12/11/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/03/2013 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	<del></del>				1830-0331
YATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			DAYE SU COMPLE	
		346144	B, WING			11115	12013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DINE BIDO	SE HEALTH AND REHAE	BILITATION CENTER			706 PINEYWOOD RD THOMASVILLE, NO 27360		1
111000				<u></u>	PROVIDER'S PLAN OF CORRECTION	T	(X6)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		CONDICTION
F 241 8S≃D	manner and in an en enhances each resid full recognition of his This REQUIREMEN' by: Based on observation interviews with staff residents to dress in dignity for 2 of 2 residents for dignity for 2 of 2 residents for dignity for 2 of 2 residents to dress in dignity for 2 of 2 residents to dress in dignity for 2 of 2 residents for dignity for dignity for dignity for dignity for 2 of	mote care for residents in a vironment that maintains or lent's dignliy and respect in or her individuality.  This not met as evidenced one, record review, and the facility failed to assist their own clothes to maintain dents (Resident #89 and			Pine Ridge Health & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain com- pliance with applicable rules and provisions of quality of care of residen The Plan of Correction is submitted as a written allegation of compliance.  Pine Ridge Health & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accura Further, Pine Ridge Health & Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal Dispute Resolution formal appeal procedure and/or any other administrativeor legal proceeding.	at .	
	assessment dated & #89 was severely or reject care. She was person assist with bedependent and one On 11/12/13 at 10:1 #89 was observed if	num Data Set (MDS) 0/18/13 indicated Resident ognitively impaired and did not us totally dependent and a two ed mobility, and was totally person assist with dressing. 2 am and 3:40 pm, Resident n bed, in a semi-fowler's green hospital-style gown.			F-241:  Residents #89 and #73 were reviewed for clothing preferences by the DON of 11/15/2013 and dressed in their own clothes according to their preferences	in s.	12/13/13 i
LABORATOR'	Y DIRECTORS OR PROVIDE	RUSUPPLIER REPRESENTATIVE'S SIGNATU	IRE		TITLE TO A		(X6) DATE 12/11/201
	Janes	Hedrick			Administrator		12/11/201
Ama datalan	w. alala hard and answerld ar	setadek (*) donotes a deliciency which the	e Institution	ma	y be excused from correcting providing it is determined that	t	

Any deficiency elatement ending with an asterisk (\*) denotes a delictency 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 delictencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsoles

