STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		1/14/16

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

Electronically Signed | 01/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to accurately post the state survey and certification agency and the complaint intake unit name and contact information. The findings included: An observation of the bulletin board located in the front hallway was made on 12/14/15. " Division of Facility Services, 701 Barbour Drive, Raleigh NC 919-855-4250. Care Line 800-624-3004 " was observed on the bulletin board. An interview was conducted with Administrative Staff #4 on 12/17/15 at 7:40 AM. She stated she was not aware that the state survey and certification agency name, address and phone number was posted incorrectly on the bulletin board. She further stated she was not aware that the complaint intake unit name was posted incorrectly on the bulletin board. Administrative Staff #4 stated she did not know why the information was posted incorrectly.	F 156	F 156 Notice of Rights, Rules, Services, Charges On 12/17/15, the administrator corrected the contact information for the Department of Health and Human Services on the posted facility displays. The corrected information included the name of the agency, the address-2711 Mail Service Center, Raleigh, North Carolina 27899-2711, the telephone number-1(919)855-4520, the Complaint Intake Unit name and telephone number 1(800)824-3004. On 12/17/15, the administrator completed a 100% audit of all facility displays regarding the Department of Health and Human Services to ensure all information was correct which included the name of the agency, the address, the telephone number, the Complaint Intake Unit name and telephone number. Any negative findings were immediately addressed. On 12/17/15, the corporate nurse re-educated the administrator on the following: 1. Contact information for the Department of Health and Human Services will be displayed accurately and updated as needed. 2. This information includes the address, telephone number, name of intake line, and name of agency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3	F 156	On 12/29/15, the administrator re-educated the assistant director of nursing, staff facilitator, QI nurse, MDS nurse, maintenance supervisor, social workers, and dietary manager on the following: 1. Contact information for the Department of Health and Human Services will be displayed accurately and updated as needed. 2. This information includes the address, telephone number, name of intake line, and name of agency. Beginning 12/29/15, the administrator will utilize a QI monitoring tool monthly titled, Postings to ensure correct contact information for the Department of Health and Human Services is displayed. This displayed information includes the name of the agency, the address, the telephone number, the Complaint Intake Unit name and telephone number. The Postings audit tool will be utilized weekly x 6 weeks. Any negative findings will be addressed immediately. The administrator will present findings at the next monthly QI meeting for suggestions and/ or recommendations to sustain compliance and continued monitoring.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 by: Based on observation and staff interview the facility failed to maintain clean resident bathrooms on 2 of 5 halls (100 and 200 halls) and failed to maintain a resident bathroom toilet in good repair on one of 2 halls (100 hall). The findings included: On 12/15/15 from 9:00 AM - 3:30 PM the following was observed: Room 113/115 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet, there were brown matter specks on the commode and the back of the toilet and the base molding had black matter at the seam between the molding and the floor. In addition, there was loose debris on the floor at the back corners of the bathroom floor. Room 109/111 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet. There was also rust color residue at the base of the toilet and where the commode legs touched the floor. There was a garbage can in the bathroom that did not have a garbage bag. Room 106/104 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet, there were brown matter specks on the commode and the back of the toilet and the base molding had black matter at the seam between the molding and the floor. Room 105/107 resident Bathroom - there was brown matter on the outside of the toilet under the commode and a dark ring around the water line inside the toilet. The floor scattered grey residue and there was rust colored residue around the base of the toilet. The toilet tank did not have a	F 253	F 253 Housekeeping and Maintenance Services On 12/16/15, the housekeeping supervisor, maintenance director, and housekeeping staff began stripping and cleaning the bathroom floors in resident bathrooms # 113/115, #109/111, #104/106, # 105/107, # 101/103, and # 212. The stripping and cleaning of the bathroom floors was completed 12/18/15. The maintenance director repaired the toilet in room # 105/107 to include replacing the toilet lid on 12/18/16. The maintenance director completed replacement of stained bathroom tiles in the identified rooms on 1/10/16. On 12/16/15, the housekeeping staff cleaned all bathrooms to include toilets in resident bathrooms # 113/115, # 109/111, # 104/106, # 105/107, # 101/103, and # 212. On 12/17/15, the administrator and housekeeping supervisor completed a 100% audit of all other resident bathrooms for floors in need of stripping, replacement of tiles, and bathrooms in need of cleaning to include toilets. Any negative findings were addressed immediately. On 12/29/15, the administrator re-educated the housekeeping supervisor and maintenance director on the following: 1. Housekeeping and maintenance services must provide	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 lid and there was a sign on the wall that said " hold down for 3 seconds to flush fully " . The base molding had black matter at the seam between the molding and the floor. Room 101/103 Resident Bathroom - there was greyish and black residue on the floor with the highest concentration in approximately a 1 foot area surrounding the toilet. At the base of the toilet there was a dark yellow wet appearing item that was approximately 2 inches x 3 inches in size stuck to the base of the toilet. Room 212 Resident Bathroom - the floor had black residue near and around the toilet and the remainder of the floor had a greyish brown tinge over the floor tile. There was also a tan sticky substance over the entire floor. On 12/16/15 at 12:30 PM the following was observed with Administrative Staff #1, Administrative Staff #4 and the Housekeeping Manager: Room 113/115 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet, there were brown matter specks on the commode and the back of the toilet and the base molding had black matter at the seam between the molding and the floor. In addition, there was loose debris on the floor at the back corners of the bathroom floor. The Housekeeping Manager confirmed that room 115 had already been deep cleaned that day but said deep cleaning did not include stripping of the floor it just included cleaning additional surfaces in the room beyond regular daily cleaning. Room 109/111 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet. There was also rust color residue at the base of the toilet and where the	F 253	necessary services to maintain a sanitary, orderly, and comfortable interior. 2. These services must include clean bathroom floors, clean bathroom baseboards, and cleaned toilets in all resident bathrooms. 3. Any negative findings must be addressed. This re-education will be completed by 1/14/16. On 12/18/15 the administrator met with housekeeping staff regarding results of survey and reiterated what the expectations are for the staff. On 1/11/16 the primary housekeeper on the 100 hall was given a written consultation regarding work his performance and on 1/14/16 the Housekeeping supervisor from a sister facility worked 1:1 with the housekeeper on 100 hall. The expectation is the provision of services to maintain a sanitary, orderly, and comfortable interior. The Housekeeping Supervisor and or Maintenance Director will educate all future housekeeping and maintenance employees during their orientation process on the above. Beginning 1/12/16, a Call Light tool and Physical Plant/Environmental Cleanliness tool will be added to the Preventative Maintenance Log to be utilized by the maintenance director monthly on an ongoing basis. Any negative findings will be addressed immediately. Beginning 12/18/15, the administrator, director of nursing (DON), QI nurse, maintenance director, and/or housekeeping supervisor initiated a QI tool titled, Physical Plant/Environmental	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 6 commode legs touched the floor. There was a garbage bag in the garbage can which had not been present on a previous observation. Room 106/104 Resident Bathroom - the floor had black residue around the toilet in a circle shape extending beyond the legs of the commode that was over the toilet, there were brown matter specks on the commode and the back of the toilet and the base molding had black matter at the seam between the molding and the floor. Room 105/107 resident Bathroom - there was brown matter on the outside of the toilet under the commode. The floor scattered grey residue and there was rust colored residue around the base of the toilet. The toilet tank did not have a lid and there was a sign on the wall that said " hold down for 3 seconds to flush fully " . The base molding had black matter at the seam between the molding and the floor. Room 101/103 Resident Bathroom - there was greyish and black residue on the floor with the highest concentration in approximately a 1 foot area surrounding the toilet. At the base of the toilet there was a dark yellow wet appearing item that was approximately 2 inches x 3 inches in size stuck to the base of the toilet. Room 212 Resident Bathroom - the floor had black residue near and around the toilet and the remainder of the floor had a greyish brown tinge over the floor tile. On 12/16/15 at 12:45 PM interview with the House Keeping Manager revealed that the black matter on the floor was wax build up that needed to be stripped off. He added that he had not been in his position long but that he had tried to strip the bathroom floor in the Room 109/111 and some of it had come up but he could not get it all off. He did not know why the floors appeared to have more discoloration and residue in an area	F 253	Cleanliness to ensure all resident bathrooms are clean to include toilets and floors are clean and unstained. This Physical Plant/Environmental Cleanliness tool will be completed weekly x 4 weeks, twice monthly x 8 weeks. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Physical Plant/Environmental Cleanliness tool by initialing the bottom right hand corner of the audit tool. The administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendation for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 7	F 253		

