED				
		345177	B. WING _			C 03/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		00/11/2021
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	stated Resident #4 oxygen concentrate In an observation of Resident #43's oxy at 3 liters. In an interview on 3 Director of Nursing expectation that Re administered as ore via NC. 3. Resident #82 wa diagnosis of Chron Disease (COPD). Review of Resident included an order of liters via nasal cant COPD. Resident #82's adm (MDS) dated 2/17/2 intact and exhibited for oxygen.	3/10/21 at 12:24 PM, NA#3 3 could not self-adjust her	F 6			
	2/24/21 for altered COPD. Intervention liters.	respiratory status due to ns included oxygen via NC at 2				
	· · · · · · · · · · · · · · · · · · ·	was lying in bed with his				

AND DLAN OF CORRECTION TO THE CATION NUMBERS		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3371172021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	AM, Resident #82 wa oxygen NC with his cat 5 liters. He stated his COPD. He stated oxygen was running. In an observation on #82's oxygen concer. In an observation on Resident #82's oxygen at 2 liters per NC. He anyone adjusted his. In an interview on 3/2 Manager (UM) #1 st physically unable to sconcentrator. UM #1 medication cart on 3/2 Resident #82's oxygen stated someone muss stated he also did no Resident #82 oxygen night. UM #1 stated experienced a rapid of his oxygen at all time Resident #82's oxygen Director. In an interview on 3/2 Assistant (NA) #1 stated adjust her oxygen could not not provide the stated of the stated oxygen at all time Resident #82's oxygen oxyge	d interview on 3/8/21 at 11:12 as lying in bed wearing his oxygen concentrator running he required oxygen due to he was unsure what rate his 3/8/21 at 2:30 PM, Resident strator was running at 5 liters. 3/10/21 at 8:50 AM, en concentrator was running e stated he did not notice if oxygen concentrator. 10/21 at 11:00 AM, Unit ated Resident #82 was self-adjust his oxygen confirmed he worked the 8/21 and did not notice en running at 5 liters. He t have adjusted it. He also t notice the order that a was only ordered for at Resident #82 had decline and wanted to wear as. He stated he would clarify en orders with the Medical	F6	95		
	concentrator.	not adjust file oxygon				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345177	B. WING			03/	11/2021
	ROVIDER OR SUPPLIER ENS AT PINEHURST REF	HAB & LIVING CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	stated he spoke with received orders for R oxygen at 2 liters via In an interview on 3/1 Director of Nursing (Dexpectation that Resi administered as orde Drug Regimen Review	0/21 at 12:50 PM, UM #1 the Medical Director and esident #82 to wear his NC continuously. 0/21 at 5:00 PM, the DON) stated it was her dent #82's oxygen be red. w, Report Irregular, Act On		695 756			4/8/21
SS=E	must be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's medical facility's medical direct and these reports mu (i) Irregularities including that meets the c (d) of this section for (ii) Any irregularities in during this review museparate, written report attending physician a director and director and the irregularity th (iii) The attending phyresident's medical recirregularity has been	imen Review. ug regimen of each resident least once a month by a view must include a review ical chart. armacist must report any tending physician and the ctor and director of nursing, ist be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2021
				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 APPROPF DEFICIENCY)	BE COMPLETION
F 756	be no change in the n	nedication, the attending ument his or her rationale in	F 7	56	
	§483.45(c)(5) The fact maintain policies and drug regimen review of limited to, time frames the process and steps when he or she identifications urgent action. This REQUIREMENT by: Based on record revisite interviews with staff, in Medical Director, the to identify and address assess residents on a abnormal involuntary (Residents #3, #18, #facility 's need to idensymptoms and to more (Residents #18 and #ensure PRN (as need medications were time (Resident #40), and the evaluate residents on for gradual dose redu #43). In addition, the recommendations made Consultant (Residents was for 8 of 10 resides were reviewed. The findings included 1. Resident #29 was a 11/2/16 with multiple of the process and steps was for 10 resides were reviewed.	procedures for the monthly that include, but are not a for the different steps in a the pharmacist must take fies an irregularity that a to protect the resident. It is not met as evidenced ew, observation, and Pharmacy Consultant, and Pharmacy Consultant failed as the facility 's need to antipsychotic medication for movement disorders 29, #31, #41, and #43), the natify target behavioral nitor those symptoms 43), the facility 's need to led) psychotropic elimited in duration the facility 's need to psychotropic medications ctions (Residents #18 and facility failed to act upon the pharmacy shall and #66). This ents whose medications		F 756 A total of 6 Abnormal Involuntary Movement Scale (AIMS) assessment were not up to date and a total of 9 residents that did not have target behaviors identified at the time of surfor those residents found to have be affected by the deficient practice of not receiving drug regimen reviews/reportive irregularities related to the Abnormal Involuntary Movement Scale (AIMS) and the Gradual Dose Reductions (GDR) were updated as follows: 1-Resident #29 santipsychotic medication was discontinued on 2/27, so therefore an AIMS assessment is required at this time. 2- a) The licensed nurse completed AIMS assessment for Resident #41 of 3/10/21. b) The licensed nurse discontinued the duplicate Ultram order on 3/10/21. 3- The licensed nurse received a	vey. en ot ts of /21, not an n

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	E SURVEY IPLETED
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THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
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F 756	Continued From p	age 40	F 7	56		
	disturbance.			physician order on 3/10/21, to the Ativan order for Resid	discontinue dent #40.	
	An Abnormal Invo	luntary Movement Scale (AIMS)		4-The physician declined to in		
		completed on 12/1/19 for		of Resident #18□s antidepres		
		a score of 0 (no involuntary		time, due to residents current		
	movements identi	fied).		condition. The behavior moni	tor was	
				updated on 3/19/21, to monito	or for signs	
		ler dated 4/5/20 indicated		of depression.		
		chotic medication) 50 milligrams		5- The licensed nurse comp		
	(mg) once daily fo	r Resident #29.		AIMS for Resident #43 on 3/1 Behavior monitor was updated		
	The quarterly Mini	mum Data Set (MDS)		target behaviors on 3/21/21.		
		I 1/8/21 indicated Resident #29		physician declined to initiate a		
		inderstood. She was assessed		time due to risks verses benef		
		symptoms, but had rejected		the residents diagnosis.		
	care on 1 to 3 day	s during the MDS review		6- The licensed nurse receiv	ved an order	
	· .	#29 was administered routine		from the physician on 3/25/21		
	antipsychotic med	ication on 7 of 7 days.		hold for Sotalol when pulse ra than 50 for Resident #66.	te is less	
		ler dated 1/15/21 indicated		7- a) The licensed nurse cor	-	
		a GDR of Seroquel decreasing		AIMS for Resident #3 on 3/10		
		mg once daily to 25 mg once		b) Sertraline and Hydroxyzine		
	daily.			diagnosis included with the or		
	The quarterly MD9	S assessment dated 2/16/21		for Resident #3 but was not put the electronic medication adm	-	
		t #29 's cognition was severely		record (EMAR). The licensed		
		d no behavioral symptoms, but		updated the orders on 3/25/21		
	· •	care on 1 to 3 days during the		diagnosis are showing on the		
		d. Resident #29 was		#3□s EMAR.		
		ne antipsychotic medication on		8- The licensed nurse cor	mpleted an	
	7 of 7 days.			AIMS for Resident #31 on 3/1	0/21.	
		ler dated 2/27/21 indicated				
	Resident #29 's S	Seroquel was discontinued.		Address how the facility will id		
				residents having the potential		
		edication Administration		affected by the same deficient	t practice;	
		from 12/2/19 through 2/27/21		All facility recidents have the	notontial to	
	Seroquel daily as	t #29 was administered		All facility residents have the public be affected by the alleged def		
	Logicy dolly as	0, 40, 04.	1	Do anotica by the aneged der	IOIOIIL	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (X3) DATE SU				
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		345177	B. WING _			03/	11/2021
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THE ODE	NO AT DINELLIDOT DEL	IAD & LIVING CENTED		2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER		F	PINEHURST, NC 28374		
(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)	TIVE ACTION SHOULD BE COMPLE CED TO THE APPROPRIATE COMPLE DATE	
F 756	Continued From page	e 41	F7	756			
	Record (EMR) from 1 revealed an AIMS ass	sessment or any other it assessment had not been			practice of failure to assess residents of antipsychotic medication for abnormal involuntary movement disorders, identi- target behaviors and monitor those symptoms, ensure PRN psychotropic medications are time limited in duration evaluate residents on psychotropic	fy	
	medical record of the identifying and addres assessment or any ot	ce in Resident #29 ' s Pharmacy Consultant ssing that an AIMS ther involuntary movement been completed for Resident			medications for gradual dose reduction and act upon pharmacy recommendations. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit on 3/10/21, of curre		
	An observation was on 3/8/21 at 12:30 PN involuntary movemen				facility residents with orders for antipsychotic medications to validate the an AIMS had been completed within the last 6 months. All AIMS were up to daily 3/10/21. A total of 6 AIMS and 0 GF	e ite	
	Nursing (DON) on 3/1 stated that the facility complete AIMS assess then every 6 months antipsychotic medical completed in the EMF section. She indicate were completed by the admission and then be months with coincidin assessments. The Description Nurses (MDS Nurses and the second and the se	ducted with the Director of 10/21 at 1:20 PM. She 's normal process was to sements on admission and thereafter for residents on tion. The assessments were R under the assessment at the AIMS assessments are admission nurse on by the floor nurses every 6 and dates of the MDS ON explained that the MDS #1 and MDS Nurse #2) put S assessments that were this was used to inform the an AIMS assessment for 2/1/19 was reviewed with confirmed there were no			were identified from the audits conduct on 3/9/21 and 3/10/21. On 3/21/21, the DON and ADON completed updating behavior monitors include target behaviors for residents the receive psychoactive medications. 9 residents were identified as not having target behaviors. On 3/10/21, the DON and ADON completed an audit of PRN psychoactive medications to assure there are stop dates and reassessment of use. 3 residents were identified that did not have stop dates for orders. On 3/9/21, the pharmacist completed a audit of current facility residents that receive psychotropic medications and made recommendations for 3 residents have a gradual dose reduction.	to hat ve ave	
	AIMS assessments c	ompleted after 12/1/19 for evealed she was not aware			On 3/25/21, the DON completed pharmacy recommendations that were		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345177	B. WING _			03/	11/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CREE	ENS AT PINEHURST REI	JAD 9 I IVING CENTED		20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER		Р	INEHURST, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 42	F 7	756			
	completed every 6 m	assessments not being onths. She indicated there			received for February and March 2021		
	completion of AIMS a #29 should have had completed since 12/1 she would have expe Consultant to identify AIMS assessments to months for residents A phone interview wa Pharmacy Consultant She stated that her ex of AIMS assessments antipsychotic medicat thereafter. The Pharm	and address the need for be completed every 6 on antipsychotic medication.			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur; When a resident has a physician order an antipsychotic medication, the licens nurse will complete an AIMS assessment will be updated at lease every 6 months and will be tracked and schedules by Minimum Data Set (MDS Nurse. The licensed nurse will implement a behavior monitor in the electronic medical record to include resident targeted behaviors and side effect monitoring every shift.	for ed ent. st i	
	assessments for antip the potential side effer Resident #29 's most 12/1/19 was reviewed Consultant. Resident and MARs that indicated daily from 12/1/19 through the Pharmacy Coshe had not identified was not completed si #29. The Pharmacy she began working wand had been doing reconstruction was revealed the assessments were in unaware that she could assessments when comonthly medication reconstruction.	osychotic medications due to cots of the medications. It recent AIMS completed on did with the Pharmacy It #29 's physician 's orders Ited she received Seroquel Ough 2/27/21 were reviewed Onsultant. She revealed Ithat an AIMS assessment Ince 12/1/19 for Resident Consultant explained that Ith the facility in May of 2020 Ithe mote reviews until January Ithat she thought the AIMS Ithe hard chart so she was Ithe hard chart so she was Ithat she thought the AIMS			When a PRN psychoactive medication ordered, the order will include a 14 day time limit, and the physician will reasse for continued use. The pharmacist will complete monthly audits of resident medication and will make recommendations to the physicia regarding gradual dosage reduction. T pharmacist will validate monthly if a GE was completed and if not, will follow up with the DON and physician to assure proper documentation is completed to support. When the DON receives the Pharmacy recommendations monthly, she will provide copies to the physician and nurses for follow up of recommendation A copy of the recommendations will be kept in a folder and the DON will monit	ess an The DR	
	began completing a r				and validate follow through of recommendations within 30 days of	= *	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL		E SURVEY MPLETED				
		345177	B. WING			C 3/11/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0		STREET ADDRESS, CITY, STATE, ZIP COD		3/11/2021
TO UNIC OF TH	TO VIDER OR GOLF EIER			205 RATTLESNAKE TRAIL	,_	
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 756	Continued From pag	e 43	F 7	56		
	medications when sh	ne started to coming to the		receipt of recommendations.		
	facility in person in Ja	anuary 2021 for her monthly		The Regional Director of Clin	ical Services	
	medication regimen i	reviews. She revealed that		provided education to the DC)N on	
	she also had not con	npleted a review for AIMS		3/10/21, regarding drug regin	nen review,	
	assessments during	her in person monthly		psychoactive med monitoring	յ, behavior	
	_	reviews in 2021. The		and side effect monitoring, G		
		t acknowledged that her		time limit for psychoactive me	edications	
	•	ave been for an AIMS		and process for pharmacy		
		mpleted a minimum of every nt #29 due to her extended		recommendation follow throu	•	
		otic medication Seroquel.		The DON provided education physician on 3/25/21, regardi		
		ged that a recommendation		regimen review, psychoactive		
	_	alert the facility that an AIMS		monitoring, behavior and side		
		to be completed for Resident		monitoring, and process/docu		
	#29.	•		regarding gradual dose reduc		
				psychoactive medication and		
				psychoactive medications.		
		s admitted to the facility on		The Pharmacy manager prov		
	10/31/18 with diagno	ses that included		education on 3/24/21, for the	•	
	schizophrenia.			regarding regulations related		
				monitoring, GDR process and		
	A physician 's order			documentation requirements,		
	milligrams (mg) once	chotic medication) 15		PRN psychoactive medication up for recommendations that		
	miligrams (mg) once	daily in the morning.		the facility.	are given to	
	An Abnormal Involun	tary Movement Scale (AIMS)		the radiity.		
		npleted for 1/28/20 for				
	Resident #41 with a	•				
				Indicate how the facility plans	s to monitor	
	The quarterly Minimu	ım Data Set (MDS)		its performance to make sure	that	
		14/21 indicated Resident		solutions are sustained;		
		moderately impaired. She		The DON and/or the ADON v		
		o behavioral symptoms, but		x week for 4 weeks then wee	•	
		1 to 3 days during the MDS		months, residents with new o		
	•	lent #41 was administered		psychoactive medications to		
	routine antipsychotic	medication on 7 of 7 days.		has been completed when m		
	A rovious of Desident	#44 ! a gurrent physician !		initiated , Behavior monitor w	-	
		#41 's current physician 's cated the 4/10/19 order for		behavior and side effect mon initiated, PRN psychoactive n	-	
	STACES OF STORE FINAL		1	minuted, i iti payonoactive i	noaloation	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF D	ROVIDER OR SUPPLIER	040111	1	-	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/11/2021
NAIVIE OF P	ROVIDER OR SUPPLIER				, , ,		
THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER			205 RATTLESNAKE TRAIL		
				P	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From p	age 44	F7	756			
		g remained an active order.			has a stop date of 14 days.		
	Ampipiazoic 10 mg	gremained an active order.			The Administrator will audit completion	of	
	A review of the Me	edication Administration			pharmacy recommendations monthly for		
		rom 1/29/20 through 3/8/21			months, to validate that pharmacy	51 0	
	· ,	t #41 was administered			recommendations, to include GDR s,		
	Aripiprazole daily				have been completed within 30 days o		
	/p.p.a				receipt of recommendations.	•	
	A review of the hard copy and Electronic Medical				The Administrator and DON will review	the	
	Record (EMR) from 1/29/20 through 3/8/21				audits monthly to identify patterns/trend		
		assessment or any other			and will adjust the plan as necessary to		
	involuntary moven	nent assessment had not been			maintain compliance.		
	completed for Res	sident #41 since 1/28/20.			The Administrator and DON will review	the	
					plan during monthly QAPI and the aud	its	
	There was no evid	lence in Resident #41 ' s			will continue at the discretion of the QA	\P Ι	
	medical record of	the Pharmacy Consultant			committee.		
	identifying and add	dressing that an AIMS					
	assessment or any	y other involuntary movement			Indicate dates when corrective action v	vill	
	assessment had n #41 since 1/28/20	not been completed for Resident			be completed; 4/8/21		
		as conducted on Resident #41 5 AM. There were no					
	involuntary moven						
		conducted with the Director of					
	, ,	3/10/21 at 1:20 PM. She stated					
		normal process was to					
		sessments on admission and					
		hs thereafter for residents on					
		ication. The assessments were					
		EMR under the assessment					
		cated the AIMS assessments					
		y the admission nurse on					
		en by the floor nurses every 6					
		iding dates of the MDS					
		e DON explained that the MDS					
	,	se #1 and MDS Nurse #2) put					
		MDS assessments that were					
	∣ uue eacn month a	nd this was used to inform the					