Event ID: LLUB11

Fecility ID: 923017

If continuation sheet Page 1 of 13

DEPARTM	IENT OF HEALTH AN	D HOWAIN SEKNIOLO					0930 0501
CENTERS	FOR MEDICARE &	MEDICAID SERVICES	OVAN BATHEY	nol F	CONSTRUCTION	(X3) DATES	SURVEY
STATEMENT (X	F DEFICIENCIES	I AAN DRAWINEROSOPPLILIVANI				COMPL	E1517
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILD	WG		İ	1
			B. WING			11/1	5/2013
		345144	D. WING	-	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANIE DE DO	NOVIDER OR SUPPLIER				MOR PINEYWOOD RD		1
					THOMASVILLE, NO 27380		
PINE RIDG	E HEALTH AND REHAL	BILITATION CENTER		$\Box$	HOMASVILLE, NO 27040	ON CONTRACT	OXO
		ATTENT OF DESCIENCIES	αl		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	เบอเร	CONSPIRATION (XQ)
(X4) ID		CONTRACT DE BRIPE REDEU DE COUR	PREF		CDUGGERELEUSED IO INCALLIN	PRIME	2014
PRÉFIX TAG	REGULATORY OR	LEC IDENTIFYING INFORMATION)	100	•	DEFICIENCY)	<del></del>	<b> </b>
			<del></del>	- <u> </u>		المقطسيين	
<u></u>			1	241	A 100% audit of residents was	completed	
F 241	Continued From pag	je 1	1 1	44	TO THE DOM, ADDIT WITH AN INC.	e to	<u> </u>
	0- 444942 At 105	n em. 12:15 pm. and 2:15			determine their dressing prefe	rences on 📑	1
	Low Resident #89 W	as observed in Ded, in a			11/22/2013, One resident was	identified	
į	semi-fowler's position	n, wearing a green	1		for wearing personal gowns of	choice	\
	hospital-style gown.		1		and had previously been care	olanned.	i
	1 -				dim time broatenest weers and		1
	On 11/14/13 at 9:30	am, 11:10 am, 12:07 pm, and			A 100% In-service for nursing	taff was	1
	1 2-20 pm Resident i	ABB MSe obseived at new in a			conducted by the Staff Facilita	tor on	· [
	semi-fovder's position	on, Meauld a pine	1		conducted by the stall racintal	tor on	. [
1	hospital-style gown	•			11/18/2013 on Resident Digni	η M	
	1		1		include residents being dresse	Q . ab. ate	1
1	During an Interview	on 11/14/13 at 2:27 pm,	1		appropriately and according to	) their	1
1	I kluran Alda (NA) #1	INGICETOR SHO WAS RESIDUOR	'		preferences. A QI tool will be	utilized	1
	L. C. Land HOO IN	a rasidant DSO Cluulius W	l		to ensure residents are appro	•	
1	Wear, and needed	assistance with dressing. She	1		priately dressed according to	their	1
	Indicated there was	e no reason the resident was	}		preferences with supporting of	ocu-	1
1	not dressed.		1		mentation as needed.		1
	* *********	1pm, Resident#89 was	Ì		Biglidadi as iregen		1
	On 11/14/15 at 213	r wearing a gown. She was	1		This Qi monitoring will be con	<b>1</b> -	1
1	dressed in a shirt	and pants.			pleted by the QI nurse as folk	nite!	1
1	1				pieted by the Children of Front	ante	
1	Dudan on Intended	w on 11/14/13 at 2:37 pm Nurse	1		A random selection of 5 resid	21163 17101 fanns	1
1	1 avi	Seetugat 1990 (th nam) and an	İ		(Including residents #89 and I	75) IFOIII	
1	אוויס נייטעני זיייט נייטעני אוויס נייטעני אוויס נייטעני אוויס נייטעני אוויס נייטעני אוויס נייטעני אוויס נייטעני	son [she] should not be, [She]			each Hall will be monitored for	or clothing	
1	should be dressed	d every day."	1		preference three times week	y for two	1
1	1		1		(2) weeks, two (2) times wee	kly for	1
1	During an intervie	w on 11/14/13 at 3:38 pm, the			two (2) weeks, then once we	ekly for	-
	Disaster of Nitrelia	4 (DOM) MORSHED MARKETINE ADD			4 weeks. Any areas of concer	n will be	}
	1 . I I . I	4 Hylage Bub I gundalon 15. 15.	1		addressed at the time noted	with the	1.
1	he or her nower o	of allomey requested a nospital	١		addressed at the time noted administrative nurses. These	fibue	ł
	Lanua Cha indina	fad spe Mas lot ameia ni a			administrative impositions those	du at tha	
1	request for the re	sident to not be dressed.	1		results will be reviewed wee	ay as sur annt	·   •
1	1				stand-up meeting with addit	ulidi.	1
1	On 11/15/13 at 1	0:21 am, Resident #89 was	ļ		follow up action taken as not	ed by .	1
1	observed dresse	d and sitting in her scoot chair.	l		the DON & ADON.		
1	Į.		1	•	. [		<u> </u>
1	On 11/15/13 at 2	:00 pm, Resident #89 was			<b>[</b>		
	sheerved dresse	d, sitting in her room, smiling,					<u> </u>
į	and remained in	her scoot chair.			Earthyllt 923017	Il continuatio	n sheet Page 20
	1				ESCHVIIE VANU		