surrounding the toilets and extending beyond the commode. The housekeeping manager did expect housekeeping staff to completely remove the commode when cleaning the bathroom floor and to properly clean the toilet.
On 12/16/15 at 12:50 PM interview with Administrative Staff #4 revealed that the bathroom floors were something she had been trying to address. She stated that they were old floors that were stained and that the stains may not be able to be removed. Administrative Staff #4 said that the corporate office wanted the facility to continue attempting cleaning strategies before new flooring could be approved.
On 12/16/15 at 5:25 PM the resident bathroom floor for Room 113/115 appeared to have been stripped and all discoloration to the floor tile had been removed. The floor looked clean.
On 12/16/15 at 5:30 PM the resident bathroom floor to Room 109/111 appeared to have been stripped and all discoloration to the floor tile had been removed. The floor looked clean and the baseboard had been removed.
On 12/17/15 at 7:37 AM interview with Housekeeping Aid #1 on 100 hall revealed that she had not been cleaning the floors daily by sweeping and mopping but acknowledged. She had been cutting corners to do it quickly, due to the workload, and was possibly missing back corners of the bathrooms. She also stated that she had not been removing the commodes to clean the floor but that she was going to start doing that after talking to the Administrator yesterday. The Housekeeping Aide said that the black matter on the floor was wax buildup which needed to be stripped and would not come clean with just mopping. She stated that in the past stripping had been done more frequently but she did not know what the current schedule was. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 8 added that in the past they used a scraping tool to clean along the baseboards but the tool was not used anymore.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 278	F 278 Assessment	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 interview, the facility failed to accurately code the Minimum Data Set (MDS) for medications for three (3) of five (5) residents reviewed for unnecessary medications (Resident #118, #47, #7) and failed to accurately code the MDS for incontinence for two (2) of two (2) residents reviewed for incontinence (Resident #151, #144). The findings included: 1. Resident #118 was admitted to facility on 9/30/15. Cumulative diagnoses included atrial fibrillation (irregular heart rate). Admission physician orders dated 9/30/15 were reviewed and revealed, in part, the following medications: Hygroton (hypertensive medication that contains chlorthalidone, a diuretic medication) 25 mg by mouth daily, Eliquis (anticoagulant medication) 5 mg by mouth twice daily and Desyrel (antidepressant medication) 150 mg by mouth every night. An Admission MDS dated 10/7/15 indicated Resident #115 received the following medications during the assessment period: seven (7) days of antidepressant medication, seven (7) days of diuretic medication and three (3) days of antibiotic medication. Anticoagulant medication was noted as"0" (not having received any of this medication) during the assessment period. A review of the October 2015 Medication Administration Record (MAR) revealed the following medications were administered to Resident #115 during the assessment reference period (October 1, 2015-October 7, 2105: Hygroton-six (6) days and Eliquis-six (6) days. On 12/17/2015 at 1:11PM, the MDS nurse stated	F 278	Accuracy/Coordination/Certified On 1/8/16, the MDS nurse updated The Minimum Data Set (MDS) assessments for residents # 118□s, #47□s, and #7□s to reflect accurate coding for medications. On 1/8/16, the MDS nurse updated residents #151□s, and #144s MDS to reflect urinary incontinence accuracy. On 1/8/16, the administrator, director of nursing (DON), MDS nurse and hall nurse initiated a 100% audit of the last completed MDS assessment for each resident to ensure the MDS assessment reflected accuracy to include coding for medications and urinary incontinence. This audit was completed on 1/14/16. Any identified areas of concern were modified by the MDS nurse as indicated by the RAI Manual. On 12/18/15, the Assistant Director of Nursing (ADON) re-educated the MDS nurses on MDS Accuracy to include the following: MDS assessments must contain accurate information of resident assessment including medications and urinary incontinence. On 1/7/16, the corporate consultant re-educated the administrator, DON, and MDS nurse on Assessment/Accuracy/ Coordination/Certified which included: 1. The MDS must be accurately coded based on guidelines listed in the Resident Assessment Instrument (RAI) manual. 2. Medications must be coded accurately per the medication□s therapeutic category	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

the information to complete the MDS was obtained by copying the MAR and obtaining the information from the MAR. She stated anticoagulants should have been accurately coded as six (6) days and the diuretic medication should have been documented as six (6) for Resident #118.

On 12/17/2015 at 3:41PM, Nurse #3 stated she completed the admission MDS for Resident #118 and was an oversight for not coding the anticoagulant medication on the MDS and not coding the diuretic medication correctly.

2. Resident # 151 was admitted to the facility 7/15/15. Cumulative diagnoses included: unspecified kidney failure and possible renal (kidney) cell carcinoma (cancer).

An Admission MDS dated 7/22/15 indicated Resident #151 was severely impaired in cognition. Extensive assistance was needed with toilet use. Resident #151 was frequently incontinent of bladder functions.
A care area assessment (CAA) for urinary incontinence dated 7/28/15 stated Resident #151 was incontinent of bladder functions.
A Quarterly MDS dated 10/12/15 indicated Resident #151 was severely impaired in cognition. Resident #151 required total assistance from nursing staff for toileting and was totally incontinent of bladder.
Nursing notes from 7/15/15 through present were reviewed and revealed Resident #151 required total assistance from staff for all areas of care.
A review of the nursing assistant documentation revealed there was no documentation regarding the bladder functioning of Resident #151.
On 12/17/15 at 11:03AM, the MDS nurse stated

and/or pharmacological classification and number of days actually received during the 7 day look back period. 3. For example, blood pressure medications such as Hygroton that contains chlorthalidone, a diuretic medication should be coded as a diuretic for the number of days actually received during the 7 day look back period. 4. Another example, Klonopin must be coded as an antianxiety regardless of the intended use. 5. Urinary incontinence on the MDS must be coded accurately to reflect the resident□s actual urinary continence status according to the number of incontinent episodes during the look back period. 6. For example, a resident who has no documented episodes of urinary continence may not be coded as frequently incontinent of bladder functions during the 7 day look back period. This re-education was completed 1/7/16. All future MDS coordinators will receive this re-education during their orientation process.

On 1/7/16, the corporate RAI/Reimbursement Auditor in serviced the administrator, DON and MDS nurse on MDS 3.0 Quality Measures which addressed coding accuracy to include medication classification and urinary (bladder) status.

