STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite 5/25/21 and continued remotely until 5/27/21. Event ID# DFYS11 4 of the 4 complaint allegations were not substantiated.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		6/4/21

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

Electronically Signed | 06/04/2021

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F 842	Continued From page 1 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records	F 842	Address how corrective action will be accomplished for those residents found to	

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F 842	Continued From page 2 for 1 of 3 residents reviewed for wound care (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 4/14/21 with multiple diagnoses that included open wound of the abdomen, Stage 4 pressure ulcer of the sacral region (a sore that extends below the subcutaneous fat into the deep tissue and even bone) and history of a stroke. Resident #1's physician orders indicated orders dated 4/14/21 for the following: - Cleanse the sacral wound with wound cleanser for 5 minutes. Use non-alcohol skin barrier to periwound and let dry for 10 seconds. Apply Aquacel AG (an antimicrobial dressing that kills wound bacteria) to the wound bed, trying to tuck the edges into the undermined areas from 3 to 6 o'clock. Cover with a foam dressing and secure. Change dressing twice a day and as needed. - Apply a wet to dry dressing to the right lower abdominal wound, twice a day. The April 2021 Treatment Administration Record (TAR) was reviewed and revealed the sacral and abdominal wound care had not been documented as completed or refused by the resident for the evening shift on 4/16/21, 4/17/21, 4/18/21, 4/23/21, 4/26/21, and 4/27/21. The admission Minimum Data Set (MDS) assessment dated 4/20/21 indicated Resident #1 was cognitively intact and displayed verbal behavior towards others and other behavioral symptoms not directed towards others 1 to 3 days during the 7 day look back period. She required limited assistance for personal hygiene and	F 842	have been affected by the deficient practice; The resident affected was sent to the hospital on 5/27/21 for a possible gastrointestinal bleed and was discharged from the hospital to the Hospice House. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a 100% audit of all current residents was conducted by the Director of Nursing on 5/27/21 of electronic medical record and electronic treatment record for the month of April and May to identify any holes present where documentation was not completed. There were 6 residents affected regarding their MAR documentation and 8 residents affected regarding TAR documentation. All holes were addressed/ corrected by either a written statement of completion by the assigned nurse or a medication error report on 5/28/21. The residents who were affected by the deficient practice were informed that the nurse failed to appropriately document their medication administration and /or their treatment record. The residents affected were informed that their doctor was notified, there was no negative outcome related to the deficient practice and that all nursing staff would be educated on the requirement to document immediately upon administering medications and treatments. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 842	Continued From page 3 extensive assistance for bed mobility, transfers, dressing, toileting, and bathing. Limited range of motion was present to 1 upper and lower extremity. Resident #1 was coded with an ostomy, was occasionally incontinent of bladder, had surgical wounds and a stage 4 pressure ulcer was present on admission. Review of the May 2021 TAR revealed the sacral and abdominal wound care had not been documented as completed or as refused by the resident for the evening shift on 5/1/21. Resident #1 was transferred to the hospital on 5/3/21 and was readmitted to the facility on 5/14/21. Resident #1's physician orders revealed orders dated 5/14/21 for the following: - Cleanse the sacral wound, then apply a moistened gauze of Dakin's 0.25% ½ strength solution (an antiseptic solution used for the treatment of wounds) and place in the wound bed. Cover with a dry dressing and change twice a day and as needed. - Cleanse the abdominal wound with normal saline or wound cleanser then apply Medihoney (a barrier cream which helps to maintain the skin's barrier properties) once a day on Monday, Wednesday and Friday and as needed. The May 2021 TAR was reviewed and indicated the sacral wound care for Resident #1 was not documented as completed or as refused by Resident #1 for the evening shift on 5/16/21, 5/20/21, 5/22/21 and 5/23/21. A quarterly MDS assessment dated 5/17/21 indicated Resident #1 was cognitively intact and	F 842	recur: Licensed nurses are expected to sign on the electronic medical record immediately following administering medication and completion of treatment. At the end of each shift, the licensed nurse will check the missed documentation report for their shift, to identify missed documentation. If there are missed documentation, the licensed nurse will complete documentation prior to end of shift. All nurses were educated on the importance of completing documentation and how to check to ensure their documentation is complete prior to the end of their shift Education was conducted on 5/28/21 by the Director of Nursing. Any nurses not educated will have education completed prior to returning to the facility. All newly hired nurses will be educated during the orientation process Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing/ Assistant Director of Nursing/ Clinical coordinator will audit 10 MAR/TAR five times weekly for four weeks and then 20 MAR/TAR monthly for two months to ensure that documentation is completed The Director of Nursing will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator/ Director of Nursing will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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F 842	Continued From page 4 displayed rejection of care 1 to 3 days during the 7 day look back period. She required extensive assistance from staff for Activities of Daily Living, had an ostomy and urinary catheter present. She was admitted to the facility with a stage 4 pressure ulcer and surgical wound. Review of the nursing progress notes from 4/14/21 to present revealed Resident #1 was noncompliant with taking supplements for wound healing and would refuse wound care at times, most often in the evening hours. On 5/25/21 at 9:34 AM, an interview occurred with the Treatment Nurse. She was familiar with Resident #1 and stated her sacral dressing was changed twice a day and currently the abdominal wound care was completed every other day. The Treatment Nurse stated Resident #1 had not refused wound care from her, but she was aware of noncompliance with wound care in the evening as well as not taking supplements for wound healing. A phone interview occurred with Nurse #1 on 5/26/21 at 3:55 PM, who was scheduled for the 7:00 PM to 7:00 AM shift on 4/16/21 and 5/16/21. She explained wound care was completed after the medication pass and Resident #1 refused wound care at times. When there was a refusal, multiple attempts were made to get wound care completed and was documented on the TAR as either completed or refused by Resident #1. Nurse #1 stated she had forgotten to document the wound care as completed or refused by the resident on the TAR, for the dates in question. A phone interview was completed with Nurse #2 on 5/26/21 at 5:11 PM, who was familiar with	F 842	Indicate dates when corrective action will be completed; 6/18/21	

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F 842	Continued From page 5	F 842		

Resident #1. He was scheduled for the 7:00 PM to 7:00 AM shift on 5/1/21, 5/20/21, 5/22/21 and 5/23/21, and was able to recall Resident #1 required dressing changes to the sacral wound twice a day. Nurse #2 was not able to recall any refusals of the wound care by Resident #1. He verified the evening shift dates in question, that he completed the wound care as ordered but had forgotten to sign them as completed.

On 5/26/21 at 5:51 PM, a phone interview occurred with Nurse #3 who was familiar with Resident #1. He was scheduled for the 7:00 PM to 7:00 AM shift on 4/17/21, 4/18/21, 4/23/21, 4/26/21 and 4/27/21. He was able to recall Resident #1 required abdominal and sacral wound care twice a day but could not recall any refusals from Resident #1 for wound care. He verified the evening shift dates in question, that he completed the wound care as ordered but had forgotten to sign them as completed.

The Director of Nursing was interviewed via telephone on 5/27/21 at 1:53 PM, who indicated she expected the nursing staff to complete wound care as ordered as well as to document that it was completed or refused by the resident.