		D HUMAN SERVICES				FORM.	APPROVED 0938-0391
DEPARTN	PENI OF MENERALISMA	MEDICAID SERVICES				(X3) DATE S	
CENTERS STATEMENT OF AND PLAN OF	F DEFICIENCIÉS	MEDICAID SERVICES  (XI) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	COMPL	E1E0
		345144	B. WING			11/1	5/2013
		040144			EET ADDRESS, CITY, STATE, ZIP CODE		
	NOVIDER OR SUPPLIER				PINEYWOOD RD		
PINE RIDG	E HEALTH AND REHAL	BILITATION CENTER		THO	DMASVILLE, NO 27860 PROVIDER'S PLAN OF CORRECTOR	N 1	(X6)
(X4) ID PREFIX TAG	- CONTRACTOR STATES	INTEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROF DEFICIENCY)	JD⊊	DATE
F 241	Continued From page diagnoses that Inclusion and diagnoses that Inclusion and diagnoses that Inclusion and diagnoses that Inclusion and diagnoses that Inclusion and diagnoses that Including and did not reject or dependent and a two mobility, and was to person assist with a continuous diagnoses of the person assist with a continuo	s admitted on 12/16/10 with ided Alzheimere, lack of ementia.  dated 8/22/13 Indicated severely cognitively impaired are. She was totally wo person assist with bed otally dependent and a one drossing.  50 am, 12:15 pm, and 2:15 was observed in bed, in a lon, wearing a hospital-style.  O am, 11:10 am, 12:07 pm, and #73 was observed in bed, in a lion, wearing a hospital-style.  W on 11/14/13 at 2:27 pm, indicated she was assigned the resident had clothing to a seletance with dressing. She as no reason the resident was resident #73) up daily and do son [she] should not be. [She] devery day."	F	241	The results of the audits will be warded to the Executive Qi Cormonthly X 3 and quarterly ther for the Identification of potent for follow-up as deemed necesto determine the need for and frequency for continued monit	mmittee eafter ial trends sary and for the	
	Director of Nursi	ew on 11/14/13 at 3:45 pm, the ng (DON) Indicated Resident #73 t with activities of daily living tressing and that the resident					Trad Page 201

should be dressed.

DEPARTM	IENT OF HEALTH AN	M HAWAM SERVICES			<u>омв No.</u>	0838-0381
CENTERS	FOR MEDICARE &	MEDICAID SERVICES	Tom Inn	Not G f	CONSTRUCTION (X3) DATE S COMPL	URVEY
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPL	EIEU
AND PLAN OF	CORRECTION	(DEMINICATION NAMES)	A BUILDI	Wo		
			B. WING		11/1	5/2013
		346144	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PR	NOVIDER OR SUPPLIER	<del> </del>	:		6 PINEYWOOD RD	:
					HOMASVILLE, NO 27360	
PINE RIDG	E HEALTH AND REHAL	SILITATION CENTER		Ti		(X5)
	CIMATADV ST	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
(X4) ID PREFIX	ALL ALL INTERMEDIAL	VINIET DE DREEELDED DI FULG	PREF		CROSS-REFERENCED TO THE APPROPRIATE	DAILE.
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	- 1		DEFICIENCY)	
_						
			-	241		
F 241	Continued From pag	şe 3	'	£41		•
•	ļ					
	On 11/15/13 at 10:2	1 am, Resident #73 was		ļ		1
	observed dressed in	her own clothes and sitting	-		r 240.	
	in her geri chair.			248	F-248:	
F 248		TIES MEE!	١.			12/13/13
8s=D	INTERESTS/NEED	S OF EACH KES	1		The Activity Director and the hall nurse evaluated resident #89 and	
1		ovide for an ongoing program			nurse evaluated resident hos and	
	The facility must pro	d to meet, in accordance with	1		#73 activity interests and accommo-	1
1	of activities designe	assessment, the Interests and			dation needs to attend activities on	
	file collible in in in	i, and psychosocial well-being	1		11/15/2013 and assisted them to	
1	of each resident.	if enion had an analysis	1		activities.	
1	Ol ANCII I DOMONII		1			
			1		A 100% audit of residents was con-	1
1	This REQUIREMEN	NT is not met as evidenced	1		ducted by the Activity Director to	
1	1 km				determine resident activity interests	
	Paced on observa	tions, record review, and	1		for group and in-room activities	1
1	I takendows with stat	If the facility talled to reside			according to their function, ability	
	maidante de need	ed, to get dressed for, be	1		and/or preference with updating of the	ŀ