Beginning 1/11/16, the Administrator, DON, and/or registered nurse (RN) supervisor will utilize a MDS Accuracy audit tool to monitor the accuracy of future completed MDS assessments for coding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 documentation regarding the urinary status for Resident #151 was obtained from a pre-conference with family, review the nursing notes written during the assessment period and from speaking to the nursing assistants who provide care for Resident #151. The MDS nurse stated they used a "working copy" form when they completed the MDS and discarded the working copy information once the MDS was completed. She reviewed the nursing notes for Resident #151 and stated she did not have anything to validate the information that Resident #151 had any continent episodes during the assessment period for the MDS dated 7/22/15. On 12/17/15 at 11:40AM, Nursing assistant (NA) #1 stated Resident #151 received total care by the nursing staff and was totally incontinent of bladder. 3. Resident #47 was admitted to the facility on 9/13/12 with multiple diagnoses including anxiety and mood disorders. A review of the Physician ' s Orders revealed an order dated 8/27/15 which stated Klonopin 0.5 milligrams (mg) 1 tablet by mouth twice a day for anxiety and an order dated 8/27/15 which stated Klonopin 0.25 mg by mouth at 12:00 PM for anxiety. A review of the Medication Administration Record dated 10/1/15 to 10/31/15 revealed the resident was administered Klonopin 0.5 mg 1 tablet by mouth twice a day for anxiety and Klonopin 0.25 mg by mouth at 12:00 PM for anxiety as ordered by the physician. A review of the annual Minimum Data Set (MDS)	F 278	of medication classification and urinary incontinence. The MDS Accuracy Audit tool will be completed for 25% of completed MDS assessments weekly x 4 weeks, then bi-weekly x 4 weeks then 10% monthly x 3 months. All identified areas of concern will be addressed immediately by the Administrator, DON, and/or RN supervisor for modification or significant correction of the MDS assessment by the MDS nurse to accurately reflect the resident□s current condition. The administrator will monitor for proper completion and follow up of the MDS Accuracy Audit tool by initialing the bottom right hand corner of the audit tool. The DON and/or QI nurse will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12	F 278		

dated 10/23/15 revealed the resident was not assessed with the use of an antianxiety medication.

An interview was conducted with the MDS Nurse on 12/17/15 at 1:10 PM. She stated Klonopin was classified as an anticonvulsant medication. The resident was not expected to be assessed with the use of an antianxiety medication due to the administration of Klonopin on the annual MDS dated 10/23/15.

An interview was conducted with the Pharmacist on 12/17/15 at 1:59 PM. She stated Klonopin was classified as an anticonvulsant and an antianxiety medication.

4. Resident #7 was admitted to the facility on 10/17/09 with multiple diagnoses that included dementia and anxiety disorder.

The annual Minimum Data Set (MDS) assessment dated 9/24/15 indicated Resident #7 had moderate cognitive impairment. The question #N0410B located in the Medications Section of the 9/24/15 MDS indicated Resident #7 did not receive antianxiety medications during the seven day look back period. A review of the Medication Administration Record (MAR) for the look back period revealed Resident #7 received Clonazepam on seven of seven days.
An interview was conducted on 12/17/15 at 1:10 PM with the MDS nurse. She stated that multiple staff assisted in the completion of the MDS, but she was responsible for the oversight. She stated that she expected the MDS to be coded accurately. She stated that the Medications section of the MDS was completed by reviewing the MAR. Resident #7's MAR was reviewed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 13	F 278		

the MDS nurse. During the review, it was determined that Resident #7 received Clonazepam on seven of seven days of the look back period. The MDS nurse revealed that they had some confusion with the medication classification of Clonazepam. She stated that the reference source they utilized listed the primary classification of Clonazepam as an anticonvulsant. She stated she was aware it was also classified as an antianxiety medication.

An interview was conducted on 12/17/15 at 1:59 PM with the facility's Pharmacist. She stated that Clonazepam had multiple medication classifications. She stated it was classified as an antianxiety medication and an anticonvulsant medication. She stated that the reference manual the facility had utilized did not classify the medication as an antianxiety medication. She stated the facility may need to change their reference manual to code the medications according to the classifications specified in their regulations.

5. Resident #144 was initially admitted to the facility on 7/8/14 and was readmitted on 7/1/15 with multiple diagnoses that included dementia and heart failure.

The quarterly Minimum Data Set (MDS) assessment dated 10/8/15 indicated Resident #144 had moderate cognitive impairment. The question #H0300 located in the Bladder and Bowel Section of the 10/8/15 MDS indicated Resident #144 was occasionally incontinent of bladder (less than seven episodes of incontinence).