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)3/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	7371172021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 756	due. The most rece Resident #41 dated the DON. The DON AIMS assessments Resident #41. She of this issue of AIMS completed every 6 is may be a problem vice completion of AIMS #41 should have had completed since 1/2 she would have exp Consultant to identify AIMS assessments months for residents A phone interview with Pharmacy Consulta She stated that her of AIMS assessment antipsychotic medic thereafter. The Phat that it was important assessments for an the potential side ef Resident #41 's mo 1/28/20 was reviewed Consultant. Reside and MARs that indic Aripiprazole daily frowere reviewed with She revealed she h assessment was no Resident #41. The explained that she is in May of 2020 and reviews until Januar	an AIMS assessment was ent AIMS assessment for 1/28/20 was reviewed with I confirmed there were no completed after 1/28/20 for revealed she was not aware assessments not being months. She indicated there with the facility 's protocol for assessments as Resident d 2 AIMS assessments as Resident d	F 7	56		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345177	B. WING			C 3/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		3/11/2021
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 756	have reviewed the Acompleting her remeregimen reviews in a Consultant was ask completing a review residents on antipsy started coming to the 2021 for her monthl reviews. She reveal completed a review her in person month reviews in 2021. The acknowledged that been for an AIMS as minimum of every 6 to her extended use medication Aripipratithat a recommendation alert the facility the	ge 46 ras unaware that she could AIMS assessments when ote monthly medication 2020. The Pharmacy ed if she had begun of for AIMS assessments for ochotic medications when she are facility in person in January y medication regimen led that she also had not for AIMS assessments during only medication regimen led Pharmacy Consultant ther expectation would have seessment to be completed a see of the antipsychotic cole. She also acknowledged tion should have been made that an AIMS assessment letted for Resident #41.	F 7	56		
	10/31/18 with multip cerebral infarction w weakness on one si hemiplegia (paralys A physician 's orde 9/25/19 indicated U 50 milligrams (mg) a than 5 out of 10. A physician 's orde 6/12/20 indicated U pain greater than 5	as admitted to the facility on one diagnoses that included with hemiparesis (muscle ide of the body) and is on one side of the body) If for Resident #41 dated (Itram (opioid pain medication)) as needed for pain greater If or Resident #41 dated (Itram 50 mg as needed for out of 10. The previous order that was initiated on 9/25/19				

STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETE		MPLETED		
		345177	B. WING _			C 03/11/2021
	DER 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
for A p dark Co Add or construction in Street Below Confirmation of the A p dark Co from a construction of the A p dark Confirmation or construction of the A p dark Confirmation of	oharmacy recompleted 12/2/20 completed 12/2/20 completed 12/2/20 completes for Ultram 50 tructions. The Plecause this is a deposition of these orders indication this phase of the quarterly Minimal of the completes of the constitution of the pain medical order orders orders for Ultime orders for Ultime pain medical orders orders for Ultime orders for Ultime pain medical orders orders for Ultime orders or under the pain medical order orders for Ultime orders orders for Ultime orders or under the pain medical order orders for Ultime orders	mained an active order. mendation for Resident #41 bleted by the Pharmacy d the Medication ord (MAR) showed 2 active ord mg with the same harmacy Consultant wrote, uplication, please discontinue from her MAR". There was harmacy recommendation esident #41 had been e facility. facility. fum Data Set (MDS) 1/14/21 indicated Resident s moderately impaired. She eeded) pain medications, no tions, and reported pain g of 02 out of 10. Resident ed opioid medication on 2 of 7 mendation for Resident #41 eted by the Pharmacy d a repeat recommendation Pharmacy Consultant reported Ultram 50 mg was present on equested one of the orders be e was no indication this endation dated 3/3/21 had	F7	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345177	B. WING _				C 11/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	ODE:	1 03/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 756	Nursing (DON) on stated that she recorded to nursing during the morning Monday through F Manager (UM) #1, reported that the responded to and/morning meeting at that same day. The for Resident #41 direcommendation of duplicate order for reviewed the with I physician 's orders Ultram 50 mg PRN reviewed with the I recalled reviewing recommendation at UM #2 and determ PRN Ultram 50 mg She reported that I unit so she most lill person who was so the Ultram 50 mg FThe DON stated the recommendation in reported that she derecommendation to upon by the time of next monthly medicated that interview was as an interview was as an interview was a context monthly medicated that interview was a context monthly medicated that interview was a context monthly medicated that she derecommendation to upon by the time of next monthly medicated that she derecommendation to the context monthly medicated that she derecommendation that she de	conducted with the Director of 3/10/21 at 1:20 PM. She eived the pharmacy from the Pharmacy Consultant cated that recommendations were reviewed within the week meetings that were conducted riday with herself, Unit and UM #2. The DON ecommendations were normally or acted upon during the and/or after the meeting during the pharmacy recommendations ated 12/2/20 and the repeat lated 3/3/21 related to a Ultram 50 mg PRN were DON. Resident #41 's active is that revealed the duplicate of order was still in place was DON. She revealed that she the 12/2/20 pharmacy and discussing with UM #1 and dining that one of the orders for geneeded to be discontinued. Resident #41 was on UM #2 's kely would have been the upposed to discontinue one of PRN orders for Resident #41. The state of the Pharmacy Consultant 's cation regimen review.	F7	756			
	-	conducted with UM #2 on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345177	B. WING _			C 03/11/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/11/2021	
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	and the repeat recorelated to a duplicate were reviewed with active physician's duplicate Ultram 50 place was reviewed that she could recal recommendations r PRN Ultram for Resort A phone interview where Pharmacy Consultates She indicated that a recommendations to acted upon by the tregimen review. The recommendations from the repeat recorelated to a duplicate were reviewed with She indicated that con 3/3/21 she realizer recommendation from the repeat recommendation from the response of Resident #41's had not been response.	or Resident #41 dated 12/2/20 mmendation dated 3/3/21 te order for Ultram 50 mg PRN UM #2. Resident #41 's orders that revealed the mg PRN order was still in with UM #2. UM #2 stated I any pharmacy elated to a duplicate order for sident #41. I was conducted with the unt on 3/10/21 at 3:25 PM. She expected her to be responded to and/or time of her next monthly the pharmacy or Resident #41 dated 12/2/20 mmendation dated 3/3/21 the order for Ultram 50 mg PRN the Pharmacy Consultant.	F 7	756			
	11/14/19 and most	s admitted to the facility on recently readmitted on 1/7/21 uses that included Alzheimer '					
		r for Resident #40 dated e was admitted to hospice					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	<u> </u>	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	1/8/21 indicated A 0.5 milligram (mg (PRN). This PRN no stop date. The significant ch assessment date #40 's cognition of noted with a prog was on hospice.	der for Resident #40 dated Ativan (antianxiety medication)) every 1 hour as needed I Ativan physician 's order had lange Minimum Data Set (MDS) d 1/13/21 indicated Resident was severely impaired. She was nosis of less than 6 months and Resident #40 had received no ation during the MDS review	F 7	756		
	dated 2/1/21 and completed by the were no recomme Resident #40 's I that was prescrib. The March 2021 Resident #40 were revealed the 1/8/2 order continued to A review of the M Records (MARs)	tant medication regimen reviews 3/8/21 for Resident #40 were Pharmacy Consultant. There endations made related to PRN Ativan (initiated on 1/8/21) ed with no stop date. active physician 's orders for re reviewed on 3/9/21 and 21 PRN Ativan physician 's o be active. edication Administration from 1/8/21 through 3/9/21 for cated no PRN Ativan had been				
	Medical Director of stated he was aw PRN Ativan and of medications were duration for all results.	was conducted with the on 3/10/21 at 3:45 PM. He are that physician 's orders for other PRN psychotropic required to be time limited in sidents including those on N Ativan order for Resident #40				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 3/11/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 756	reviewed with the Methat not including a sindicated he had bee psychotropic medicatime limited duration regulations. A phone interview was Pharmacy Consultant She stated she was a orders for PRN Ativa psychotropic medicatime limited in duration those on hospice. Torder dated 1/8/21 th Resident #40 was reconsultant. The mediated 2/1/21 and 3/8 recommendations recommendations reconsultant. She revorder when she computer when she computer for PRN Ativan order having no stop. An interview was cornursing (DON) on 3/stated she was awar required all PRN psytime limited in duration this regulation applies the reported that she Consultant to identify	at included no stop date was edical Director. He revealed top date was an error. He in ensuring all PRN tions were prescribed with a in accordance with the as conducted with the PRN as and other PRN tions were required to be an and other PRN as and continued to be active for viewed with the Pharmacy dication regimen reviews all that included no lated to the PRN Ativan for eviewed with the Pharmacy ealed that she missed this poleted her February and She indicated she should amendation to discontinue the for Resident #40 due to the date. Inducted with the Director of 10/21 at 1:20 PM. The DON to of the regulation that chotropic medications to be on, but she had not realized do to residents on hospice. The properties and dation to bring it the nursing the properties are set in the properties.	F7	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345177	B. WING_		C 03/11/2	021	
ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		03/11/2021	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE CO	(X5) MPLETION DATE	
Continued From pag	e 52	F 7	56			
4/4/19 read Cymbalt	a (antidepressant) delayed					
4/15/19 read monitor yes or no. If behavior	for behaviors and indicated s present please document					
indicated she was co	gnitively intact and exhibited					
read she was at risk history of depression plan dated 2/14/21 al for adverse effects re	for behaviors related to a . Resident #18's revised care so indicated she was at risk lated antidepressant					
telehealth medication #18 indicated the foll 4/23/20-no recomme 5/12/20-recommendathe need for lab work 6/10/20-recommendathe continued use of 7/8/20-no recommen 8/4/2020- recommen	a review notes for Resident owing: ndations ation completed regarding an anti-inflammatory dation completed regarding					
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page 4. Resident #18 was diagnosis of depression. Review of Resident #4/4/19 read Cymbalt release particles 30 r for depression. Review of Resident #4/15/19 read monitor yes or no. If behavior in the medical record Resident #18's Minimindicated she was cono behaviors. She was antidepressant. Resident #18's revise read she was at risk thistory of depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effects remedication for depression plan dated 2/14/21 all for adverse effect	A 345177 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression. Review of Resident #18's Physician order dated 4/4/19 read Cymbalta (antidepressant) delayed release particles 30 milligrams every afternoon for depression. Review of Resident #18's Physician order dated 4/15/19 read monitor for behaviors and indicated yes or no. If behaviors present please document in the medical record every shift. Resident #18's Minimum Data Set dated 1/15/21 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of an	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 52 4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression. Review of Resident #18's Physician order dated 4/4/19 read Cymbalta (antidepressant) delayed release particles 30 milligrams every afternoon for depression. Review of Resident #18's Physician order dated 4/15/19 read monitor for behaviors and indicated yes or no. If behaviors present please document in the medical record every shift. Resident #18's Minimum Data Set dated 1/15/21 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of an antidepressant. Resident #18's revised care plan dated 2/8/21 read she was at risk for behaviors related to a history of depression. Resident #18's revised care plan dated 2/14/21 also indicated she was at risk for adverse effects related antidepressant medication for depression. Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #18 indicated the following: 4/23/20-no recommendation completed regarding the need for lab work 6/10/20-recommendation completed regarding the continued use of an anti-inflammatory 7/8/20-n recommendation completed regarding the need for lab work 6/10/20-recommendation completed regarding the need for lab work	ROUNDER OR SUPPLIER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression. Review of Resident #18's Physician order dated 4/4/19 read Cymbalta (antidepressant) delayed release particles 30 milligrams every afternoon for depression. Review of Resident #18's Physician order dated 4/15/19 read monitor for behaviors and indicated yes or no. If behaviors present please document in the medical record every shift. Resident #18's Minimum Data Set dated 1/15/21 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of an antidepressant. Resident #18's revised care plan dated 2/8/12/1 read she was at risk for behaviors related to a history of depression. Resident #18's revised care plan dated 2/14/21 also indicated she was at risk for adverse effects related antidepressant medication for depression. Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #18 indicated the following: 4/23/20-no recommendation completed regarding the need for lab work 6/10/20-recommendation completed regarding the need for lab work 6/10/20-r	A BUILDING COMPLETE C C COMPLETE C C C 33/11/12 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC DICKTEYING INFORMATION) Continued From page 52 4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 756	reduction (GDR) of M 1/6/21-no recomment 2/5/21- recommend need for lab work 3/8/21-no recomment Review of Resident 1/1/21 to 3/8/21 did I documentation of be Review of Resident administration record present indicated shoordered and exhibite not list any targeted monitor. Review of Resident administration record present indicated shoordered and exhibite not list any targeted monitor. Review of Resident and exhibite not list any targeted monitor. Review of Resident and exhibite not list any targeted monitor. Review of Resident and exhibite not list any targeted monitor. Review of Resident and concerns. No GDR decompensation. Be clinical indication for medications. 11/13/20-Conversation and endorsed a stab recommended due to Benefits outweigh rist for any GDR of psycolin an observation and 2:17 PM, Resident # isolation unit for testis She appeared in good spirit and president and 2:17 PM, Resident # isolation unit for testis She appeared in good spirit and president and presiden	endation ation for a gradual dose Melatonin (hormone) adation ation completed regarding the adation ation co	F7	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 756	In an interview on 3/stated Resident #18 exhibited no signs of stated he had not obsadness such as cry nurses documented every shift. Nurse #7 behaviors identified assumed it would be appetite or lack of at In an interview on 3/Manager (UM) #1 stapsychotropics should behaviors for the staresident. He stated welectronic medical readd specific target by program populated a	d she enjoyed being in a she could have some privacy. 8/21 at 2:30 PM, Nurse #7 was in good spirits and depression. Nurse #7 served any evidence of ing or worry. He stated the yes or no to her behaviors on stated there was no specific for the staff to look for but e crying, withdrawal, loss of tention to personal hygiene.	F	756	DEFICIENCY)			
	behaviors listed for F knew what to look fo has had a difficult 6 i normally a very socia stated she had been COVID-19. In an interview on 3/ Director of Nursing (Pharmacist complete remotely and would and recommendation received the report a printed a copy for the address. There was	Resident #18 so the staff r. He stated Resident #18 months because she was al person before COVID. He in isolation twice for 10/21 at 1:20 PM, the DON) stated the Consultant ed her medication reviews email her a pharmacy report his each month. Once she and recommendations, she						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 756	times per week. He wrote orders if need recommendations the back in a folder for f Medical Director did recommendation, he recommendation to be filed. The DON Consultant Pharmac recommendations for regarding gradual demissing targeted be nursing recommend morning meetings. In a telephone intended the facility in May 20 during Resident #18 review that a GDR he 2019 for Resident # She stated since she 2020 and due to Consultant Pharmac for an antidepressar in the first year and stated she was unawated she was un	came to the facility several went through the folder and ed and responded to the nen put the recommendation iling. The DON stated if the not agree with a e would write the rationale on and put it back in the folder I stated she expected the	F 75	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 756	normalize. He state behaviors to be ide behaviors to look for the behavior to look for the	depressant until things ed he expected targeted entified so the staff knew what or and document. 3/10/21 at 5:00 PM, the DON expectation that the Consultant of the lack of targeted behavior didentify the need for a gearding a GDR of Resident entituness contraindicated with ale. Tryiew on 3/11/21 at 1:40 PM, rese Practitioner stated she has GDR recommendations from the encist regarding Resident #18's lata. She stated the facility he Medical Director preferred mmended GDRs. She stated ecific documentation as to why indicated and the behaviors facility was too vague and liftic to Resident #18. The same admitted on 12/12/18 with sees for Cerebral Vascular chizophrenia and Bipolar	F 7	56		
	included an order of (antipsychotic) Ext milligrams at bedtin Also included was to monitor and indi occurred on every	t #43's Physician orders dated 4/15/19 for Seroquel ended Release 24 hour 50 me for Paranoid Schizophrenia. an order dated 2/5/20 for staff cate yes or no if behaviors shift. If yes, please record -pharmacological interventions				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			5 RATTLESNAKE TRAIL		
				PII	NEHURST, NC 28374		
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F 756	Continued From page	e 57	F	756			
	in the medical record						
	(MDS) dated 1/18/21 cognitively intact and	erly Minimum Data Set indicated Resident #43 was exhibited rejection of care coded for the use of an					
	read she was at risk the use of antipsychological Schizophrenia and Bincluded the completion Involuntary Movement	ipolar Disorder. Interventions					
	Review of Resident # indicated the last AIM 1/29/20.						
	telehealth medication #43 indicated the follo 4/23/20-no recomme 5/12/20-no recomme	ndations ndations ed pain monitoring and ngular dations dations dations ndations ndations ndations dations dations dations dations dations dations dations					
	Review of Resident # notes indicated the fo	43's psychiatry telehealth ollowing:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			1 03/11/2021	
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F 756	decompensation. E clinical indication for medications. 6/3/20-Pleasant and thoughts, hallucina none. Current regimedication adjustm of decompensation no clinical indication medications. 9/11/20-Reported refriends to talk too-remaking symptoms emotions, gets upstrecommendations of Benefits outweight for any GDR of psy 10/9/20- Reported coping. GDR would decompensation. Not risk of decompensation. Not risk of decompensation. In the compensation of the compensation of the compensation. Elinical indication for medications. Review of Residen 1/1/21 to present in regarding the refuse.	d friendly-no delusional tions, and mania. Staff report me recommended due to risk and no ment recommended. No ment recommended due to risk and ment for any GDR of psychiatric me privacy, stressful, wanting reported isolation and lonely worse. Staff report occasional ret easily-no new due to risk of decompensation. This isk and no clinical indication rechiatric medications. The improvements in mood and different in risk of lo GDR recommended due to risk of the cation. Benefits outweigh risk reation for any GDR of recommended due to risk of the station for any GDR of recommended due to risk of the station for any GDR of recommended due to risk of the station for any GDR of recommended due to risk of the station for any GDR of psychiatric medication for any GDR of psychiatric medicat	F 7	56			
	administration reco present indicated s ordered and no bel	rds (MARs) from 1/1/21 to he received her Seroquel as haviors exhibited. The MAR did behaviors for staff were to					

(X3) DATE SURVEY COMPLETED	
03/11/2021	
00/11/2021 	
RRECTION (X5) SHOULD BE COMPLETION APPROPRIATE DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE COMP	SURVEY LETED				
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F 756	Continued From page	e 60	F	756			
	stated the current MD on the list. He stated record set up would have due. UM #1 stated specify targeted behave regarding the use of when an order for any into the electronic metemplate populated for UM #1 stated an AIM use of an antipsychot regarding the need to GDR unless it was considered in the Consultant medication reviews reapharmacy report and medication reviews reapharmacy report and for the Medical Director to a f	DS Nurse's did not specify it the old electronic medical et staff know when an AIMS ed the medical record should aviors for Resident #43 an antipsychotic. He stated by psychotropics was entered edical record, a generic for only yes or no responses. S, target behaviors for the edic and documentation of evaluate the need for a contraindicated. 10/21 at 1:20 PM, the DON the Pharmacist completed her emotely and would email her and recommendations each					