1	transported to, and	participate in desired activities	1		Activity Supplemental Assessment as	
1	for 2 of 2 residents	(Resident #89 and #73)			needed.	
1	reviewed for activity	n⊕s.			Meagan'	
	والمحالم ووالمحال والمحال والم				A cook to anodae for Arthity and	
	Findings included:				A 100% in-service for Activity and	1
1	4 Posident ting wa	as admitted on 11/17/11 with	[		Nursing Staff was conducted by the	
	diagnosas that inc	Juded dementia, altered mental			Staff Facilitator on 11/18/2013 to	l
1	etatus deneralize	d muscle weakness and fallure			encourage residents to participate in	
	to thrive.				group and/or individual activities,	•
1	1				dress residents appropriately and	
	The care plan dat	ed 2/7/13 Indicated the resident	1		assist residents to and from activities	
1	I so wistered applicant	na for all transiers related to			as provided based on their interests	
1	dability of chronic	disease and cognitive detects.			and needs. A QI audit tool will be	
	Interventions incli	uded: assist of two with all lift	1		used to monitor resident activity	
	transfers.				participation in group and individual	
1	The care plan dal	ted 4/25/13 Indicated a	Ì		activities, clothing preferences and	
	progressive decil	ne in intellectual functioning			assistance to and from activities.	
1	related to demen	tia. Interventions included:	-		applacation to and from assessment	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILOING AND PLAN OF CORRECTION 11/15/2013 346144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 706 PINEYWOOD RD PINE RIDGE HEALTH AND REHABILITATION CENTER THOMASVILLE, NO 27360 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Monitoring will be completed by the F 248 Continued From page 4 F 248 QI Nurse as follows: A random selection encourage group activities and establish a dally of 5 residents (including residents #89 routine with the resident. and #73) from each Hall will be mon-The quarterly Minimum Data Set (MDS) itored (3) three times weekly for two assessment dated 9/18/13 indicated Resident (2) weeks, two (2) times weekly for #89 was severely cognitively impaired and did not two (2) weeks, then once weekly for reject care. She was totally dependent and a two 4 weeks. Any areas of concern will be person assist with transfers, was totally addressed at the time noted by the dependent and one person assist with dressing. administrative nurse. Audit results will and locomotion on and off the unit. be reviewed weekly at the stand-up The activity progress note dated 9/18/13 indicated meeting with additional follow up action Resident #89's group interests were music taken as noted by the DON and ADON. groups and women's groups. Her independent interests were television and chair rides. The The results of the audits will be fornote indicated Resident #89 actively participated warded to the Executive QI Committee in out-of-room activities 2-4 times weekly, that monthly X 3 and quarterly thereafter for in-room activities were in keeping with her the identification of potential trends for interests, and that her activity needs and goals follow-up as deemed necessary and to were being met. determine the need for and/or the The Activity Assessment dated 11/11/13 indicated frequency for continued monitoring. Resident #89's activity interests included gospel music, television and movies. A review of the resident's group activities dated 10/14/13-11/14/13 revealed she participated in 1 music program that month and 2 religious programs that month. On 11/12/13 at 10:12 am and 3:40 pm Resident #89 was observed in bed, in a semi-fowler's position, wearing a hospital gown. There was no music, television or other activity in the room. On 11/13/13 at 10:50 am, 12:15 pm, and 2:15 pm Resident #89 was observed in bed, in a semi-fowler's position, wearing a hospital gown. There was no music, television or other activity in