A review of Resident #144's nursing progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 14 notes for the seven day look period of the 10/8/15 MDS was conducted. The nursing progress notes for all seven days indicated that Resident #144 was continent of bladder. There was no documentation that indicated Resident #144 had an episode of bladder incontinence during the seven day look back period assessed for the 10/8/15 MDS. An interview was conducted on 12/17/15 at 1:10 PM with the MDS nurse. She stated that question #H0300 was answered predominantly by reviewing nursing progress notes. She stated that Nursing Assistants (NAs) did not document resident's urinary continence status. She stated that she had asked NAs for additional information when needed, but there was no documentation of the information they provided. The MDS nurse reviewed Resident #144's nursing notes for the seven day look back period of the 10/8/15 MDS. The nursing notes indicated the resident was continent. There was no documentation that indicated the resident was incontinent. The MDS nurse stated that she could not recall the information that would have contradicted the nursing notes for Resident #144's 10/8/15 MDS.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 15 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan for 1 of 1 residents on dialysis (Resident #179). The findings included: Resident #179 was admitted on 10/28/15 with diagnoses including kidney failure and cerebral infarction. The resident was also on dialysis. Review of the Admission Minimum Data Set (MDS) dated 11/9/15 revealed the resident was cognitively intact and on dialysis. Review of the Care Plan dated 11/20/15 revealed that there was not a plan of care for dialysis for Resident #179. On 12/17/15 at 2:27 PM interview with the MDS Coordinator revealed that she had been unaware the resident did not have a care plan for dialysis but acknowledged there should have been one. She said she did not know why a dialysis care plan had not been developed and that it must have been a oversigh but would be corrected.	F 279	F 279 Develop Comprehensive Care Plans On 12/17/15, the MDS nurse reviewed the plan of care for resident # 179 to include the addition of a care plan for dialysis. On 12/18/15, the assistant director of nursing (ADON) completed a 100% audit of all residents on receiving dialysis services to ensure each resident on dialysis had a care plan for dialysis included in his/or her plan of care. 100% of the dialysis residents have a care plan for dialysis included in his/her plan of care. No further action was taken. On 12/18/15, the ADON provided re-education for the MDS nurse(s) on Comprehensive Care Plans which included the following: Any resident receiving dialysis must have a care plan specific to dialysis. On 1/8/16, the corporate nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 16	F 279	re-educated the administrator, director of nursing, RN supervisor, QI nurse, and MDS on Comprehensive Care Plans. The re-education included the following: 1. A facility must use the results of the assessment to develop, review and revise the resident□s comprehensive plan of care. 2. For example, a resident who receives hemodialysis should have a plan of care for dialysis. All future MDS nurses will receive this re-education during the orientation process. Beginning 1/11/16, The Director of Nursing (DON), QI nurse, and/or RN supervisor will utilize a Care Plan Audit tool to ensure that care plans reflect the resident□s' current medical status to include dialysis needs. The Care Plan Audit tool will be utilized weekly for 25% of resident care plan completed x 8 weeks, then bi-weekly x 4 weeks, then 10% monthly x 3 months. All identified areas of concern will be addressed immediately by the MDS nurse to make needed care plan updates. The administrator will monitor for proper completion and follow up of the Care Plan Audit tool by initialing the bottom right hand corner of the audit tool. The DON and/or QI nurse will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 17	F 279	process and/or any recommendations for sustaining compliance and continued monitoring.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and physician interview, the facility failed to obtain a digoxin (heart medication) level and basic metabolic panel (BMP) as ordered by the	F 329	F 329 Drug Regimen is Free From Unnecessary Drugs On 12/17/15, the QI nurse received a	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18 physician for one of five sampled residents (Resident #118). The findings included: 1. a. Resident #118 was admitted to facility 9/30/15. Cumulative diagnoses included atrial fibrillation (irregular heart rate) and carotid artery disease. An Admission Minimum Data Set (MDS) dated 10/7/15 indicated Resident #118 was moderately impaired in cognition. Admission orders were reviewed and revealed a physician's order for lanoxin (digoxin) 0.125 milligrams (mg) po (by mouth) daily. A physician's order dated 10/8/15 at 9:15AM stated HgbA1C (laboratory test for average glucose level), CMP (comprehensive metabolic panel) and digoxin levels stat now to (name) hospital. A nursing note dated 10/8/15 at 2:36PM stated Resident #118 had a toxic digoxin level of 3.8. A normal digoxin level is 0.9-2.0. A physician's order dated 10/8/15 at 4:00PM stated to hold digoxin pending digoxin level on Monday 10/12/15. A review of the medical record revealed no documentation that the digoxin level had been drawn. No laboratory results for a digoxin level for 10/12/15 was in Resident #118's medical record. On 12/16/2015 at 2:58PM, Administrative staff #2 stated the nurse who took off the physician's order for the repeat digoxin level to be done	F 329	telephone order to do a STAT BMP and Digoxin level for resident # 118. The BMP and Digoxin level was drawn on 12/18/15. The results of the BMP was faxed to the physician 12/18/15 by the hall nurse. Resident # 118 is no longer taking digoxin. On 1/2/16, the QI nurse completed a 100% audit for all resident labs that had been ordered for the past 90 days which included results being in each resident's medical record. If labs could be not located on the resident's chart or lab data base a physician telephone order was obtained to re-draw the ordered lab. The hall nurse, charge nurse, and/or RN supervisor notified the physician of the lab results upon receipt. On 1/8/16, the director of nursing (DON), RN supervisor and QI nurse initiated a re-education for 100 % licensed nurses (to include all shifts, prn, and weekend nurses) on Drug Regimen is Free from Unnecessary Drugs. This re-education included the following: 1. each residents drug regiment must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use: or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 2. For example, when a digoxin level is ordered by a physician for a resident taking digoxin who has a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 10/12/15 should have entered the lab order in the computer. When the phlebotomist (person who draws the blood) came to draw the blood, the requisition is printed off and would indicate what labs should be drawn. Administrative staff #2 stated she did not know if the digoxin level on 10/12/15 was drawn and, if it had been done, why the results were not in the medical record. She stated she would have to speak to the nurse who took off the physician's order and that nurse no longer worked at the facility. She stated she expected physician's orders to be carried out in a timely manner (upon receiving the order). On 12/17/2015 at 9:09AM, Administrative staff #1 stated there was not a repeat digoxin level done on 10/12/15. She stated she did not know why it was not done but she expected nursing staff to follow the physician's orders and a repeat digoxin level should have been obtained. On 12/17/15 at 3:00PM, Resident #118's physician (MD) was interviewed and stated he was not aware that the digoxin level was not done on 10/12/15 and he expected nursing staff to obtain the labs as ordered by the physician. 1. b. Resident #118 was admitted to facility 9/30/15. Cumulative diagnoses included atrial fibrillation (irregular heart rate) and carotid artery disease. An Admission Minimum Data Set (MDS) dated 10/7/15 indicated Resident #118 was moderately impaired in cognition. A review of Resident #118's physician's orders revealed a physician's order dated 11/24/15 to check BMP in one week.	F 329	history of a critical digoxin level, it should be drawn as ordered. The physician should be notified of the results upon receipt. 3. For example, when a BMP is ordered by a physician for a resident taking Glucophage, the BMP should be drawn as ordered. The physician should be notified of the results upon receipt. 4. When a physician orders a lab, the hall nurse, charge nurse and or RN Supervisor should schedule the lab as ordered. When the lab is drawn as scheduled, the hall nurse charge nurse and or RN Supervisor should follow up to make sure the lab was drawn and the physician is notified of the results upon receipt. 5. Labs that are ordered to be done STAT by the physician, must be drawn immediately by the hall nurse, charge nurse or RN Supervisor and are taken to the lab by transporter or nursing staff. The physician should be notified by the hall nurse, charge nurse and or RN Supervisor of the lab results upon receipt. Routine labs are entered into the electronic lab system by the nurse receiving the order and the phlebotomist prints out requisitions upon arrival to the facility of labs to be drawn. This re-education was completed 1/14/16. All future licensed nurses will be given this education during their orientation process. On 1/11/16, the director of nursing (DON) completed education for the QI nurse and the RN supervisor on the Laboratory Monitoring audit tool. Beginning 1/15/16 the facilitys Point Click	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20 A physician progress note dated 11/24/15 stated Resident #118 was seen for routine follow-up. Plan: increase Glucophage (medication for diabetes) to 1000 milligrams (mg) twice daily. Check basic metabolic panel (BMP) in one week. A review of Resident #118's medical record was completed. No documentation was noted that the BMP was drawn on 12/1/15. No laboratory results for 12/1/15 were noted in the medical record. On 12/16/15 at 2:58PM, Administrative staff #2 stated she was not sure if the BMP had been drawn. She stated she would need to check the computer and see if the physician order had been entered and ordered to be drawn. Administrative staff #2 stated the nurse who signed off the physician's order was not currently working at the facility. She stated she expected that physician orders be carried out timely upon receipt of the order. On 12/17/15 at 9:09AM, Administrative staff #1 stated the lab ordered on 11/24/15 for 12/1 (BMP) had not been entered into the computer system to be completed and, therefore, had not been done. She stated the computer system the facility used to enter laboratory orders had broken so nursing staff had been instructed to make a copy of the physician's order, resident's face sheet and tape it on the top of the computer so the phlebotomist would know what needed to be drawn that day. She stated she expected nursing staff to follow physician's orders and the BMP should have been done 12/1/15 as ordered. On 12/17/15 at 3:00PM, Resident #118's	F 329	Care (PCC) Lab Integration for Carolina Medical Lab Services is scheduled for implementation. The facility may reasonably expect to begin receiving electronically transmitted lab report results beginning on Monday afternoon 1/18/16. Beginning 1/12/16, the QI nurse, and/or RN supervisor will utilize an audit tool titled Laboratory Monitoring to monitor timely completion of ordered labs with availability in the residents medical record. The Laboratory Monitoring audit tool will be completed for 100% of ordered labs 5 x weekly x 2 weeks, 75% of ordered labs 3 x weekly x 2 weeks, 50% of ordered labs 1 x weekly x 4 weeks, 25% of ordered labs twice monthly x 4 weeks, and then 25% of ordered labs every 4 weeks x 12 weeks. Any negative findings will be addressed immediately. The DON will monitor for proper completion and follow up of the Laboratory Monitoring audit tool by initialing the bottom right hand corner of the audit tool. The DON and/or QI nurse will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 physician was interviewed. He stated the order for the repeat BMP had been written by the nurse practitioner and he was not aware that the BMP had not been done. He stated he expected nursing staff to obtain the labs as ordered by the physician.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to discard eight single serving packets of sour cream by their expiration date and failed to label and date a four quart storage container of shredded cheese located in the kitchen reach in refrigerator. The findings included: On 12/14/15 during the initial tour of the kitchen that began at 3:45 PM an observation of the reach in refrigerator revealed eight single serving packets of sour cream each with an expiration date of 11/1/15 and a four quart storage container of shredded cheese that was not labeled and dated. At the time of the observation, the Dietary	F 371	F 371 Sanitary Conditions On 12/14/15, the dietary manager (DM) discarded the expired sour cream packages and the unlabeled container of shredded cheese. On 12/14/15, the DM completed a 100% audit of all foods which included refrigerated foods to ensure no other foods were expired. Any negative findings were immediately addressed. On 12/14/15, the DM completed a 100 % audit of all foods to ensure each food was labeled with the name of the product and the date it was opened. Any negative findings were immediately n addressed.	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 Manager (DM) stated that they must not have checked the expiration date on the sour cream packets. She stated that the storage container of shredded cheese without a label and date was an oversight. The DM disposed of the sour cream packets and she labeled and dated the storage container of shredded cheese. An interview was conducted with the DM on 12/17/15 at 2:45 PM. She stated that the facility did not have a written policy that addressed labeling and dating opened food items or the disposal of expired food items. She stated that it was the facility protocol to label and date all opened food items and to discard all expired items immediately.	F 371	On 12/15/15, the DM and the assistant dietary manager (ADM) initiated re-education for all dietary employees on Labeling and Dating Food Items and Discarding Out of Date Items. This re-education included the following: 1. Foods that have reached the expiration dates should be discarded immediately. 2. Items should be labeled when opened-the name of the product and the date it was opened. Re-education was completed on 12/17/15. All future dietary employees will receive this education during orientation. Beginning 12/15/15, the ADM and/or cook will utilize a QI monitoring tool, Noncompliance Items, to ensure all expired foods are discarded and that all containers of foods are labeled with the name of the product and the date it was opened. The ADM and/or cook will utilize the Noncompliance Items tool 7 times weekly x 2 weeks, then 3 times weekly x 4 weeks, then twice weekly ongoing. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Noncompliance Items tool by initialing the bottom right hand corner of the audit tool. The DM will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and	F 431	F 431 Drug Records, Label/Store Drugs	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 24 observations, the facility failed to discard one tuberculin vial 30 days after opening in one of three medication refrigerators (500 Hall Refrigerator) and the facility failed to monitor and record temperatures in two of three medication refrigerators (100-400 Hall Refrigerator and Narcotics Refrigerator). 1. A review of the Medication Expiration Dates policy revised 1/1/14 stated tuberculin purified protein derivative was to be discarded 30 days after opening. The manufacturer ' s specifications for tuberculin read " Discard opened product after 30 days. " An observation of the 500 Hall medication refrigerator on 12/17/15 at 11:05 AM revealed one opened 1 milliliter vial of tuberculin. The vial was marked with an opening date of 9/29/15. An interview was conducted with Nurse #4 on 12/17/15 at 11:05 AM. The Nurse stated tuberculin was expected to be discarded 60 to 90 days after opening. An interview was conducted with Administrative Staff #1 on 12/17/15 at 1:44 PM. She stated the night shift nursing staff was expected to monitor the medication refrigerators at least monthly for expired medications. She stated the nursing staff was expected to discard tuberculin 30 days after opening. 