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admission and their of MDS assessment floor completed the does not have any nurses that an AIM she was unaware that the A being done. The Dexpectation that the identified the need Resident #43, iden Seroquel been add #43 targeted behave antipsychotic. In an interview on Surse #2 stated she calendar with all of given to the UM's. In an interview on Surse #1 confirment that indicated they AIMS assessments they gave to the UI information on what due. In a telephone inte the Consultant Phat the facility in May 2 expectation of an Aladmission and every and a significant processing and every surse services and the services are services and the ser	e did the baseline AIMS on the MDS Nurses put out a list ats due and the nurses on the eAIMS. She said the system automatic prompt to alert the S was due. The DON stated that Resident #43's last AIMS ompleted on 1/29/20 and was alms assessments were not ON stated it was her to easily consultant Pharmacist for an AIMS assessment on tified the need for a GDR in alteressed and identified Resident wiors for the use of an an AIMS assessments was the most and most and most are reported that each month a state MDS assessments was and that the monthly calendar and the that	F 75	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 756	in the electronic med Pharmacist stated is May 2020 and note been addressed sir had planned to add in April 2021. She is need for targeted by psychotropics but k adverse side effects. In a telephone inter the Medical Director GDRs personally unantipsychotic then it stated Resident #4: hallucinations and vand talk to people with Director stated her recommendations in Seroquel, the need identification of specific to was her experienced it was her expharmacist identify documentation, ide recommendation referenced in the psychiatric Number 1 at elephone inter the Psychiatric Number 2 and it was her experienced in the psychiatric Number 2 and it was her expharmacist identify documented rational every 6 months. Since the Psychiatric Number 2 and it was her experienced in the p	re the AIMS were documented edical record. The Consultant she started at the facility in d no GDR on Seroquel had noce 4/2019. She stated she ress Resident #43's Seroquel stated she was unaware of the ehaviors with the use of new the facility looked for s. view on 3/10/21 at 3:45 PM, r stated he handled all the nless the medication was an ne differed to Psychiatry. He 3 experienced auditory, visual was known to often yell out who weren't there. The Medical nad not received any egarding Resident #43's for an AIMS or the need for cific targeted behaviors.	F 7	56		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1	03/11/2021	
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F 756	informed her that the to address all recomme her understanding the attempted due to Res Schizophrenia. She se Pharmacist should has specific documentation contraindicated, the massessment and identificated to be specific to the specific documentation of the specific documenta	Medical Director preferred mended GDRs and it was at a GDR could not be sident #43's diagnosis of stated the Consultant ave identified the need for on as to why a GDR was need for an AIMS stified that the behavior sility was too vague and at to Resident #43. admitted to the facility on diagnoses including fial fibrillation. doctor's order dated 2/21/21 eat heart rhythm problems) daily for atrial fibrillation. 66's pulse rate revealed that below 50's. The following pulse rate recorded on the and/or progress notes: 46 per minute 1 - 48 per minute 4 per minute 5 per minute 6 per minute 7 - 45 per minute 6 per minute 7 - 45 per minute	F 75	66			
	On 1/7/21, the Pharm	nacy Consultant had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	#66 and had recommon for pulse readings with has been in the low 50 Resident #66 doctor's Administration Recommon March 2021 were revorder for pulse reading. On 3/10/21 at 1:20 P (DON) was interview. Pharmacy Consultant regimen review remote 2021). The Consultant recommendations via that once she receives she printed them out folder for the doctor the explained that the doseveral times a week folder and responded After he responded to placed the forms back nurse's station for filling during the COVID out the doctor was not coplaced the folder in the doctor or his Physiciathem up and brought after. On 3/10/21 at 3:25 P was interviewed. The had been doing her moviews remotely in 2 to the facility in Januarshe expected the face.	gimen review on Resident tended to add a hold order th Sotalol since the pulse 60's frequently. So order and Medication ds (MARs) for February and fiewed. There was no hold figs with Sotalol. M, the Director of Nursing ed. She stated that the the the was completing the drug tely until this month (March fint was sending the fine and placed them in the fine address. The DON further ctor comes to the building find and he went through the fint to the recommendations, for the recommendations, for the recommendations, for the recommendations, he will to the folder at each fing. The DON reported that the folder at the lobby and the fine office at the lobby and the find Assistant (PA) would pick them back off the week M, the Pharmacy Consultant the Consultant stated that she monthly drug regimen find find the find find find find find find find find	F 75	56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 756	not seen any of he resident's medical On 3/10/21 at 3:45 interviewed. The F pharmacist's recomin his stack at each them up and addrestem up and addrestem in the DON's The Physician addithe recommendation there were recommaddressed, he new On 3/10/21 at 3:55 conducted with the Pharmacy Confor Resident #66 to Sotalol in January didn't know what he recommendation for not addressed. The was an issue, so short correction. She we pharmacist recommendation for addressed and 1 copy for the sident was an issue, so short correction.	oming to the facility, she had recommendations in the records. PM, the Physician was Physician stated that the amendation forms were placed a nurse's station. He picked ssed them on Saturdays and the following week. He placed office or Unit Manager's office. Led that he had responded to ons that he had received and if the nendations that were not the received them. PM, a follow up interview was DON. The DON verified that sultant had a recommendation of have hold order for the 2021. She stated that she	F 7	756		
	11/20/20 with multi schizophrenia. The (MDS) assessmen Resident #3 had se	vas admitted to the facility on ple diagnoses including e quarterly Minimum data Set to dated 2/25/21 indicated that evere cognitive impairment and antipsychotic drug during the .				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C)3/11/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		33/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC 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 756	for Risperdal (an ammilligrams (mgs.) by disorder and on 1/27 bedtime for schizople Review of Resident revealed that the Ab Scale (AIMS) test or System Condensed not completed since psychotropic drug at On 3/10/21 at 1:20 ff (DON) was interview she expected the Prrecommendation for completed. On 3/10/21 at 3:25 ff was interviewed. The had been doing her reviews remotely in to the facility in Januresidents on antipsy test or DISCUS completed that AIMS to hard copy chart so scompleted AIMS test	octor's order dated 11/21/20 tipsychotic drug) 0.5 mouth daily for bipolar 7/21 for Risperdal 1 mgs at a threnia. #3's medical records mormal Involuntary Movement Dyskinesia Identification User Scale (DISCUS) was admission to monitor for the diverse reaction. PM, the Director of Nursing yed. The DON indicated that farmacy Consultant to make the AIMS test to be PM, the Pharmacy Consultant the Consultant stated that she monthly drug regimen 2020 and just started coming fary 2021. She indicated that chotic drug should have AIMS pleted on admission at least every 6 months. She ests were documented in the the could not see the twhen she was reviewing the	F 7				
	the AIMS test were a medical records, she had the AIMS test/D different places and they were document The Consultant repo	/hen she was informed that actually in the electronic explained that every facility ISCUS documented in for some reason she thought ed in the hard copy chart. Inted that she had not been ed of AIMS test since she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345177	B. WING _			C 03/11/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE	00/11/2021
THE OBEI	INC AT DINEULIDET DEI	HAD & LIVING CENTED		205 RATTLESNAKE TRAIL		
THE GREE	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	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA	DATE
F 756	_	facility, but she would start	F 7	756		
	conducted with the D residents on antipsyc AIMS test or DISCUS and then every 6 mor Resident #3 did not h DISCUS completed of that the MDS Nurses floor nurses when AII admission Nurse was AIMS test on admissi antipsychotic drug. 7b. Resident # 3 was	M, a follow up interview was ON. The DON stated that shotic drug should have an Scompleted on admission on this. She verified that have an AIMS test nor on admission. She explained were supposed to notify the MS test was due and the sc supposed to complete an ion for residents on				
	11/20/20 with multiple schizophrenia. The of (MDS) assessment of Resident #3 had seven had received an athe assessment period. Resident #3 had a dofor Sertraline 50 milling and on 11/20/20 for Holy mouth every 6 house. Resident #3's drug repharmacy Consultant Consultant had record asking to have approof Sertraline and Hyden Review of Resident #4".	e diagnoses including quarterly Minimum data Set ated 2/25/21 indicated that ere cognitive impairment and intidepressant drug during od. Octor's order dated 11/21/20 grams (mgs) by mouth daily Hydroxyzine 25 mgs 1 tablet urs as needed. egimen was reviewed by the t on 1/7/21 and the immendation. She was priate diagnosis for the use lroxyzine.				
	revealed that the Ser					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _		,	C 3/11/2021
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		SJ 11/2021
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 756	(DON) was intervent Pharmacy Consuregimen review recommendations that once she recommendations that once she printed them folder for the doctexplained that the several times a weighter for the respondent placed the forms nurse's station for during the COVID the doctor was not placed the folder doctor or his Physisthem up and brown after. On 3/10/21 at 3:2 was interviewed. had been doing here in the facility in Jashe expected the recommendation when she started not seen any of heresident's medica.	O PM, the Director of Nursing lewed. She stated that the stant was completing the drug semotely until this month (March cultant was sending the sivia email. The DON added served the recommendations, out and placed them in the or to address. The DON further of doctor comes to the building seek and he went through the ded to the recommendations. In the folder at each of filing. The DON reported that to outbreak in December 2020, at coming to the facility. She in the office at the lobby and the sician Assistant (PA) would pick ght them back off the week 5 PM, the Pharmacy Consultant The Consultant stated that she er monthly drug regimen in 2020 and just started coming anuary 2021. She indicated that facility to respond to her within 30 days. She added that coming to the facility, she had er recommendations in the I records.	F 7			
	pharmacist's reco	Physician stated that the mmendation forms were placed the nurse's station. He picked essed them on Saturdays and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED			
		345177	B. WING			C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	CODE	03/11/2021
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	brought them back them in the DON's of The Physician added the recommendation there were recomme addressed, he never On 3/10/21 at 3:55 Pconducted with the Ethe Pharmacy Consufor Resident #3 to hat the Sertraline and the that she didn't know recommendation for not addressed. The was an issue, so she correction. She wou pharmacist recommendation and 1 copy fo verify if the recommend.	ne following week. He placed ffice or Unit Manager's office. I that he had responded to s that he had received and if ndations that were not	F	756		
	5/22/20 with diagnos dementia with behave schizophrenia. An Abnormal Involuntiassessment was con Resident #31. The quarterly Minimulassessment dated 1/431's cognition was shad received routine of 7 days during the A review of the currelindicated an order for the schizophrenia.	es that included vascular ior disturbance and stary Movement Scale (AIMS) inpleted on 5/22/20 for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345177	B. WING		03/11/2021		
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		1 00/11/2021			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION		
F 756	Continued From pa	ge 70	F 756				
	a day, had remaine admission date of 5	d active since Resident #31's /22/20.					
	record from 5/22/20 assessment or any	l copy and electronic medical to 3/10/21 revealed an AIMS other involuntary movement t been completed for Resident					
	record of the Pharm and addressing that other involuntary me	nce in Resident #31's medical nacy Consultant identifying an AIMS assessment or any ovement assessment had not Resident #31 since 5/22/20.					
	(DON) on 3/10/21 a facility's normal productions. She in assessment was conurse at the time of floor nurses every 6 of the MDS assessments due e assessments due e	dicated the initial AIMS mpleted by the admitting admission and then by the months with coinciding dates ment. The DON further stated t out a calendar of MDS ach month and this was used urses when an AIMS					
	Pharmacy Consulta stated her expectati assessments was o medication and ther Pharmacy Consulta to complete routine antipsychotic medic	vas completed with the nt on 3/10/21 at 3:25 PM. She on for the completion of AIMS n initiation of an antipsychotic n every 6 months. The nt explained it was important AIMS assessments for ations due to the potential dication could cause. Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		JSJ 11/2021
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	was reviewed with well as the physic 5/22/20 through 3 #31 received Risp confirmed she had assessment had r 5/22/20 for Reside Consultant further the facility in May remote reviews ur the AIMS assessment had rother the same assessment monthly medication. The Pharmacy Cohad not completed assessments duri medication regime Pharmacy Consul expectation would assessment to be 6 months for Resi antipsychotic medication assessment was a consultant of the pharmacy Consultant properties of AIMS assessment was a consultant properties. On 3/10/21 at 4:50 had reviewed Reselectronic medication was no AIMS assessment was not	AIMS, completed on 5/22/20, a the Pharmacy Consultant as ian's orders and MAR's from /9/21 that indicated Resident peridone twice a day. She do not identified an AIMS and been completed since ent #31. The Pharmacy estated she began working at 2020 and had been doing antil January 2021. She thought ments were in the hard chart so she could have reviewed the tax when completing her remote on regimen reviews in 2020. Insultant further revealed she do a review for AIMS and her in-person monthly en reviews in 2021 either. The tant acknowledged her is have been for an AIMS completed a minimum of every dent #31 due to her use of the lication Risperidone. She also the should have initiated a calerting the facility an AIMS needed for Resident #31. Sign PM, the DON indicated she sident #31's hard copy and a record and confirmed there essment completed since is expressed she was not aware as assessments not being sign months. She further stated Pharmacy Consultant to identify need for AIMS assessments to ry 6 months for residents on	F 7	756		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY	ſ	
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	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03/11/202	
(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 COMP	K5) LETION ATE
F 758 SS=E	CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreheresident, the facility of the second and the s	copic Drugs. Schotropic drug is any drug that is associated with mental vior. These drugs include, drugs in the following ensive assessment of a must ensure that ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic all dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive entrained to a PRN order on is necessary to treat a condition that is documented and enders for psychotropic drugs is. Except as provided in attending physician or	F 7	58	4/8/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 03/11/2021	
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				PII	NEHURST, NC 28374		
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F 758	1 3		F 7	758			
		or she should document their					
		ent's medical record and					
	indicate the duration t	for the PRN order.					
		rders for anti-psychotic					
	drugs are limited to 14	4 days and cannot be					
	renewed unless the a	ttending physician or					
		er evaluates the resident for					
	the appropriateness of that medication.						
	This REQUIREMENT by:	is not met as evidenced					
	Based on record revi	iew, observation, and			F 758		
	interviews with staff, Pharmacy Consultant, and						
		facility failed to assess			A total of 6 Abnormal Involuntary		
	residents on antipsyc				Movement Scales (AIMS) were not up	to	
	abnormal involuntary				date at the time of survey and a total of		
		¹ 29, #31, #41, and #43),			residents did not have target behaviors		
	,	et behavioral symptoms and			identified at the time of survey.		
		ptoms (Residents #18 and			Adjustments were made for those		
		te residents on psychotropic			residents found to have been affected by	οv	
	medications for gradu				the deficient practice as follows;1		
		ailed to ensure PRN (as			Resident #29 s antipsychotic medicati	on	
	, ,	medications were time			was discontinued on 2/27/21, so theref		
		esident #40). This was for 7			an Abnormal Involuntary Movement Sc		
	,	medications were reviewed.			(AIMS) assessment is not required at the		
					time.		
	The findings included	:			2- a) The licensed nurse completed a	an	
	-				AIMS assessment for Resident #41 on		
	1. Resident #29 was	admitted to the facility on			3/10/21.		
	11/2/16 with multiple	diagnoses that included			b) The licensed nurse discontinued the		
	schizophrenia and de	ementia without behavioral			duplicate Ultram order on 3/10/21.		
	disturbance.				3- The licensed nurse received a		
					physician order on 3/10/21, to disconting	nue	
	An Abnormal Involunt	tary Movement Scale (AIMS)			the Ativan order for Resident #40.		
	assessment was com				4-The physician did not initiate a Gradu	ıal	
		score of 0 (no involuntary			Dose Reduction (GDR) of Resident		
	movements identified				#18□s antidepressant at this time, due	to	
					residents current health condition. The		
	A physician 's order of	dated 4/5/20 indicated			behavior monitor was updated on 3/19/		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345177	B. WING			03/	11/2021	
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F 758	Continued From pag		F	758				
	(mg) once daily for R	Seroquel (antipsychotic medication) 50 milligrams (mg) once daily for Resident #29.		to monitor for signs of depression. 5- The licensed nurse completed an AIMS assessment for Resident #43 on 3/10/2				
The quarterly Minimum Data Set (Nassessment dated 1/8/21 indicated was rarely/never understood. She with no behavioral symptoms, but h		/8/21 indicated Resident #29 lerstood. She was assessed			The Behavior monitor was updated to include target behaviors on 3/21/21. The physician did not initiate a GDR at this time, due to risks vs benefit related to the state of th			
	care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days.				residents diagnosis. 6- a) The licensed nurse completed a AIM assessment for Resident #3 on			
	A physician 's order dated 1/15/21 indicated Resident #29 had a GDR of Seroquel decreasing the dose from 50 mg once daily to 25 mg once daily. The quarterly MDS assessment dated 2/16/21 indicated Resident #29 's cognition was severely impaired. She had no behavioral symptoms, but she had rejected care on 1 to 3 days during the MDS review period. Resident #29 was				3/10/21. b) Sertraline and Hydroxyzine had diagnosis included with the original ord for Resident #3 but was not pulling ove the EMAR. The licensed nurse update	er to ed		
					the orders on 3/25/21 and the diagnosi are showing on the Resident #3□s EM. 8- The licensed nurse completed a AIMs assessment for Resident #31 on 3/10/21.	AR.		
	administered routine 7 of 7 days. A physician 's order Resident #29 's Ser			Address how the facility will identify oth residents having the potential to be affected by the same deficient practice Current facility residents have the potential to be affected by the alleged				
	A review of the Medication Administration Records (MARs) from 12/2/19 through 2/27/21 indicated Resident #29 was administered Seroquel daily as ordered.				deficient practice of failure to assess residents on antipsychotic medication f abnormal involuntary movement disorders, identify target behaviors and			
	A review of the hard Record (EMR) from revealed an AIMS as involuntary movemen	copy and Electronic Medical 1/1/20 through 3/8/21 ssessment or any other nt assessment had not been ent #29 since 12/1/19.			monitor those symptoms, ensure PRN psychotropic medications are time limit in duration, evaluate residents on psychotropic medications for gradual d reduction and act upon pharmacy recommendations.	ed		
	An observation was	conducted of Resident #29			The Director of Nursing (DON) and Assistant Director of Nursing (ADON)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C /11/2021	
NAME OF PR	ROVIDER OR SUPPLIER	_ I	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2021	
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From pag	ge 75	F 7	758				
	on 3/8/21 at 12:30 P				completed an audit on 3/10/21, of curr	ent		
	involuntary moveme				facility residents with orders for	One		
	involuntary moveme	The objectives.			antipsychotic medications to validate the	nat		
	An interview was co	nducted with the Director of			an AIMs had been completed within the			
		/10/21 at 1:20 PM. She			last 6 months. All AIMs assessments			
	- , ,	y 's normal process was to			were up to date by 3/10/21.			
		essments on admission and			On 3/21/21, the DON and ADON			
	then every 6 months thereafter for residents on				completed updating behavior monitors	to		
	antipsychotic medication. The assessments were				include target behaviors for residents t			
	completed in the EM	IR under the assessment			receive psychoactive medications. 9			
	section. She indicat	ted the AIMS assessments			residents were identified as not having			
	were completed by t	he admission nurse on			target behaviors.			
	admission and then	by the floor nurses every 6			On 3/10/21 the DON and ADON			
	months with coincidi	ing dates of the MDS			completed an audit of PRN psychoacti	/e		
		DON explained that the MDS			medications to assure there are stop			
	-	#1 and MDS Nurse #2) put			dates and reassessment of use. 3			
		OS assessments that were			residents were identified as not having			
		this was used to inform the			stop dates.			
		an AIMS assessment was			On 3/9/21, the pharmacist completed a	n		
		nt AIMS assessment for			audit of current facility residents that			
		12/1/19 was reviewed with			receive psychotropic medications and			
		confirmed there were no			made recommendations for 3 residents	s to		
		completed after 12/1/19 for			have gradual dose reductions.			
		revealed she was not aware			On 3/25/21, the DON completed			
		assessments not being			pharmacy recommendations that were			
		nonths. She indicated there			received for February and March 2021			
		rith the facility 's protocol for assessments as Resident						
		d 2 AIMS assessments			Address what measures will be put into			
	completed since 12/				place or systemic changes made to	,		
	outipleted silie 12/	1/ 10.			ensure that the deficient practice will no	nt .		
	An interview was co	nducted with MDS Nurse #2			recur;	J.		
		M. She was asked what			When a resident has a physician order	for		
		to let staff know when an			an antipsychotic medication, the licens			
		as due. She stated that she			nurse will complete an AIMs assessme			
		completed no tasks related to			Physicians orders and including new			
		nts. She reported that each			admissions will be reviewed daily at			
	month a calendar wi	·			morning clinical meeting The assessm	ent		
		ere due was given to Unit			will be updated at least every 6 months			