During an interview on 11/14/13 at 2:37 pm Nurse #1 stated, "I like [Resident #89] up daily and do not know of a reason [she] should not be."

During an interview on 11/14/13 at 2:65 pm with the Activities Director she stated, "We take [Resident #89] to music and to watch videos. If we can get her out we do that. She doesn't

bed.

CENTERS FOR MEDICARE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CUA	(X2) MUL	IPLE CO	(X3) DAT	(X3) DATE SURVEY COMPLETED			
STATEMENT ( NND PLAN OF	of Deficiencies Foorrection	IDENTIFICATION NUMBER:	1 '			30/	(8: FF1772)
		345144	B. WING			1	1/15/2013
	ROVIDER OR SUPPLIER GE HEALTH AND REHA			706 F	ET ADDRESS, CITY, STAYE, ZIP CODE PINEYWOOD RD MASVILLE, NC 27360		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREF	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD 85	CONSTITUTE (CONSTITUTE)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		_
F 248	actively participate. activities in the past rub her hands with it for activities. It dependent in the hallway as she indicated Resident if the hallway as she in further indicated the activities was that it assistant for 29 residents dressed and out of scheduled activity and conserved activity and the dining room wit television. She was reaching out to the smilling.  On 11/15/13 at 10: observed in a grout residents. She was alert, smilling, inter other residents and reaching out her at the balloon being to came close to her.  On 11/16/13 at 2:0 observed sitting in remained in her second	She has had 3 group month. We read to her and often. There is no minimum ands on her moods." She #89 "is not as active now on was on the looked unit." She reason for her decreased he looked unit has one activity dents and "the rest of the residents, is handled by er activity assistant." She that require lifts and are not bed at the time of the are not able to participate.  21 am, Resident #89 was and sitting in her scoot chair in the 5 other residents, watching a interactive, looking around, resident sitting beside her and 40 am, Resident #89 was p activity with 8 other is sitting in her scoot chair, active and looking around at distaff in the activity. She was mad attempting to catch used in the activity when it. She was holding the balloon her feet when the balloon was her room, smiling, and coot chair.	F	248			
	2. Resident #73 w	ras admitted on 12/16/10 with cluded Alzheimers, lack of					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/03/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NO</u>	<u>. 0938-0391</u>
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE ( COMPL	
		346144	a. WNG			11/1	5/2013
NAME OF PE	ROVIDER OR SUPPLIER	Address of the second of the s		1 '	FREET ADDRESS, CITY, STATE, ZIP CODE		1
PINE RIDO	BE HEALTH AND REHAB	ILITATION CENTER		1	06 Pineywood RD Homasville, NC 27860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	e ATE	CONTECTION CONTECTION
F 248		wn, There was no music,	f	248			
	#1 stated, "I like [Res	n 11/14/13 et 2:37 pm Nurse ident #73] up dally and do [she] should not be. [She] rery day."			·	Hamilton de la principal de la	
	Director of Nursing (D was a total assist with	n 11/14/13 at 3:45 pm, the DON) indicated Resident #73 n activities of dally living Ing and that the resident				SAMMADE TO THE PERSON OF THE P	
F 367	observed dressed an the dining room with t television was on and in front of it. 483.35(e) THERAPE	am, Resident #73 was d sitting in her geri chair in 5 other residents. The I the resident was positioned UTIC DIET PRESCRIBED	F	367			
\$\$ <b>=</b> D	BY PHYSICIAN Therapeutic diets mu attending physician.	st be prescribed by the			F-367 Resident #136 was referred to Spe Therapy for re-evaluation of diet c	on-	12/13/13
	by: Based on observation Interview the facility for diet for 1 of 1 sample who had orders by a	•			sistency on 11/14/2013. The Dieta Manager and Registered Dietitian re-evaluated the resident's diet for protein and intake on 11/13/2013. Resident #136 receives diet as ord and continues in restorative dining	ered	
		idmitted to the facility on osis to include; Dysphagia,				•	

## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		-		OMB NO	), 0938-0381
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	в. WING			11/	15/2013
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MILIE MINA				7	706 PINEYWOOD KD		
PINERIDO	3E HEALTH AND REHAE	RELITATION VENIER		1	THOMASVILLE, NO 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BY: PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	Х	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 367	Continued From page gastroesphageal refit acute renal failure.  The latest Minimum I 9/25/13 indicated Research and long term memor cognitively impaired for Physician Order date patients diet to no consider a self (NA6) pur Review of Resident #7/18/13 revealed the goals in regards to Renountehment"; Will act will provide protein to requirement. The integration of Reston 12:25 pm revealed Neproviding assistance set up. Housekeepin NA#3 beginning to feevidenced by stating receive meats due to yesterday (11/11/13). further indicated that held to discuss possili	para Set (MDS) dated sident #136 required with eating. The MDS dent #136 had short term y loss and was severely or daily decision making.  d 8/23/13 dictated; change neentrated sugare (NCS), no see with HTL.  136's care plan revised on resident had the following perident #136 "state of there to prescribed diet and meet residents daily erventions included; provide for closely during meal sident with extensive assist mative dining on 12/12/13 at ursing Assistant (NA) #3 to Resident #136 with meal g Staff #1 intervened prior to sed Resident #136 was not to the resident choking Housekeeping staff #1 a meeting was going to be consistency changes.		367	DEFICIENCY)	nis/her A 1:1 ed as f #1 Staff  id ed by cor on scribed be liets  he lection #136) o (2) nen as of lime audit the follow	·
	from Resident #136's #136 meal card dated	to remove the meat item plate. Review of Resident I 11/12/13 located on the Ited the resident was to					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 12/03/2013 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
, ,		345144	в, имо			11	15/2013
	ROVIDER OR SUPPLIER SE HEALTH AND REHAB	ILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 08 PINEYWOOD RD THOMASVILLE, NC 27360	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies y must be preceded by full sc identifying information)	ID PRESI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
	receive pureed double observed to not proving pureed meat or gain or Resident #136's diet of interview with NA# 3 or revealed she was una not to have meats or it choking. The NA furtit been told by Houseke have known that reside meats. NA#3 stated it meal should be located oard.  Continued interview with 136's diet changes un housekeeping staff #1 resident was not to resident was not to resident was not to resident #136's she did not locate a not determine if there was diet. NA #3 did not att food item due to remo NA#3 stated that she it Resident #136 to chok discussed Resident #1 food item due to remo NA#3 stated that she it Resident #136 to chok discussed Resident #1 food item swall dumplings and items sinterview with Houseke 11/14/2013 at 9:42 am did have a choking epi	e meate. NA #3 was de resident with an alternate clarification of a change in constancy.  In 11/12/13 at 12:30 pm owere that the resident was nad any episodes of ner indicated is she had not eping Stalf #1 she wouldn't ent #136 was not to receive that changes to resident's d on the resident's meal  ith NA#3 on 11/14/13 at was not aware of Resident til 11/12/13 when communicated the ceive meate due to choking. municated by IA #3 removed the meat plate. NA #3 stated that curse to determine whether of to have meate or to a change in the resident's tempt to locate a substitute ving the resident's meate. has never observed te. NA #3 indicated she is6's diet with the head of m (NA #4) on 11/14/13 in the resident was only owing pureed chicken and such as roast beef.		367	The results of the audits will be for warded to the Executive QI Commi monthly X 3 and quarterly thereaft the identification of potential trends for folk as deemed necessary and to determ the need for and/or the frequency continued monitoring.	ttee er for ow-up nine	

CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED Y BRITISHS Y 345144 B. WING 11/15/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 708 PINEYWOOD RD PINE RIDGE HEALTH AND REHABILITATION CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID PREFIX (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 367 Continued From page 11 F 367 the resident would occasionally choke on stringy meats that were pureed but recently had been choking on everything. Staff #1 indicated that while feeding resident on Friday (11/11/13), Resident #136 choked. Staff #1 further indicated that she communicated the choking incident to nurse #2 who informed the housekeeping staff not to provide the resident with any meat. Staff #1 revealed she'd communicated to NA #3 that Resident #136 was not to have meate until the facility had a meeting to determine consistency changes. The Housekeeping staff indicated changes to the resident 's diet would be documented on the resident's meal card. Review of nursing notes from 11/9/13 through 11/12/13 revealed no documentation in regards to Resident #136 having difficulty consuming or choking on meat items. Review of the facility incident log for 11/8/13 through 11/12/13 did not reveal any incidents Involving Resident #136. Interview with the head of Restorative NA #4 on 10/14/13 at 10:40 am revealed Resident #136 was having only having issues swallowing pureed food Items that are stringy such as chicken and dumplings and roast beef. NA#4 revealed Housekeeping staff do not feed residente. Staff #1 is in restorative dining to act as an assistant as evidenced by retrieving times that may be needed by the NA. NA#4 indicated no other staff had communicated any choking problems in regards to Resident #136. NA #4 stated that Housekeeping Staff #1 was trained to feed residents although she was not to feed any

resident with swallowing difficulty or on a thickened liquid. Staff are made aware of

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY APLETED
		345144	B. WING	• • • •		11	1/16/2013
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	ILITATION CENTER		708	reet address, city, state, zip code Pineywood RD OMASVILLE, NC 27380		
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPA DEFICIENCY)	38	DATE COMPLETION (X6)
F 367	located on the resider stated it was her experience on the resident instance there is a quitocated on the diet ship consultant with the nudetary to confirm the removing an item from interview with the DOI revealed the facility do assistants and Housel residents. The DON thousekeeping staff do have specialized diets her expectation that et transcribed on residen further indicated staff and the respectation of the staff and the staff	diets as they are to be his meal cards. NA#4 rotation that NA's follow the r's meal card. In the estion or an entry is not set, the NA should ree, speech therapy or resident's diet prior to hithe resident's plate.  Non 11/14/13 at 1:34 pm hes not have paid feeding teeping staff do not feed further indicated that not feed residents who The DON revealed it was	F	367			

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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 of the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 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 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.