2. On 12/17/15 at 10:40AM, an observation of the main medication room refrigerators was	F 431	& Biologicals On 12/17/15, the hall nurse discarded the expired vial of tuberculin. On 12/17/15, the medication room refrigerator temperature logs were reviewed for completeness by the administrator. On 12/17/15, the director of nursing (DON), RN supervisor, and QI nurse completed a 100% audit of all medication carts, medication rooms, and medication refrigerators for medications that had expired per the manufacturer□s recommendations. No negative findings were identified. On 12/17/15, the administrator completed a 100% audit of the medication refrigerator temperature logs. Any negative findings were addressed immediately. On 12/18/15, the DON and ADON initiated a 100% re-education for all licensed nurses on checking medication refrigerator temperatures and recording the temperatures on the log. The re-education was completed on 1/14/16. On 1/8/16, the DON, RN supervisor and/or QI nurse initiated a 100% re-education for all licensed nurses on F431 Drug Records, Label/Store Drugs & Biologicals. This re-education included the following: 1. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 25 conducted. The main medication room contained two refrigerators-one with narcotic medications (refrigerator #1) and one with insulin medications, eye drop medication, influenza vaccines, pneumococcal vaccines, Intravenous antibiotic medications and tuberculin medications (refrigerator #2). The temperature of refrigerator #1 was 37 degrees Fahrenheit. The temperature of refrigerator #2 was 44 degrees. Manufacturer recommendations for insulin medications, influenza vaccines, tuberculin vaccines and pneumococcal vaccines recommend the medications be stored in refrigerators at 36 degrees Fahrenheit to 46 degrees Fahrenheit. A review of the temperature chart for the medication refrigerators (also has a narcotic refrigerator that is locked and only supervisors have key) was conducted. Recommendations at the bottom of the temperature log indicated the medication room refrigerator temperatures should be between 36 degrees Fahrenheit to 46 degrees Fahrenheit. The temperatures recorded on the November 2015 log were as follows: 11/2/15-44 degrees Fahrenheit; 11/6/15-36/40 degrees Fahrenheit; 11/7/15-36/40 degrees Fahrenheit; 11/8/15-36/40 degrees Fahrenheit; 11/10/15-36/40 degrees Fahrenheit; 11/12/15-36/40 degrees Fahrenheit; 11/13/15-36/40 degrees Fahrenheit; 11/15/15-34/40 degrees Fahrenheit; 11/22-34/40 degrees Fahrenheit; 11/23/15-36/40 degrees Fahrenheit; 11/24/15-36/40 degrees Fahrenheit; 11/27/15-36/40 degrees Fahrenheit; 11/29/15-34/40 degrees Fahrenheit; 11/30/15-30/40 degrees Fahrenheit. A total of four days were outside of the recommended temperature parameters of 36 degrees-46 degrees Fahrenheit. In November 2015, the	F 431	appropriate accessory and cautionary instructions, and the expiration date when applicable. 2. In accordance with State and Federal Laws, the facility must store all drugs and biologicals 3. All medications must be discarded when expired per the manufacturer□s recommendations. 4. For example, open tuberculin vials that are stored in the medication refrigerators must be discarded 30 days after opening. 5. For example, all medication room refrigerator temperatures must be maintained between 36-46 degrees. All refrigerator temperatures must be monitored and recorded on the posted refrigerator temperature record twice daily. This re-education was completed 1/13/16. All future licensed nurses will be given this education during their orientation process. On 1/13/16 at 9:30am and on 1/14/16 at 1:30pm the facility□s consultant pharmacist presented an in-service for all licensed nurses on Medication Expiration Dates. On 1/12/16, the Executive QI committee met to discuss the QI Action Plan for tag F 520 which included F 431: Drug Label and Storage. The committee consisted of the administrator, DON, QI nurse, RN supervisor, corporate consultant and medical director. Beginning 1/11/16, the DON, RN supervisor, and QI nurse will utilize a Medication Cart Inspection audit tool to monitor for expired medications in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 26 following days were blank with no documentation that the temperature had been checked-1/1,3,4,5,9,11,14,16,17,18,19,20,21,25,26. The temperatures recorded on the December 2015 log were as follows: 12/2/15-36 degrees Fahrenheit; 12/3/15-36/40 degrees Fahrenheit; 12/4/15-38/40 degrees Fahrenheit; 12/8/15-36/40 degrees Fahrenheit; 12/11/15-38/40 degrees Fahrenheit. The December 2015 log had no documentation that the refrigerator had been checked-12/1,5,6,7,9,10,12,13,14,15,16,17. On 12/17/15 at 1:33PM, Administrative staff #1 stated she expected the nursing staff to check the medication refrigerators twice daily and document the temperatures in the refrigerator temperature log books. She stated she had in-serviced the nursing staff in November on checking the refrigerator log temperatures twice daily on first shift and second shift. On 12/17/15 at 2:50PM, Nurse #1 stated the night shift nurse was responsible for checking and recording the medication refrigerator temperatures. Nurse #1 stated she had never been instructed to do the temperatures in the refrigerators and has never had an in-service on refrigerator temperatures. On 12/17/15 at 3:15PM, Administrative staff #1 stated she could not find a record of the in-service regarding obtaining and recording the refrigerator temperatures.	F 431	medication carts, medication rooms, and medication refrigerators. The Medication Cart Inspection audit tool will also be utilized by the DON, RN supervisor, and QI nurse to monitor the medication room refrigerator temperature logs. The temperature logs will be checked by the first and second shift nurse supervisors upon checking the medication refrigerator temperature to verify temperatures and ensure the logs are completed. The DON, RN supervisor, and QI nurse will utilize the Medication Cart Inspection audit tool 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, 1 x week x 4 weeks, and then twice monthly x 4 weeks, then 1 x monthly x 8 weeks. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Medication Cart Inspection audit tool by initialing the bottom right hand corner of the audit tool. The DON will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 27 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview the facility failed to maintain functioning call bells in resident rooms on 3 of 4 observed halls (100, 200 and 400 halls) and failed to maintain a functioning call bell in the resident bathroom for 1 room (Room 212) on one of 4 halls (hall). The findings included: 1. On 12/16/15 at 10:05 AM a call light was heard beeping at the 100/200 halls nursing station, however the display panel for Rooms 100 - 114 and on 100 hall and for Rooms 200 - 214 and 216 on 200 hall, did not have any indicator lights, light up, to show which room the call bell had been triggered in. The 100 and 200 halls were toured at this time and none of the rooms on either of these two halls had an indicator light, lit up, above the doorway to show which room the call bell had been triggered in. On 100 hall, after passing room 104 the call bell sound emanating from the call bell in the Nursing Station became faint and difficult to hear. On 200 hall after room 204 the call bell sound emanating from the call bell in the Nursing Station became faint and difficult to hear. On 12/16/15 at 10:15 AM to 10:46 AM continuous observation was conducted from the Nursing Station for 100 and 200 halls. Both 100 and 200 halls could be observed from the Nursing Station and the indicator lights above the doorways on each hall were visible. The call light that was beeping was still not showing up on the call light panel or on any of the indicator lights above the resident room doors. At 10:23 AM the indicator	F 463	F 463 Resident Call System-Rooms/Toilet/Bath On 12/16/15, the maintenance director initiated repairs the Resident Call System on 100, 200, and 400 halls to include the display panel for rooms 100-114 and room 214 and 216. The resident call system including the indicator lights above the resident room doors, call lights in resident rooms and bathrooms in the following rooms: Room # 104, #204, #103B, #101A, # 206A, #407A, #410B, #103, #409A, #410A, and #212. On 12/16/15 the call bell cord with duct tape in room #204A was replaced by the maintenance supervisor. The administrator, director of nursing, assistant director of nursing, maintenance director, and/or hall nurse gave each resident who was identified as not having a functioning call light a bell to use to notify staff of assistance needed until the resident□s call bell was repaired. All Resident Call System repairs were completed on 12/17/15 by the maintenance director with the exception of room bathroom call bell in room 212 part was ordered from corporate office and received 1/14/16 and repaired on 1/14/16 by the Maintenance Director. Prior to call bell being repaired was provided with a hand bell given to her by the Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 28 light for a call bell in room 216, light up. The call bell for room 216 was answered at 10:25 and the indicator light went out, however a beeping only call bell could still be heard. At 10:30 AM the indicator light for a call bell in room 213, light up and was answered at 10:46 AM but a beeping only call bell could still be heard. Various staff members were observed to pass through or be in the Nursing Station during the continuous observation. None of the staff noticed that there was an unanswered call beeping or that there was no indication of what room the call light was in. On 12/16/15 at 10:47 a tour of the resident rooms on 200 hall and then 100 hall was initialed. In room 103 B the call bell panel at the resident ' s bedside was observed and the small indicator light showing the call bell had been triggered was noted to be on. The call bell indicator light above the entrance door for room 103 B was still observed to be off. There was a resident in room 103 B (Resident #115) during this observation. She was sitting up in a scoot type wheelchair close to her bed with the call bell in reach. This resident had also been observed in this same location earlier during the tour of 100 hall that occurred on 12/16/15 at 10:05 AM as noted above. Resident #115 was interviewed and stated that she had not mashed the call bell and did not need anything. She indicated she was not aware that the call bell was on but said if she needed anything she would use it. The call bell was not turned off at this time. Review of the Admission Minimum Data Set Assessment for Resident #115 dated 10/22/15 showed the resident was cognitively impaired. On 12/16/15 at 11:20 AM a call bell without an indicator light could still be heard at the 100 and 200 hall nursing station. The call bells in all but 2	F 463	on 12/17/15. On 12/16/15, the administrator, maintenance director and assistant director of nursing completed a 100% audit of the Resident Call System to include resident room and bathroom lights. Any negative findings were immediately addressed. On 12/17/15, the administrator initiated re-education of the director of nursing and maintenance director regarding Resident Call System. The re-education included the following: 1. Call lights must be functional at all times. 2. If a call light is not functioning properly, an alternative way for the resident to call for help must be put in place. 3. The administrator should be notified immediately if the Resident Call System is not functioning properly. 4. For example, a hand bell should be given to the resident to use to notify staff that he or she needs help. On 12/17/15, the administrator, director of nursing, assistant director of nursing, and QI nurse expanded the re-education to all staff. This re-education was completed 1/14/16, any staff who hasn't completed in-service(d/t Illness, LOA, or vacation) will not be allowed to work until in-service is completed. All future employees will be educated by Staff Development Assistant and or HR during their orientation process. On 1/14/16, the administrator re-educated the Maintenance Director and Evening Supervisor to check the check the bathroom call light to see if it is left halfway between on and off when a staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 29 rooms on 100, 200, 300 and 400 halls were checked to see if they were triggering the call bell indicator light above the resident room doors to light up. The findings of this check revealed the following: Room 101 A call bell indicator lights above the resident room door did not light up when the call button was mashed. The resident in this bed appeared to be sleeping. Her roommate in room 101 B (Resident #122) was interviewed and indicated that the call light for room 101 A had not worked for some time (amount of time not specified), so Resident #122 would mash the call bell button for 101B when the resident in bed 101A needed something. She added that she believed that answered the call bell were aware that the call bell for room 101 A did not work. Review of the Quarterly Minimum Data Set Assessment dated 10/1/15 for Resident #122 revealed she was moderately cognitively impaired. Room 204 A and Room 206 A call bell indicator lights above the resident room door did not light up when the call button was mashed Room 407 A and Room 410 B call bell indicator lights above the resident room door did not light up when the call button was mashed On 12/16/15 at 11:30 AM the call bell indicator panel at the 100 and 200 hall Nursing Station was observed and did not have any light up call bell indicator lights. A beeping call bell could still be heard from the panel. On 12/16/15 at 11:40 AM Resident #115 was observed in Room 103 B in her wheelchair beside her bed with the call bell in reach. The bedside call bell panel indicator light was on however the call bell indicator light above the resident ' s room door was not on. The bathroom emergency call light for the shared bathroom between rooms 101	F 463	person reports a call light is not working. On 12/18/15, the assistant director of nursing, QI nurse, and RN supervisor initiated re-education on the following: 1. Each resident must have a functioning call bell. 2. If you are aware that a call bell is not functioning you must do the following. a. Initiate every 15 minute checks b. Give hand bell to resident to alert staff c. Administrator, director of nursing and maintenance director are to be notified immediately to ensure prompt repair of call bell system. 3. Call bells must be answered timely. 4. Please ensure that all cords are in good repair. This re-education will be completed 1/14/16. Beginning 12/18/15, the administrator, director of nursing, maintenance director, RN supervisor and/or QI nurse, social worker, activities director, and/or housekeeping director utilized a Call Light audit tool to monitor for functioning Resident Call System. This Call Light audit tool will be completed by auditing 25% of resident rooms to include room and bathroom lights 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks, and then weekly on an ongoing basis. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Call Light audit tool by initialing the bottom right hand corner of the audit tool. Beginning 1/12/16, a Call Light tool and Physical Plant/Environmental Cleanliness tool will be added to the Preventative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 30 and 103 was checked at this time. The activation switch was noted to be half way between the on and off position. The bathroom emergency call light was then triggered by pulling down to place the call bell in the on position. The bathroom call bell indicator light above the resident ' s room door or above the door for room 101 did not light up however the quicker beep of a bathroom emergency call bell could be heard. The bathroom call bell was then turned off by pushing the switch all the way to the off position. On exiting the room the call bell indicator light above the door to room 103 was observed to be on. On 12/16/15 at 11:49 AM the call bell for room 103B had been answered. On 12/16/15 at 11:50 AM Nurse #5, the 100 hall nurse, was interviewed. She stated that she had not been aware of a call bell on 100 hall (Room 103 B) that had been beeping, unanswered, from 10:05 AM - 11:49 AM (1 hour and 44 minutes). She also said that she had not noticed a beeping call bell, without a corresponding call bell indicator light on the call bell panel at the Nursing Station, when she was working at the Nursing Station computer during the time the call bell in room 103 B was beeping . She added that since the building was old they sometimes had electrical issues. Nurse #5 also said that if she did become aware of a beeping call light that had no indicator lights she would initiate a room to room check to locate the source of the call light. On 12/16/15 at 11:55 AM Nursing Assistant #2 was interviewed. He stated that she had not been aware of a call bell on 100 hall (Room 103 B) that had been beeping, unanswered, and without indicator lights from 10:05 AM - 11:49 AM (1 hour and 44 minutes). He stated that if he had noticed a call bell without an indicator light above the door or at the Nursing Station he would check	F 463	Maintenance Log to be utilized by the maintenance director monthly on an ongoing basis. Any negative findings will be addressed immediately. The administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 31	F 463		