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 / 11/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 03	/ 1 1/202 1	
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F 758	Continued From p	page 76	F 7	758				
	_	Unit Manager #2. MDS Nurse this calendar had not included			with Minimum Data Set (MDS) Nurse tracking and scheduling AIMS.			
	any information o due.			The licensed nurse will implement a				
					behavior monitor in the electronic med	lical		
	An interview was	conducted with MDS Nurse #1			record to include resident targeted			
	on 3/10/21 at 2:30			behaviors and side effect monitoring e	very			
	Nurse #2 's inter			shift.				
	involvement with			When a PRN psychoactive medication				
		dar they give to the Unit			ordered, the order will include a 14 da	•		
	_	t included any information on			time limit, and the physician will reass	ess		
	what AIMS asses	sments were due.			for continued use.			
	A				The pharmacist will complete monthly			
		was conducted with the ltant on 3/10/21 at 3:25 PM.			audits of resident medication and will	on		
	· ·	er expectation for the completion			make recommendations to the physici regarding gradual dosage reduction.			
		ents was on initiation of an			pharmacist will validate monthly if a G			
		dication and every 6 months			was completed and if not, will follow u			
		harmacy Consultant explained			with the DON and physician to assure			
		ant to complete routine AIMS			proper documentation is completed to			
		antipsychotic medications due to			support.			
		effects of the medications.			When the DON receives the Pharmac	y		
					recommendations monthly, she will			
	During a follow up	interview with the DON on			provide copies to the physician and			
		M she revealed that the MDS			nurses for follow up of recommendation	ns.		
		ware that they were responsible			A copy of the recommendations will be			
		oor nurses when AIMS			kept in a folder and the DON will moni	tor		
		e due. She indicated it was her			and validate follow through of			
		AIMS assessments be			recommendations within 30 days of			
		residents on antipsychotic			receipt of recommendations.			
		dmission and every 6 months			The Regional Director of Clinical Serv	ices		
		urther indicated that she			provided education to the DON on			
	•	S Nurses to notify the floor AIMS assessments were due			3/10/21, regarding drug regimen revie			
		es were then to complete an			psychoactive med monitoring, behavior and side effect monitoring, GDR processing and side effect monitoring.			
	AIMS assessmen	·			time limit for psychoactive medications			
	Auno assessilleli	till tile Livii t.			and process for pharmacy	,		
					recommendation follow through.			
					The DON provided education to the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER		 	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	111/2021
TO WILL OF T	NOVIBER OR COLL FEEL				5 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST	REHAB & LIVING CENTER			NEHURST, NC 28374		
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(X4) ID PREFIX TAG	(EACH DEFICI	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From p	age 77	F 7	758			
	2. Resident #41 w	as admitted to the facility on			physician on 3/25/21, regarding drug		
		noses that included			regimen review, psychoactive med		
	schizophrenia.				monitoring, behavior and side effect		
					monitoring, and process/documentatio	n	
	A physician 's ord			regarding gradual dose reductions of			
		Aripiprazole (antipsychotic medication) 15			psychoactive medication and time limit	for	
	milligrams (mg) or			psychoactive medications.			
					The Pharmacy manager provided		
		luntary Movement Scale (AIMS)			education on 3/24/21, for the pharmaci		
		completed on 1/28/20 for			regarding regulations related to AIM a		
	Resident #41 with	a score of 1.0.			monitoring, GDR process and documentation requirements, time limit	for	
	The quarterly Mini	mum Data Set (MDS)			PRN psychoactive medications and fol		
		I 1/14/21 indicated Resident			up for recommendations that are given		
		vas moderately impaired. She			the facility.		
	_	n no behavioral symptoms, but			,		
		on 1 to 3 days during the MDS					
	review period. Re	sident #41 was administered					
	routine antipsycho	tic medication on 7 of 7 days.			Indicate how the facility plans to monitor	or	
					its performance to make sure that		
		ent #41 's current physician 's			solutions are sustained;	_	
		ndicated the 4/10/19 order for			The DON and/or the ADON will monito	r 5	
	Aripiprazole 15 mg	g remained an active order.			x week for 4 weeks then weekly for 2		
	A ravious of the Me	edication Administration			months, residents with new orders for psychoactive medications to assure Al	Ma	
		rom 1/29/20 through 3/8/21			has been completed when medication	VIS	
		t #41 was administered			initiated, Behavior monitor with target		
	Aripiprazole daily				behavior and side effect monitoring		
	7	a			initiated, PRN psychoactive medication	1	
	A review of the ha	rd copy and Electronic Medical			has a stop date of 14 days.		
	Record (EMR) from	m 1/29/20 through 3/8/21			The Administrator will audit completion	of	
		assessment or any other			pharmacy recommendations monthly f	or 3	
		nent assessment had not been			months, to validate that pharmacy		
	completed for Res	sident #41 since 1/28/20.			recommendations, to include GDR□s	•	
					have been completed within 30 days o	f	
		as conducted on Resident #41			receipt of recommendations.		
		5 AM. There were no			The Administrator and DON will review		
	involuntary moven	nents observed.			audits to identify patterns/trends and w adjust the plan to maintain compliance		
	1		1	- 1	aujust the plan to maintain compliance		1