If continuation sheet Page 1 of 3

PRINTED: 12/08/2013

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 12/05/2013 B. WING 345144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 706 PINEYWOOD RD PINE RIDGE HEALTH AND REHABILITATION CENTER THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (XS) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 025 All smoke walls in the facility were Continued From page 1 K 025 checked by the maintenance director COM. SS≃D Smoke barriers are constructed to provide at on 12/12/2013 to ensure there are least a one half hour fire resistance rating in no other unsealed penetration areas. accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are The maintenance director will monitor protected by fire-rated glazing or by wired glass smoke/fire walls monthly to ensure panels and steel frames. A minimum of two continued compliance. separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted The results of the monthly monitoring heating, ventilating, and air conditioning systems. will be forwarded to the next monthly 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 **Executive QI Committee meeting and** quarterly thereafter for the identification of potential trends and follow-up as deemed necessary to determine This STANDARD is not met as evidenced by: the need for and/or frequency of Based on the observations and staff interviews continued monitoring. on 12/5/2013 the following Life Safety item was observed as noncompliant, specific findings include: There was unsealed penetrations in the smoke wall above the cross corridor doors leading from the center core to the 400 hallway. **K029** CFR# 42 CFR 483.70 (a) 1/19/14 K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 The combustion chamber of the SS=E One hour fire rated construction (with % hour identified dryers were cleaned by fire-rated doors) or an approved automatic fire the housekeeping supervisor on extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When 12/6/2013. the approved automatic fire extinguishing system option is used, the areas are separated from All dryers were cleaned thoroughly other spaces by smoke resisting partitions and by the housekeeping supervisor doors. Doors are self-closing and non-rated or on 12/6/2013. field-applied protective plates that do not exceed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LLUB21

Facility ID: 928017

If continuation sheet Page 2 of 3



12/3	19/2013 14:31	336		PINE	RIDGE ADMISSIONS	PA	
	O AP LIEAL TE	AND WIMAN SERVICES				FORM A	<del>12/08/2013</del> \PPROVED
DEPART	MENT OF HEALTH	AND HUMAN SERVICES					0938-0391
OTATELECNIT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;	(X2) MÜL A. BUILD	TIPLE ING 01	CONSTRUCTION  - MAIN BUILDING 01	(X3) DATE COMP	PLETED
			B, WING			12/0	5/2013
_		345144	0, 11,10	811	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				PINEYWOOD RO		1
PINE RID	GE HEALTH AND RE	EHABILITATION CENTER		TH	IOMASVILLE, NC 27380		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LU DE	COMPLETION DATE
K 029	This STANDARD Based on the obs during the tour on was observed as i	Is not met as evidenced by; ervations and staff interview 12/5/2013 the following item noncompliant, specific findings ty had a buildup of dust and lint chamber of the gas fired dryers		029	An inservice of all laundry staff "Fire Prevention - Monitoring a Cleaning Dryer Combustion Ch was completed by the houseke laundry supervisor. Using a QI the housekeeping/laundry sup- will monitor all dryer combustic chambers weekly to ensure the are clean and free of dust and The results of the weekly moni- will be forwarded to the Execu- Committee monthly X3 and qu thereafter for the identification potential trends for follow-up deemed necessary and to dete the need for and/or the freque- of continued monitoring.	and ambers" eping- i Tool, ervisor on ey lint. itoring tive QI earterly n of as ermine	