the bathroom call bells and reset them to make sure they were properly turned off.
On 12/16/15 at 12:05 PM the Administrative Staff #4, Administrative Staff #1 and Maintenance Director were informed of the observations concerning the call light in Room 103 B. The Maintenance Director was interviewed with the Administrative Staff #4 and #1 present. He indicated that he had parts on order from the corporate office to fix the call lights in Room 103 B and 409 A and added that 409 A had a broken switch in the panel. He said he was unaware of problems with more than two call lights. He added that sometimes the call bell indicator lights above a resident ' s room door would go out but added that the call bell would always still light up at the Nursing Station. Administrative Staff #1 stated that because call lights were frequently triggered and the ringing of a call bell beeping sound was so common to staff that is was understandable why they did not notice a call bell when it did not have a corresponding indicator light. She acknowledged that 1 hour and 44 minutes was too long to wait for a call bell to be answered but that it was an unusual occurrence.
On 12/16/15 at 12:10 PM - 12:30 PM a tour was conducted with the Administrative Staff #4, Administrative Staff #1 and Maintenance Director and the following observations were made:

Room 103 B - bathroom emergency call light switch was moved to the position half way between on and off and did not trigger. The bedside call light for 103 B was then activated but the indicator lights above the resident room door and at the Nursing Station panel did not light up, however a beep could be heard. The bathroom emergency light for rooms 103/101 was then reset and the indicator lights above the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 32	F 463		