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	
NAME OF D	DOVIDED OD CUDDUED	040177	1	CTDEET ADDRESS SITY STATE 3		3/11/2021	
NAIVIE OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	LIP CODE		
THE GREI	ENS AT PINEHURST	REHAB & LIVING CENTER		205 RATTLESNAKE TRAIL			
				PINEHURST, NC 28374			
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F 758	Continued From p	age 78	F 7	758			
F 730	An interview was on Nursing (DON) on that the facility 's complete AIMS as then every 6 montantipsychotic med completed in the Esection. She indictivere completed by admission and the months with coincassessments. The Nurses (MDS Nurses (MDS Nurses (MDS Nurses (MDS Nurses) (MDS Nurses) (MDS Nurses) (MDS Nurses) (MDS Nurses) (MDS assessment) (MDS assessment) (MDS assessment) (MDS assessment) (MDS Nurse) (MDS Nur	conducted with the Director of 3/10/21 at 1:20 PM. She stated normal process was to sessments on admission and the thereafter for residents on ication. The assessments were EMR under the assessment sated the AIMS assessments by the admission nurse on the by the floor nurses every 6 adding dates of the MDS as PON explained that the MDS as #1 and MDS Nurse #2) put MDS assessments that were not this was used to inform the en an AIMS assessment for ad 1/28/20 was reviewed with DN confirmed there were not so completed after 1/28/20 for the revealed she was not aware MS assessments not being a months. She indicated there with the facility 's protocol for S assessments as Resident and 2 AIMS assessments		The Administrator and I plan during the monthly and the audits will conti discretion of the QAPI of Indicate dates when conbe completed; 4/8/21	QAPI meeting nue at the committee.		
	#2 indicated that the	Jnit Manager #2. MDS Nurse his calendar had not included n what AIMS assessments were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 03/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	0071112021
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F 758	on 3/10/21 at 2:30 Nurse #2 's intervision involvement with the monthly calend Managers had not what AIMS assession. During a follow up 3/10/21 at 3:55 PM Nurses were unawfor notifying the floor assessments were expectation that All completed for all remedications on adrithereafter. She fur expected the MDS nurses when the AIMS in the second	onducted with MDS Nurse #1 PM. She confirmed MDS ew that indicated they had no he AIMS assessments and that har they give to the Unit hincluded any information on hents were due. Interview with the DON on he revealed that the MDS hare that they were responsible for nurses when AIMS hare that they were responsible hor nurses when AIMS hare that they were responsible hor nurses when AIMS he indicated it was her has assessments be his idents on antipsychotic his indicated that she hurses to notify the floor has assessments were due his were then to complete an	F 7:	58		
	11/14/19 and most with multiple diagnost Disease. A physician 's order 1/8/21 indicated shocare. A physician 's order care.	as admitted to the facility on recently readmitted on 1/7/21 oses that included Alzheimer ' er for Resident #40 dated e was admitted to hospice er for Resident #40 dated				
	0.5 milligram (mg)	van (antianxiety medication) every 1 hour as needed Ativan physician ' s order had				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		00/11/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 758	The significant char assessment dated #40 's cognition wa noted with a progno was on hospice. Reantianxiety medicate period. The March 2021 at Resident #40 were revealed the 1/8/21 order continued to be A review of the Med Records (MARs) from Resident #40 indicated administered. An interview was considered at 11:30 AM Resident #40 initiated that was entered intreviewed. She was the regulations related to medications applied. An interview was considered that she was regulation related to medications applied.	order was entered into the Record (EMR) by Nurse #6. Inge Minimum Data Set (MDS) 1/13/21 indicated Resident as severely impaired. She was usis of less than 6 months and resident #40 had received no ion during the MDS review 1/10 tive physician 's orders for reviewed on 3/9/21 and PRN Ativan physician 's or active. Ilication Administration of 1/8/21 through 3/9/21 for ated no PRN Ativan had been 1/8/21 with no stop date to the EMR by Nurse #6 was asked if she was aware of ted to PRN psychotropic ime limited in duration. She was not aware that this of PRN psychotropic if to antianxiety medication.	F	758			
	stated she was awa required all PRN ps time limited in durat this regulation appli	8/10/21 at 1:20 PM. The DON are of the regulation that ychotropic medications to be ion, but she had not realized ed to residents on hospice. was her expectation for the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345177	B. WING_		C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03/11/2021
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F 758	Medical Director on a stated he was aware PRN Ativan and other medications were reduration for all reside hospice. The PRN A initiated on 1/8/21 the reviewed with the Methat not including a sindicated he had been psychotropic medical.	as conducted with the 8/10/21 at 3:45 PM. He that physician 's orders for PRN psychotropic quired to be time limited in ents including those on ativan order for Resident #40 at included no stop date was edical Director. He revealed top date was an error. He	F 75	58	
	Review of Resident a 4/4/19 read Cymbalt release particles 30 for depression. Review of Resident a 4/15/19 read monitoring yes or no. If behavior in the medical record not include any targe monitoring. Resident #18's Minimindicated she was cono behaviors. She wantidepressant.	s admitted on 4/2/18 with a ion. #18's Physician order dated a (antidepressant) delayed milligrams every afternoon #18's Physician order dated for behaviors and indicated rs present, please document a every shift. The order dideted behaviors for staff to be num Data Set dated 1/15/21 ognitively intact and exhibited as coded for the use of an ed care plan dated 2/8/21			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	1 00	11/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page 82		F 75	58			
	history of depressic plan dated 2/14/21 risk for adverse effe medication for depression. Review of the Constelehealth medication #18 indicated the for 4/23/20-no recommend	sultant Pharmacist monthly on review notes for Resident ollowing: nendations					
	the need for lab wo 6/10/20-recommen the continued use of 7/8/20-no recommen the need for lab wo 9/1/20-no recommen 10/2/20-no recommen 12/2/20-no recommen 12/2/20-recommen	dation completed regarding of an anti-inflammatory endation endation completed regarding ork endation nendation dendation dation for a gradual dose Melatonin (hormone)					
2/5/21- need fo 3/8/21-	2/5/21- recommend need for lab work 3/8/21-no recomme	dation completed regarding the endation					
	1/1/21 to present didocumentation of b	•					
	present indicated s ordered and no bel	t #18's medication rds (MARs) from 1/1/21 to he received her Cymbalta as naviors exhibited. The MAR did d behaviors for staff were to					
	Review of Resident	t #18's psychiatric telehealth					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
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F 758	reported a stable more concerns. No GDR decompensation. Be clinical indication for medications. 11/13/20-Conversat and endorsed a state recommended due to Benefits outweigh rifor any GDR of psycolonic process. In an observation are 2:17 PM, Resident and engaging. She sadness, isolation, conjoyed being in a rehave some privacy. In an interview on 3 stated Resident #18	following: irits, denies depression and bod. Staff reported no recommended due to risk of enefits outweigh risk and no rany GDR of psychiatric ional, appeared at baseline ble mood. No GDR to risk of decompensation. sk and no clinical indication chiatric medications. Ind interview on 03/08/21 at #18 appeared in good spirits reported no feelings of or boredom. She stated she boom but herself so she could	F	758			
	enjoyed having a ro isolation. Nurse #7 s any evidence of sad He stated the nurse her behaviors on ev there was no specific staff to look for but a withdrawal, loss of a personal hygiene. In an interview on 3. Director of Nursing of #18's medical record behaviors. She state electronic medical records.	f depression. He stated she om to herself while in stated he had not observed iness such as crying or worry. It is documented yes or no for ery shift. Nurse #7 stated to behaviors identified for the assumed it would be crying, appetite or lack of attention to (10/21 at 11:53 AM, the (DON) confirmed Resident to did not identify targeted ed it was an issue with the ecord when entering any pics and the facility was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED				
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F 758	Manager (UM) #1 stapsychotropics should behaviors for the staresident. He stated welectronic medical readd specific target be program populated a behaviors. UM #1 stabehaviors listed for Fix knew what to look for has had a difficult 6 in normally a very social stated she had been COVID-19. In an interview on 3/stated the Consultant medication reviews in a pharmacy report experience was Director at each nurse the Medical Director times per week. He was Director at each nurse the Medical Director times per week. He words orders if needed recommendations the back in a folder for find Medical Director did recommendation, he the recommendation to be filed. The DON facility identified the targeted behaviors.	to it. 10/21 at 1:00 PM, Unit lated all residents on a have identified target ff to look for specific to each when an order was put in the cord, there was no place to ehaviors but rather the a generic order to observe for lated there should be targeted desident #18, so the staff r. He stated Resident #18 months because she was all person before COVID. He in isolation twice for 10/21 at 1:20 PM, the DON the Pharmacist completed her latent month. Once she latent month. Once she latent month in the model of the facility several went through the folders and latent month on the latent month on the latent month of the month o	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	HAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			,	
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F 758	Continued From pag		F 7	758			
	Nurse #2 stated she completed no tasks assessments. She it						
	Nurse #1 confirmed that indicated they w AIMS assessments they gave to the UM	10/21 at 2:30 PM, MDS MDS Nurse #2's interview vere not involved with the and that the monthly calendar 's did not included any AIMS assessments were					
	the Consultant Phar the facility in May 20 during Resident #18 review that a GDR h 2019 on Resident #2 She stated since she 2020 and due to CO address the Cymbal The Consultant Pha for an antidepressar in the first year and stated she was unaw behaviors with the u	riew on 3/10/21 at 3:20 PM, macist stated she started at 1/20. She stated she noted 1/20. She stated she noted 1/20 medication and not been done since April 1/20 medication 1					
	the Medical Director GDRs personally un antipsychotic. He sta difficult year becaus positive twice and ha	riew on 3/10/21 at 3:45 PM, stated he handled all the less the medication was an ated Resident #18 has had a e she tested COVID-19 as had to isolate twice. The ted he would not recommend					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		•		
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F 758	normalize. He state behaviors to be ide behaviors to look for In an interview on 3 stated it was her exidentified the lack of documentation and recommendation re #18's antidepressa documented rations In a telephone inter the Psychiatric Nur not received any G facility regarding Re Cymbalta. She stat that the Medical Dir recommended GDI specific documenta contraindicated and the facility was too specific to Residen 5. Resident #43 was cumulative diagnose	depressant until things and he expected targeted intified so the staff knew what or and document. 8/10/21 at 5:00 PM, the DON expectation that the facility of targeted behavior didentify the need for a regarding a GDR of Resident intition unless contraindicated with ale. Proview on 3/11/21 at 1:40 PM, see Practitioner stated she has DR recommendations from the resident #18's prescribed and the facility informed her rector preferred to address all Rs. She stated there should be atton as to why a GDR was at the behaviors monitoring by vague and needed to be to the standard on 12/12/18 with sees for Cerebral Vascular	F 7:	,			
	Review of Resident included an order of Extended Release bedtime for Paranci included was an ormonitor and indicat occurred on every	t #43's Physician orders lated 4/15/19 for Seroquel 24 hour 50 milligrams at id Schizophrenia. Also der dated 2/5/20 for staff to the yes or no if behaviors shift. If yes, please record -pharmacological interventions					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345177	B. WING _			03/	11/2021
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F 758	Continued From page	e 87	F 7	758			
	in the medical record						
	(MDS) dated 1/18/21 cognitively intact and	erly Minimum Data Set indicated Resident #43 was exhibited rejection of care coded for the use of an					
	read she was at risk the use of antipsychological Schizophrenia and Bincluded the completion Involuntary Movement	ipolar Disorder. Interventions					
	Review of Resident # indicated the last AIM 1/29/20.						
	telehealth medication #43 indicated the follo 4/23/20-no recomme 5/12/20-no recomme	ndations ndations ed pain monitoring and ngular dations dations dations ndations ndations ndations dations dations dations dations dations dations dations					
	Review of Resident # notes indicated the fo	43's psychiatry telehealth ollowing:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODI 205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
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F 758	decompensation. Be clinical indication for medications. 6/3/20-Pleasant and thoughts, hallucinary none. Current regimedication adjustment of decompensation no clinical indication medications. 9/11/20-Reported in friends to talk too-romaking symptoms of emotions, gets upsure recommendations of Benefits outweight in risk of decompensation in machinary GDR of psy improvements in more sult in risk of decompensation. Benefits outweight in for any GDR of psy 2/26/21-No GDR redecompensation. Be clinical indication for medications. Review of Resident 1/1/21 to present in regarding the refus 1/18/21 and a refuse Review of Resident Review of Review of Resident Review of Review of Review of Review of Review of Review of Review Review of Review of Review of Review of Review of Review of Revie	ecommended due to risk of enefits outweigh risk and no or any GDR of psychiatric differently-no delusional cions, and mania. Staff report me recommended. No ent recommended due to risk and the for any GDR of psychiatric opprivacy, stressful, wanting exported isolation and lonely worse. Staff report occasional et easily-no new due to risk of decompensation. isk and no clinical indication chiatric medications. Reported ood and coping. GDR would empensation. No GDR to risk of decompensation. isk and no clinical indication chiatric medications. Reported ood and coping in GDR would empensation of the risk of decompensation. In the risk of decompensation chiatric medications. Reported one clinical indication chiatric medications and clinical indication chiatric medications. Reported one clinical indication chiatric medications and clinical indication chiatric medication chiatric medic	F 7	58			
	ordered and no bel	he received her Seroquel as naviors exhibited. The MAR did I behaviors for staff were to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 89	F 75	58		
	10:51 AM, Residen appeared pleasant, There was no evide reported her only coshowers.	and interview on 3/8/21 at t #43 was in bed. She cooperative, and engaging. ence of psychosis. She oncern was regarding her				
	8:20 AM, Resident appeared pleasant, There was no evide	#43 was again in bed. She cooperative, and engaging. ence of psychosis. She stated and reported no concerns.				
	stated the MAR did behaviors to docum Resident #43 exhib and verbal behavio understanding that	i/10/21 at 8:30 AM, Nurse #1 not specify any target nent in the medical record but ited agitation, short temper rs. Nurse #1 stated it was her the MDS Nurse or the Unit ed the AIMs assessments.				
	Director of Nursing #43 medical record behaviors. She stat electronic medical r	b/10/21 at 11:53 AM, the (DON) confirmed Resident did not identify targeted ed it was an issue with the eccord when entering any pics and the facility was fix it.				
	stated either floor n #43's AIMS every 6 previous MDS Nurs MDS assessments be completed and t left in December 20 MDS Nurses did no	w/10/21 at 1:00 PM, UM #1 urses completed Resident months. He stated the lie would give the UM's a list of due and if an AIMS needed to hat the previous MDS Nurse 120. He stated the current of specify it on the list. He ronic medical record set up				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		345177	B. WING		C 03/11/2021	
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	OULD BE COMPLETION	
F 758	#1 stated the medical targeted behaviors for the use of an antipsy order for any psychological periodical responsibility of the use of an antipsy order for any psychological responsibility of the use of an AIMS, target and the edge of the was contraindicated. In an interview on 3/Nurse #2 stated she completed no tasks assessments. She is calendar with all the given to the UM's. In an interview on 3/Nurse #1 confirmed that indicated they we AIMS assessments they gave to the UM information on what due. In an interview on 3/Director of Nursing (Pharmacist complete remotely and would each month. Once some recommendations, some Medical Director to a for the Medical Director the Medical Director the Medical Director the	when an AIMS was due. UM al record should specify or Resident #43 to support ychotic. He stated when an stropics was entered into the ecord, a generic template es or no responses. UM #1 set behaviors for the use of an ecumentation regarding the eneed for a GDR unless it	F 7:	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 03/11/2021	
	ROVIDER OR SUPPLIER	REHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	DON stated if the with a recommend rationale on the rein the folder to be expected the Conrecommendations regarding gradual missing targeted to AIMS. She stated were addressed in DON stated the AIMS and every 6 month nurse did the base then the MDS Nursessments due completed the AIM not have any autonurses that an AIM was unaware that assessment was identified the need Resident #43, ide Seroquel been ad #43 targeted behave antipsychotic. In a telephone into the Consultant Phen the facility in May expectation of an admission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need was not aware whin the electronic mission and evistated she did not record for the need the electronic mission and evistated she did not record for the need the electronic mission and evistated she did not record for the need the electronic mission and evistated she did not record for the need the electronic mission and evistated she did not record for the need the electronic mission and evistated she did not	page 91 back in a folder for filing. The Medical Director did not agree dation, he would write the ecommendation and put it back filed. The DON stated she sultant Pharmacist to make for the Medical Director dose reductions (GDRs), behaviors and need for an any nursing recommendations in the morning meetings. The IMS protocol was on admission the thereafter. The admitted eline AIMS on admission and rese put out a list of MDS and the nurses on the unit MS. She said the system does smatic prompts to alert the MS is due. The DON stated she Resident #43's last AIMS completed on 1/29/20 and was AIMS were not being done. The sher expectation that the facility differ an AIMS assessment on intified the need for a GDR in dressed and identified Resident aviors for the use of an activities of an AIMS assessment on the review of an AIMS assessment on the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the review Resident #43' medical dof an AIMS assessment and the started at the facility in	F	758			