PRINTED: 12/08/2013 DEC 1 9 2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING 02 - BUILDING 02 AND PLAN OF CORRECTION 12/05/2013 B. WING 345144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 706 PINEYWOOD RD PINE RIDGE HEALTH AND REHABILITATION CENTER THOMASVILLE, NC 27360 (XE) PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD BE (X4) (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Pine Ridge Health & Rehabilitation K 000 K 000 INITIAL COMMENTS Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that This Life Safety Code (LSC) survey was the summary of findings is factually conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing correct and in order to maintain com-Health Care section of the LSC and its referenced pliance with applicable rules and provisions of quality of care of residents. publications. This facility is Type III (211) protected construction utilizing North Carolina The Plan of Correction is submitted Special locking arrangements, and is equipped as a written allegation of compliance. with a complete automatic sprinkler system. LIC # NH0187 and the census for the facility at the Pine Ridge Health & Rehabilitation's survey was 138. response to this Statement of Deficiencies does not denote CFR#: 42 CFR 483.70 (a) agreement with the Statement of K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 Deficiencies nor does it constitute an admission that any deficiency is accurate. SS=D Building construction type and height meets one Further, Pine Ridge Health & Rehab of the following, 19,1,6,2, 19,1,6,3, 19,1,6,4, reserves the right to refute any of the 19.3.5.1 deficiencies on this Statement of Deficiencies through informal Dispute Resolution formal appeal procedure and/or any other administrativeor legal proceeding. This STANDARD is not met as evidenced by: Based on the observations and staff interviews 1/19/14 on 12/5/2013 the following Life Safety item was **BUILDING 02** K012 observed as noncompliant, specific findings include: The radiation dampers in the return air The identified radiation damper at registers of the following area was not well maintained and had dust and lint on the heat the shower room across from room sensitive elements of the radiation dampers. #503 was cleaned by the housekeeping supervisor on 12/5/2013. 1. The shower room just across the hallway from room 503. All other radiation dampers in the facility were checked and cleaning CFR#: 42 CFR 483.70 (a) K 058 NFPA 101 LIFE SAFETY CODE STANDARD completed on 12/11/2013 by the K 056 housekeeping supervisor. SS≒D If there is an automatic sprinkler system, it is (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

amustrator ance 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 lindings 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

Facility ID: 923017

program participation.

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		& MEDICAID SERVICES	CYON BELLET	י יפוץ	E CONSTRUCTION	(X3) DATI	0938-039 SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			22 - BUILDING 02	COM	PLETED
		345144	B. WING			12/0	15/2013
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa installed in accorda for the Installation of provide complete of	HABILITATION CENTER  ITEMENT OF DEFICIENCIES IT MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  IGE 1 INCE With NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the	ID PREFD TAG	70 TI	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE OF CORRECTIVE ACTION	TION ULD BE OPRIATE SÍNG E	(XS) COMPLETIC DATE
	accordance with NI Inspection, Testing Water-Based Fire I supervised. There supply for the systems are equipped switches, which are building fire alarms.  This STANDARD Based on the observed as no include: The facility standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed as principal standard head spring was observed.	em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler and tamper electrically connected to the system. 19.3.5			dampers weekly to ensure the clean, and free of dust and lint. The results of the weekly mon will be forwarded to the Executornmittee monthly X3 and quantities for the identification potential trends for follow-up deemed necessary and to detect the need for and/or the frequencentinued monitoring.	y are itoring itive Ql parterly in of as ermine	
	was the only stand facility.	ead sprinkler head in this office ard sprinkler head noted in the			K056	, .	1/19/1
٠		ot have extra standard he sprinkler riser room. 3.70 (a)			The identified standard sprinkle head was verified as an active sprinkler. An extra standard sprinkler head was received fro the sprinkler company and is not the sprinkler riser room.	om ·	



12/15/2015 14:31	336	,	LINEKINGE UNMISSIONS	RINTED: 12/08/2013	
DEPARTMENT OF HEALT	HAND HUMAN SERVICES			FORM APPROVED	
CENTERS FOR MEDICARI			C	MB NO, 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 02 - BUILDING 02	(X3) DATE SURVEY COMPLETED	
	345144	B. WING		12/05/2013	
NAME OF PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS; CITY, STATE, ZIP CODE		
PINE RIDGE HEALTH AND REHABILITATION CENTER			706 PINEYWOOD RD THOMASVILLE, NC 27360		
PREFIX FACH DEFICIENC	ATEMENT OF DEF(CIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD (	O BE COMPTETION	
K 056 Continued		К0	uated the identified sprinkler head for replacement on 12/17 The sprinkler head has been orc	/2013. fered	
Insel	T To		to be consistent with the sprink system on the 500 hall unit and be installed upon receipt.  All other sprinkler heads in the	S will	
Continu	rt To we K056 page 292 ing 02		facility were checked by the ma tenance director to ensure they comply with the current system	<i>t</i>	
Buildi	ng 02	٠	The Sprinkler Company, Suniar Fire Protection, Inc will provide inspection of the sprinkler system quarterly and annually to ensur compliance. This will be monit by the Maintenance Director.	em re	
			The inspection results will be for warded to the Executive QI Cormittee by the maintenance din at the next monthly meeting all quarterly thereafter for followers deemed necessary for continuous compliance.	m- ector nd -up	