room door at the nursing station then came on.

Room 101 A - call light triggered but no light on above resident room door and no sound heard

Room 204 A - the emergency call bell in the resident bathroom was observed in the fully off position but when the bedside call light was triggered the call bell indictor light above the resident room door did not light up. The call bell cord was also observed to have been repaired with duct tape. The Maintenance Director stated he would replace the call bell cord.

Room 206 A - the emergency call bell in the resident bathroom was observed in the fully off position but when the bedside call light was triggered the call bell indictor light above the resident room door did not light up.

Room 407 A - the emergency call bell in the resident bathroom was observed in the fully off position but when the bedside call light was triggered the call bell indictor light above the resident room door did not light up.

Room 410 A - the emergency call bell in the resident bathroom was observed in the fully off position but when the bedside call light was triggered the call bell indictor light above the resident room door did not light up. After the emergency call bell in the bathroom for room 410 was tested the 410 A bedside call bell was tested again and the light above the resident ' s room door came on at that time.

On 12/17/15 at 9 AM the following call bells were checked, 101 A, 103 B, 204 A, 206 B, 407 A and 410 B. The call bell indicator light above the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 33	F 463		

resident room door for Room 410 A did not light up. The light above the door did light up when the other call bells were triggered.

On 12/17/15 at 9:47 AM the Maintenance Director was interviewed and stated that he had never done any call bell audits as he relied on staff to let him know when there were problems with the call bells.

On 12/17/15 at 1:30 PM Administrative Staff #4 was interviewed she stated that all the bedside call lights had been fixed on 12/16/15. She was informed that the call bell indictor light above the resident room door for Room 410 A was not coming on again. Administrative Staff #4 acknowledged that functioning call bells were important for resident safety and that the Maintenance Director had recently ordered parts to fix two call bells. She provided the email documentation from prior to 12/14/15 regarding the requested parts which revealed a request for 2 call bell cords.

2. On 12/16/15 at 11:30 AM the bathroom emergency call bell for Room #212 was triggered but did not function. The indicator light at the call bell panel in the bathroom did not come on, the bathroom call bell indicator light above the door to room 212 did not light up and the sound of the call bell could not be heard. Resident # 21 was in bed 212 B was interviewed and stated that she got up to the bathroom independently and that she did use that bathroom. She added that she had never needed to use the call bell in that bathroom so she had not known it wasn ' t working but said that she thought it should be fixed as she may need it someday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 34	F 463		

Review of the Quarterly Minimum Data Set dated 9/24/15 for Resident #22 revealed she was cognitively intact.

On 12/16/15 at 12:20 PM the Maintenance Director, Administrative Staff #4 and Administrative Staff #1 observed that the bathroom emergency call bell in Room 212 was not functioning. Administrative Staff #1 acknowledged that the resident in bed 212 B did use the bathroom independently and the Maintenance Director indicated he had been unaware that the call bell in the bathroom did not function. Administrative Staff #4 stated that it would be fixed and that in the meantime the resident would be given a hand held bell and staff would do checks on the resident every 15 minutes.

On 12/17/15 at 9:05 AM the bathroom emergency call bell was triggered and did not function. Resident #21 was interviewed and stated that she had not been given a hand held call bell and that she was unaware of anyone coming in to check on her every 15 minutes.

On 12/17/15 at 9:47 AM the Maintenance Director was interviewed and stated that he had never done any call bell audits as he relied on staff to let him know when there were problems with the call bells.

On 12/17/15 at 1:30 PM Administrative Staff #1 was interviewed. She stated that the resident in Room 212 B had been given a hand held bell and that staff were doing checks on her and her roommate every 15 minutes.