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 03/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		•	
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F 758	been addressed sir had planned to add in April 2021. She is need for targeted b psychotropics but k adverse side effects. In a telephone inter the Medical Director GDRs personally us antipsychotic then his stated Resident #43 hallucinations and value and talk to people with Director stated her recommendations in Resident #43's Senthe need for identified behaviors. In an interview on 3 stated it was her exidentified the lack of documentation, ide recommendation re #43's antipsychotic documented rational every 6 months. Showith the facility's province AIMS. In a telephone interthe Psychiatric Nurselector and some properties of the proposition of the psychiatric Nurselector in the psychiatric Nurselector	d no GDR on Seroquel had nce 4/2019. She stated she ress Resident #43's Seroquel stated she was unaware of the ehaviors with the use of new the facility looked for s. View on 3/10/21 at 3:45 PM, r stated he handled all the nless the medication was an ne differed to Psychiatry. He as experienced auditory, visual was known to often yell out who weren't there. The Medical nad not received any rom the facility regarding oquel, the need for an AIMS or cation of specific targeted	F 7	758		
	Seroquel. She state	esident #43' prescribed ed the facility informed her that r preferred to address all Rs and it was her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			1	C 11/2021	
	ROVIDER OR SUPPLIER ENS AT PINEHURST RE	HAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		AKE TRAIL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 758	due to Resident #43' Schizophrenia. She sidentified the need for to why a GDR was can AIMS assessmen behavior monitoring and needed to be sp 6. Resident #3 was 11/20/20 with multiple schizophrenia. The (MDS) assessment of Resident #3 had seven he had received an assessment period. Resident #3 had a defor Risperdal (an ant milligrams (mgs.) by disorder and on 1/27 bedtime for schizophrenia for schizophrenia (AIMS) test or System Condensed not completed since psychotropic drug according to the complete of	GDR could not be attempted is diagnosis of stated the facility should have or specific documentation as contraindicated, the need for it and identified that the by the facility was too vague ecific to Resident #43. admitted to the facility on e diagnoses including quarterly Minimum data Set dated 2/25/21 indicated that ere cognitive impairment and antipsychotic drug during the coctor's order dated 11/21/20 ipsychotic drug) 0.5 mouth daily for bipolar 1/21 for Risperdal 1 mgs at arenia. #3's medical records common linvoluntary Movement Dyskinesia Identification User Scale (DISCUS) was admission to monitor for the	F	758				

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 03/11/2021	
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	On 3/10/55 at 3:55 conducted with the residents on antipsy AIMS test or DISCU and then every 6 m. Resident #3 did not DISCUS completed that the MDS Nurse floor nurses when A admission Nurse wa AIMS test on admis antipsychotic drug. 7) Resident #31 wa 5/22/20 with diagno dementia with beha schizophrenia. An Abnormal Involu assessment was concesident #31. The quarterly Minimassessment dated #31's cognition was had received an antidays during the MD. A review of the currindicated an order frantipsychotic medical aday, had remained admission date of 5. A review of the hard record from 5/22/20 assessment or any	completing the AIMS test. PM, a follow up interview was DON. The DON stated that vehotic drug should have an IS completed on admission on this. She verified that have an AIMS test nor on admission. She explained is were supposed to notify the IMS test was due and the as supposed to complete an ision for residents on admitted to the facility on ses that included vascular vior disturbance and Intary Movement Scale (AIMS) impleted on 5/22/20 for for the IMS and she in the importance in the impo	F 7	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 758	#31 since 5/22/20. During an interview of (DON) on 3/10/21 at facility's normal proced. AIMS assessment or months for residents medications. She inconsessment was consurse at the time of a floor nurses every 6 of the MDS assessments due eatto inform the floor nurses expected in the electron of the MDS Nurses put assessment was due completed in the electron of the MDS assessment was due completed in the electron of the MDS assessment was due completed in the electron of the MDS assessment of the Unit Managers calendar had not included with MDS assessments as and MDS Nurse #2 halms assessments approvided to the Unit Managers of the MDS assessments as a provided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit Managers of the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit Managers of the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #2 halms assessments approvided to the Unit MDS and MDS Nurse #4 halms assessments approvided to the Unit MDS and MDS Nurse #4	with the Director of Nursing 1:20 PM, she stated the ess was to complete an admission and then every 6 on antipsychotic licated the initial AIMS appleted by the admitting admission and then by the months with coinciding dates ent. The DON further stated out a calendar of MDS ch month and this was used rses when an AIMS e. The assessments were ctronic medical record (EMR) and with MDS Nurse #2 on She stated she and MDS no tasks related to the AIMS ch month a calendar with all tts that were due were given she must be she and mode of the stated any information on ents were due.	F	758		
	Pharmacy Consultan	as completed with the it on 3/10/21 at 3:25 PM. She ectation for the completion of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		
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	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		00/11/2021
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F 758	AIMS assessments o antipsychotic medica months. The Pharma was important to com assessments for antip	n initiation of an tion and then every 6 cy Consultant explained it	F 7	58		
F 803 SS=D	On 3/10/21 at 4:56 Pl had reviewed Reside electronic medical rec was no AIMS assessing 5/22/20. The DON ex of the issue of AIMS acompleted every 6 method MDS Nurses were responsible for notify AIMS assessment was her expectation from the MDS Nurses to man AIMS assessment murses to complete the MDS Nurses to man AIMS assessment nurses to complete the EMR. Menus Meet Resident CFR(s): 483.60(c)(1)- §483.60(c) Menus and Menus must-	pressed she was not aware assessments not being onths. She further stated e unaware they were ng the floor nurses when an as due. The DON stated it for AIMS assessments to be ion and every 6 months for ntipsychotic medications, for otify the floor nurses when was due and for the floor ne AIMS assessment in the total Nds/Prep in Adv/Followed (7) In diffusional adequacy. The nutritional needs of the stablished national coared in advance;	F 8	03		4/8/21

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
	345177	B. WING _		03/11/2021
			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	03/11/2021
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Continued From pag	e 97	F 8	03	
reasonable efforts, the thnic needs of the rinput received from rigroups; §483.60(c)(5) Be upple \$483.60(c)(6) Be reduction of the reduction	the religious, cultural and resident population, as well as residents and resident dated periodically; riewed by the facility's fically qualified nutrition tional adequacy; and resident's right to make resident and staff failed to serve the menu as residents observed during 1, #10 & # 66). The facility rently serve the menu as alert and oriented residents Resident Council meeting 12, #13, #19, #23, #25, #38, and #55).		#25, #38, #39, #47, #50, #53, and a were identified as being affected by deficient practice and voiced that the menu specified is not what is served All residents have the potential to be affected by the deficient practice. On 3/17/21 Ellen Kindred, R.D. edu the Dietary Manager on food ordering and all dietary personnel including the Dietary Manager on adhering to the posted menu. The Dietary Manager review daily the menu for the follow and every Thursday for the weeken insure that the menu items are avail Should changes need to be made, to	#55 the e d. e cated ng, he will ing day d to lable.
Resident #1 had a d	octor's order for regular diet.		substitutions are of equal nutritional	
	SUMMARY S (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR S483.60(c)(4) Reflect reasonable efforts, the ethnic needs of the rinput received from regroups; §483.60(c)(5) Be upon s483.60(c)(6) Be revidentian or other climit professional for nutrice services of an and Registered Dietrices of and Registered Dietrices of an and Registered Dietrices of an and Registered Dietrices of an an antendance at the services of an attendance at the (Residents #1, #2, #139, #47, #50, #53, and Findings included: 1. Resident #1 was an an antendance of the companion of t	CORRECTION JA5177 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 97 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on review of facility's menu, observation and Registered Dietician (RD), resident and staff interview, the facility failed to serve the menu as planned for 3 of 3 residents observed during dining (Residents # 1, # 10 & # 66). The facility also failed to consistently serve the menu as planned for 13 of 13 alert and oriented residents in attendance at the Resident Council meeting (Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55).	A BUILDIN 345177 B. WING 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 97 \$483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; \$483.60(c)(5) Be updated periodically; \$483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and \$483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on review of facility's menu, observation and Registered Dietician (RD), resident and staff interview, the facility failed to serve the menu as planned for 3 of 3 residents observed during dining (Residents # 1, #10 & # 66). The facility also failed to consistently serve the menu as planned for 13 of 13 alert and oriented residents in attendance at the Resident Council meeting (Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55). Findings included: 1. Resident #1 was admitted to the facility on 8/9/19 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated that Resident #1 had moderate cognitive impairment.	A BUILDING 345177 ROVIDER OR SUPPLIER ENS AT PINEHURST REHAB & LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 97 \$483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; \$483.60(c)(5) Be updated periodically; \$483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on review of facility's menu, observation and Registered Dietician (RD), resident and staff interview, the facility failed to serve the menu as planned for 3 of 3 residents observed during dining (Residents #1, #10 & # 66). The facility also failed to consistently serve the menu as planned for 13 of 13 alert and oriented residents in attendance at the Resident Council meeting (Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55). Findings included: 1. Resident #1 was admitted to the facility on 8/9/19 with multiple diagnoses including 4 hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated that Resident #1 had moderate cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
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NAIVIE OF PI	ROVIDER OR SUPPLIER				=	
THE GREE	ENS AT PINEHURST R	EHAB & LIVING CENTER		205 RATTLESNAKE TRAIL		
				PINEHURST, NC 28374		
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F 803	Continued From pa	nge 98	F 8	03		
	Review of the ment conducted. The ment grilled chicken breat buttered cabbage. was glazed ham, be greens. Resident #1 was in AM. He stated that of the time. Resided dinner yesterday (3 breast, roasted red cabbage. He report coleslaw and looked. On 3/10/21 at 12:3-conducted. Resided instead of collard general. 2. Resident 366 was 10/9/20 with multip Hypertension. The (MDS) assessment Resident #66's cog Resident #66 had at Review of the ment conducted. The ment grilled chicken breat buttered cabbage.	a for regular diet was enu for 3/9/21 (dinner) was est, roasted red potatoes and The menu for 3/10 (lunch) lack eyed peas, and collard terviewed on 3/10/21 at 10:55 to menu was not followed 50% ent #1 stated that the menu for 8/9/21) listed grilled chicken potatoes, and buttered ted what was served were dike "pot pie". 4 PM, lunch observation was ent #1 was served green beans reens that was listed on the sea admitted to the facility on the diagnoses including a quarterly Minimum Data Set at dated 2/4/21 indicated that enition was intact. a doctor's order for regular diet. but for regular diet was enu for 3/9/21 (dinner) was est, roasted red potatoes and The menu for 3/10 (lunch)	FO	posted on the substitution list residents are made aware of t Dietary Manager will audit the to insure they are the same as menu for 5x/week for 4 weeks 3x/week for 2 months. The Ad will review audits weekly. The Dietary Manager will atter Committee Meetings monthly interview all resident council meritage additional alert and ories residents to insure the meal residents to insure the meal residents to insure the meal residents. The Dietary Manager test trays 3x/week to Director Services to review menu accurongoing basis. The systemic of the Dietary Manager will not be alter the menu without approve Registered Dietician. The Administrator will review the monthly to identify patterns/treadjust the plans necessary to compliance. The Interdisciplinary Team will plan during the monthly QAPI and the audits will continue at discretion of the QAPI commits.	he changes. meal trays sthe posted the posted the posted the the ministrator and the Food and will members the deceived was the will both for 3 r will provide of Nursing racy on an change is the able to al from the the audits the meating the	
	was glazed ham, b greens. Resident #66 was i AM. He stated that	The menu for 3/10 (lunch) lack eyed peas, and collard nterviewed on 3/8/21 at 9:39 t most of the time, the menu as not the menu being served.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			C 03/11/2021
	ROVIDER OR SUPPLIER	EHAB & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374			(A) 11/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 803	observed during lur	nge 99 PM, Resident #66 was nch. He was served green ollard greens that was listed on	F 8	03		
	9/12/17 with multiply hypertension. The	as admitted to the facility on le diagnoses including quarterly Minimum Data Set dated 12/21/20 indicated that nition was intact.				
	Review of the menu for regular diet was conducted. The menu for 3/9/21 (dinner) was grilled chicken breast, roasted red potatoes and buttered cabbage. The menu for 3/10 (lunch) was glazed ham, black eyed peas, and collard greens.					
	Resident #10 had a carbohydrate diet.	a doctor's order for consistent				
	Resident #10 was interviewed on 3/8/21 at 9:42 AM. She stated that the menu that was posted was not the menu being served. She added that this happened frequently.					
	observed during lur	PM, Resident #10 was nch. She was served green ollard greens that was listed on				
	interviewed. She re on the menu was n substitute it with so the menu for 3/10/2 be collard greens b	PM, Dietary Cook #1 was eported that at times the item ot available, so she had to mething. Cook #1 verified that 21 for lunch was supposed to out since it was not available, te it with green beans.				