On 12/17/15 at 1:35 PM the bathroom emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 35 call bell was observed with Administrative Staff #4 and when it was triggered it did not turn on. The resident in Room 212B was interviewed with the Administrative Staff #4 present and stated she had not been given a hand held call bell. On 12/17/15 at 1:40 PM Nurse #1 was interviewed with Administrative Staff #4 present. She stated that she had not been aware that every 15 minute checks were to be done for room 212 so no one had been doing them. She also said that she had been unaware that the bathroom emergency call bell for Room 212 did not work.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and physician interview, the facility failed to maintain complete and accurate medical records as evidenced by not having laboratory results in the	F 514	F 514 Res Records-Complete/Accurate/Accessible On 1/11/16, medical records placed a	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 36 medical record for stat labs ordered by the physician on 10/8/15 for one of five sampled residents (Resident #118). The findings included: Resident #118 was admitted to facility 9/30/15. Cumulative diagnoses included atrial fibrillation (irregular heart rate) and carotid artery disease. An Admission Minimum Data Set (MDS) dated 10/7/15 indicated Resident #118 was moderately impaired in cognition. A review of the medical record revealed a physician's order dated 10/8/15 at 9:15AM for the following labs: HgbA1C (laboratory test for average glucose level), CMP (comprehensive metabolic panel) and digoxin levels stat now to (name) hospital. A physician's progress note dated 11/3/15 stated, in part, labs ordered 10/8/15 but not in record. Put labs in chart. A review of the medical record revealed no laboratory results for 10/8/15 were in Resident #118's medical record. On 12/16/2015 at 2:58PM, Administrative staff #2 stated medical records personnel print off the lab results and scan and upload the lab results in the computer medical record. She stated the lab results should have been in the computer medical record or a hard copy should have been placed on Resident #118's chart. She stated she did not know why the lab results for 10/8/15 were not on the chart. On 12/17/2015 at 2:09PM, Administrative staff #3 stated audited the charts once a month for labs	F 514	copy of the previously acknowledged Hgb A1c, CMP, and digoxin level on resident # 118□s chart. On 1/2/16, the QI nurse completed 100% audit for all resident labs that had been ordered for the past 90 days which included results being in each resident□s medical records. Any negative findings were addressed immediately. On 1/8/16, the director of nursing (DON), RN supervisor, and/or QI nurse initiated re-education for all licensed nurses on F 514 Res Records-Complete Accurate Accessible. This education included the following: 1. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily available; and systematically organized 2. For example, when a physician orders labs to be put in a chart i.e. CMP, it should be placed in the resident□s chart. 3. For example, any ordered lab should be placed in the resident□s medical record for the physician to review. This re-education was completed 1/14/16. All future licensed nurses will be educated during their orientation process. On 1/11/16, the director of nursing (DON) completed education for the QI nurse and the RN supervisor on the Laboratory Monitoring audit tool. Beginning 1/15/16 the facility□s Point Click Care (PCC) Lab Integration for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 37 (that they had been obtained and the results were in the medical record). Administrative staff #3 stated she chose five charts at random and had not audited Resident #118's chart in October or November. On 12/17/15 at 9:09AM, Administrative staff #1 stated the laboratory results from the stat labs done on 10/8/15 should have been obtained and placed in the medical record. She stated the labs had been done but the results had not been obtained by the facility and placed on the chart until 12/17/15. On 12/17/15 at 3:00PM, Resident #118's physician was interviewed. He stated he was not aware that the laboratory results from 10/8/15 were not in the medical record. He stated he expended nursing staff to obtain the labs as ordered and the laboratory results from 10/8/15 should have been on the medical record.	F 514	Carolina Medical Lab Services is scheduled for implementation. The facility may reasonably expect to begin receiving electronically transmitted lab report results beginning on Monday afternoon 1/18/16. Beginning 1/15/16, the QI nurse, and/or RN supervisor will utilize an audit tool titled Laboratory Monitoring to monitor timely completion of ordered labs with availability in the resident□s medical record. The Laboratory Monitoring audit tool will be completed 5 x weekly x 2 weeks, 3 x weekly x 2 weeks, 1 x weekly x 4 weeks, twice monthly x 4 weeks, and then every 4 weeks x 12 weeks. Any negative findings will be addressed immediately. The DON will monitor for proper completion and follow up of the Laboratory Monitoring audit tool by initialing the bottom right hand corner of the audit tool. The DON/and or QI nurse will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process. The administrator will present all findings at the next quarterly Executive QI committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 38 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility's Quality Assessment and Assurance committee (QAA) failed to maintain the implementations and monitor these interventions that the facility put into place February of 2015. This was for 1 recited deficiency which was originally cited in January of 2015 on a recertification survey deficiency in the area of drug label and storage on the recertification survey of 12/17/15. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to	F 520	F 520 QAA Committee On 12/18/15, the QI committee met to discuss the results of the annual recertification survey which was completed 12/17/15. Each survey concern was discussed including the QAA tag for a repeat citation regarding F 431: Drug Label and Storage. Minutes were taken. The QI committee consisted of the administrator, director of nursing (DON), assistant director of nursing (ADON), QI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 39 sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F431: Drug Label and Storage: Based on record review, staff interviews and observations, the facility failed to discard one tuberculin vial 30 days after opening in one of three medication refrigerators (500 Hall Refrigerator) and the facility failed to monitor and record temperatures in two of three medication refrigerators (100-400 Hall Refrigerator and Narcotics Refrigerator). During the recertification survey dated 1/23/15, the facility was cited at F431 for failure to date Advair and Prostat when opened on three of five carts and failed to discard expired Fleets enema from one of two medication rooms. On the present recertification survey the facility failed to discard tuberculin serum 30 days after it was opened and to monitor the temperatures in a medication refrigerator. On 12/17/2015 at 4:25PM, an interview was conducted with Administrative Staff #4, Administrative Staff #1 and Administrative Staff #3. Administrative Staff #3 stated the facility had a lot of new nursing staff and all staff was educated in drug storage, checking for expired medications in the refrigerators and medication carts and the need to monitor refrigerator temperatures. Administrative Staff #1 stated a lot of the nursing staff were not accustomed to check for expired medications and checking the refrigerator temperatures and that was the reason the tasks might have not been done.	F 520	nurse, RN supervisor, MDS nurse, maintenance supervisor, dietary manager, medical records and housekeeping supervisor. On 1/8/16, the corporate nurse consultant re-educated the administrator on F 520 QAA Committee to include the following: 1. A facility must maintain a quality assessment and assurance (QAA) committee consisting of the director of nursing services/ a physician designated by the facility: and at least 3 other members of the facility□s staff. The QAA committee must maintain implementations and monitor interventions that are put into place by the facility for any identified area in need of quality improvement to sustain compliance. 2. For example, F tag 431 was cited during the recertification survey in January 2015. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility□s inability to sustain an effective Quality Assurance Program. F tag 431 was cited again during the recertification survey dated 1/23/15. On 1/8/16 the administrator initiated re-education for the administrative staff to include the DON, QI nurse, RN supervisor, MDS nurse, maintenance supervisor, dietary manager, medical records and housekeeping supervisor. This re-education will be completed 1/14/15. All future administrative employees will be educated during their orientation process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	12/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 40	F 520	On 1/12/16, the Executive QI committee met to discuss the QI Action Plan for tag F 520 which included F 431: Drug Label and Storage. The committee consisted of the administrator, DON, QI nurse, RN supervisor, corporate consultant and medical director. Beginning 1/11/16, weekly QI committee meetings will be held in morning meeting to review compliance for F 431: Drug Label and Storage. All findings will be reviewed from the audit tools for any compliance issues with recommendations to correct and/or sustain compliance. The administrator and/or DON will present all compiled findings from the weekly QI meetings for review at the next Executive QI committee meeting which will include the medical director and consultant pharmacist. The Executive QI committee will validate the facility□s progress in correction of the deficient practices or identified concerns. The administrator and/or DON will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator and/or DON will report back to the Executive QI committee at the next scheduled meeting.	