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		345177	B. WING			C 03/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	•	33/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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 803	interviewed. He starmenu was not being the 3/9/21 dinner me grilled chicken breast buttered cabbage. To potatoes and cabbaghad served coleslaw pot pie instead. On 3/10/21 at 4:35 F (DM) was interviewed new to the facility and manager (started in indicated that he was complained of menu reported that he was in ordering food sup supplies at least a wastill ran out of items had to substitute it. On 3/10/21 at 4:45 F interviewed. She independent of the facility manager. Sino previous experies signed up for the classification of the facility pandemic. She kneed to the facility today (new DM. The RD residue) and the was still to the facility today (new DM. The RD residue) and the was still to the facility today (new DM. The RD residue) and the was still to the facility today (new DM. The RD residue) and the was still to the facility today (new DM. The RD residue).	PM, Dietary Cook #2 was seed that at times the planned followed. He verified that enu was supposed to be st, roasted red potatoes and The chicken breast, red ge were not available, so he representation (prepackaged) and chicken PM, the Dietary Manager dd. He stated that he was dd was new as a dietary January 2021). The DM is aware that residents had not being followed. He is still trying to learn especially polies. He ordered food eek ahead but at times they on the menu so, the cook PM, the Administrator was dicated that she expected the as planned. The that the DM was new as he reported that the DM had noe as DM, but he was	F8	03		

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		03	C 3/11/2021
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		71172021
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 803	sure to order enough regular, renal, and sp she expected at times not frequently. The F might have ran out of census and this impa 4. A review was cond submitted by the Resthrough 3/9/21. A grithe Resident Council were not what was st grievance indicated the and Administrator sporelated to this concern grievance was noted A Resident Council m 3/10/21 at 11:00 AM. oriented residents (R #19, #23, #25, #38, #in attendance. The reconcerns related to the followed. The group per week the menu the matched the food that On 3/10/21 at 12:15 F conducted of the lunca regular diet. The miglazed ham, black ey The meal tray observed follard greens. On 3/10/21 at 1:05 Plinterviewed. She repon the menu was not substitute it with some	advised the DM to make food on the menu for recial diet. She added that is substitution happened but RD stated that the facility food due to the increase in cted the ordering of food. The provided form the prov	F 80	03		

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(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 803	Continued From page be collard greens but	ge 102 ut since it was not available,	F 803	3	
	On 3/10/21 at 4:10 linterviewed. He starmenu was not being. On 3/10/21 at 4:35 line stated that he was a dietary ma 2021). The DM indicresidents had comp followed. He report learn, and this learn food supplies. He or week ahead but at ton the menu so, the	PM, the DM was interviewed. as new to the facility and was anager (started in January cated that he was aware that lained of the menu not being ed that he was still trying to ing process included ordering rdered food supplies at least a imes they still ran out of items a cook had to substitute it.			
	interviewed. She in menu to be followed Administrator added dietary manager. S	I that the DM was new as he reported that the DM had nce as DM, but he was			
	(RD) was interviewed not been to the facil pandemic. She knee DM and he was still to the facility today (new DM. The RD reaware of resident's not being followed. sure to order enoug regular, renal, and she expected that a	AM, the Registered Dietician ed. She stated that she had ity since March 2020 due to ew that the facility had a new learning. She started coming (3/11/21) and would train the eported that she was made concerns that the menu was She advised the DM to make h food on the menu for special diets. She added that t times a substitution would nould not happen frequently.			

		(X3) DATE SURVEY COMPLETED			
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F 803	The RD stated that th	e facility might have ran out rease in census and this	F 8	03	
F 812 SS=D	Food Procurement,St	ore/Prepare/Serve-Sanitary	F 8	12	4/8/21
	§483.60(i) Food safet The facility must -	y requirements.			
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ilations. s not prohibit or prevent roduce grown in facility bmpliance with applicable			
	serve food in accorda standards for food se This REQUIREMENT by: Based on record revi Registered Dietician a facility failed to label a container after openir nutritional supplement	ew, observation and and staff interview, the and date food items in the ag, failed to date thawed ts, and failed to wear hair This is evident in 2 of 2		F812 During the facility annual survey, surveyor observed on 3/10/21, modietary staff without a hair net or be guard and food items without date labels. These food items were distributed as be affected by the deficient practice. All residents have the potential to affected by the deficient practices On 3/17/21 Registered Dietician 6	ale beard es or scarded. eing be

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		1, ,		SURVEY
		345177	B. WING _				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2021
					05 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER					
				r	PINEHURST, NC 28374		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 104	F 8	312			
	part" all foods stored will be covered, labele All perishable prepare within 7 days from proof The facility's policy or reviewed. The policy employees must weat 1. On 3/8/21 at 9:05 Awas conducted. The observed to have a fuwearing a hair net no kitchen. When intervinormally wears a hair when in the kitchen. to the facility and new 2021 and was still lead On 3/10/21 at 9:35 All	n dress code (undated) was read in part" all kitchen r hair and beard nets". AM, initial tour of the kitchen Dietary Manager (DM) was all beard. He was not reard guard while in the iewed, he stated that he reard and a beard guard He added that he was new of as DM, started in January arning. M, a follow up kitchen			all dietary personnel regarding the requirement to wear hair nets and bear guards when in the kitchen and on the facility spolicy and procedure for food storage, labeling and dating. Beard guards/hair nets have been provided for all dietary staff to be worn on duty. The DON will observe that dietary staff are donning hair nets and beard guard 5x/week for 4 weeks; then 3x/week for weeks; then once weekly for 4 weeks. The Dietary Manager will audit the refrigerator/freezer and nourishment rooms for accurate storing, dating and labeling of food to be done 5x/week for weeks; 3x/week for 4 weeks then once weekly for 4 weeks. The Administrator will review the audits monthly to identify patterns/trends and adjust the plan as necessary to maintal compliance.	or s 4	
	observed not wearing interviewed, he stated out of the kitchen and beard guard. 2. On 3/8/21 at 9:10 A observation was conducted: - A 4-quart container, dated 2/26/21. The E and stated that it show opened. The DM ver and stated that it was opening. - A 4-quart container unlabeled. The DM identifications are stated to the time of time of time of the time of	ducted. The DM was again g a beard guard. When d that he had been in and he forgot to put on his AM, walk-in cooler ducted. The following were 1/3 full, unlabeled, and DM identified it as pudding uld have been labeled when ified the pudding as expired a good for 7 days after - 1/3 full - undated and dentified it as apple sauce. uld have been labeled and			The Interdisciplinary Team will review to plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	he	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	good for 7 days after -16 cartons of nutritio undated. DM stated to be dated. The inst "shelf life - 1 year fror state. Once thawed, days".	ated that opened food was opening. nal shakes-thawed and that the shakes did not need ruction on the carton read m production date in frozen refrigerate for up to 14	F 812		
	interviewed. The Adr facility's policy on foo dress code. She indi DM to follow the facili and dress code. She				
F 908 SS=E	(RD) was interviewed not been to the facility the pandemic. She k new DM and he was coming to the facility train the new DM. She the facility's policy on code. Essential Equipment,	M, the Registered Dietician She stated that she had y since March 2020 due to new that the facility had a still learning. She started today (March 11) and would e expected the DM to follow food storage and dress Safe Operating Condition	F 908		4/8/21
	and patient care equi condition. This REQUIREMENT by:	in all mechanical, electrical, pment in safe operating is not met as evidenced ew, observation and staff failed to maintain the		F908 The facility failed to maintain the safe	

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				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST	REHAB & LIVING CENTER		PINEHURST, NC 28374		
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F 908	Continued From p	age 106	F9	08		
	evidenced by the wash temperature of 2 kitchen obser Findings included During the initial to 9:05 AM, the staff dishes using the hard The dish-machine reading "0" degree wash cycle. The dish-machine March 2021 was mand rinse tempera 3/1/21 through 3/9	our of the kitchen on 3/8/21 at were observed washing the high temperature dish-machine. wash temperature gauge was es Fahrenheit (F) during the (high temperature) log for eviewed. There was no wash latures recorded for supper from 6/21. There was no wash ded for breakfast and lunch		operating condition of the discresidents were identified to be the deficient practice. All diece were educated on 3/17/21 the equipment is to be checked to working condition and that an malfunctions shall be reported immediately to the Director of Maintenance. The Director of Maintenance verified on 3/10 water entering the kitchen is 160 degrees. Dietary Aides with the final rinse temperature explored by the final rinse temperature explored and sanitizing does not occur at a dishwasher use will disconting manual dishwashing will occur chemical sanitizer until the discan be repaired. All residents have the potents	pe affected by etary staff lat all for safe my equipment ed of 0/21 that the greater than will verify that exceeds 180 y point 180 degrees, nue and ur with a ishwasher	
	interviewed. He sigauge had not be (3/6/21). On 3/8/21 at 9:08 was interviewed. that the wash tem working since Sat the dietary aides wand at times forgorinse temperature A follow up kitcher 3/10/21 at 9:35 Ar washing the dishedish-machine. The	AM, Dietary Aide (DA) #1 was tated that the wash temperature en working since the weekend AM, the Dietary Manager (DM) He stated that he was aware perature gauge was not urday 3/6/21. He indicated that working in the evening were new it to document the wash and on the log. In observation was conducted on M. The staff were observed is using the high temperature e dish-machine wash reading "0" degrees F during		The temperature log will be r include that manual dishwas of a chemical sanitizer must should dishwasher rinse tem below 180 degrees. The Die will audit all essential dietary for proper working condition one month; 3x/week for one weekly for one month. Audits reviewed weekly by the Adm monthly to identify patterns/tiplan will be adjusted as necemaintain compliance. The IDT will review the plant monthly QAPI meeting and a continue at the discretion of tommittee.	modified to hing with use be initiated peratures fall tary Manager equipment 5x/week for month and s will be inistrator and rends. The essary to during the audits will	

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				20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER	PINEHURST, NC 28374		INEHURST, NC 28374		
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F 908	the wash cycle. On 3/10/21 at 9:38 Al He stated that it was I the Maintenance Dire wash temperature gareported that he just in Director this morning was supposed to com On 3/10/21 at 9:50 Al was interviewed. He informed him this mor dish-machine wash to was reading 0 degree checked the water ter between 160-165 degalready ordered the poon 3/10/21 at 4:45 Pl interviewed. She stat DM to inform the Main immediately when the working. The Administrated	M, the DM was interviewed. his fault, he forgot to inform ctor about the dish-machine uge not working. He informed the Maintenance (3/10/21) and somebody he to fix it. M, the Maintenance Director stated that the DM had raing (3/10/21) that the emperature gauge was not check it and the wash gauge has however when he interaction in the waste of that he art and was coming today. M, the Administrator was seed that she expected the intenance Director is dish-machine was not strator added that she was morning (3/10/21) that the	FS	908	All corrective action to be completed be April 8, 2021	y	