

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345144</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE RIDGE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 PINEYWOOD ROAD</b> <b>THOMASVILLE, NC 27360</b>		
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F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, family and staff interviews, the facility failed to provide showers as scheduled for 4 (Residents # 1, #3, #4 &amp; #5) of 4 sampled residents who needed extensive assistance or totally dependent with bathing. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/1/16 with multiple diagnoses including Alzheimer's disease. The admission Minimum Data Set (MDS) assessment dated 9/8/16 indicated that Resident #1 had severe cognitive impairment, totally dependent with bathing and had no behavior. Resident #1 was not due for a comprehensive care plan as of 9/13/16 but he was scheduled to receive a shower twice per week on Wednesdays and Saturdays on the 3-11 shift. On 9/13/16 at 10:30 AM, the family member of Resident #1 was interviewed. The family member stated that she came to visit every day. She indicated that the resident was admitted 2 weeks ago and her concern was the facility was short of staff. The family member stated that she had been asking the nurse aide (NA) to give the resident a shower. The family member indicated that the resident was scheduled to have a shower every Wednesday and Saturday on 3-11 shift but</p>	F 312	<p>F312 resident #1 was provided a shower 9/17/16 resident #3 was provided a shower 9/21/16 #4 was provided shower(full BB per preference) on 9/21/16 resident #5 was provided a shower on 9/21/16. A 100% audit was completed on 9/20/16 of all residents to determine bathing preference by the facility consultant. 100% of all residents were offered and provided a shower on date by title. A new shower schedule was designed by DON and initiated on 9/21/16. 100% in-service was initiated on 9/21/16 by DON for all nursing staff regarding bathing, and showers. After date no nursing staff will be allowed to work until in-service completed. All newly hired nursing staff will be trained on during orientation. On 9/22/16 the DON, SDC, or RN supervisor will audit 100% of all residents weekly x 4 weeks, then biweekly x 8 weeks to ensure 2 showers were given. If shower was not given, then reason is documented in the resident chart. The audits will be documented on the Shower</p>	9/30/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 there was only one nurse aide assigned on the hall. When asked for a shower, the nurse aide responded that they were short of staff and they would give him a shower if they have time. The family member stated that the resident had one shower (9/10/16) since he was admitted to the facility after repeatedly asking for a shower. On 9/13/16 at 10:45 AM, Resident #1 was observed in bed. The resident's hair was uncombed. The form where the nurse aide had documented what type of bath was given to the resident was reviewed from September 1 - September 13, 2016. The form indicated that Resident #1 was not provided a shower since admission. On 9/13/16 at 10:05 AM, Nurse #1 was interviewed. She stated that several NAs had called out today (9/13/16). She was the Staff Development Coordinator (SDC) and was working on the floor to pass medications and provide treatments because the facility had not enough staff. On 9/13/16 at 12:00 noon, NA #1 was interviewed. NA #1 stated that she worked 7-3 shift on the hall where Resident #1 resided. She indicated that the staffing for NAs was very short, 2 NAs with 28 residents on the hall plus the assisted living residents. NA #1 further stated that she had to do her best but there was no time to do showers. NA #1 further stated that residents scheduled to have a shower were provided a partial bed bath. On 9/13/16 at 2:30 PM, the actual staffing for NAs working on the floor for 7-3 shift was observed. There were 2 NAs observed on 100 (28 residents) hall, 200 (27 residents) hall, 300 (22 residents) hall and 400 (24 residents)hall. At 5:00 PM, the actual staffing for the NAs working on the floor for 3-11 shift was observed. There was 1	F 312	Audit tool. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the audits monthly x 6 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.		

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F 312	<p>Continued From page 2</p> <p>NA working on 100, 200, 300 and 400 halls. On 9/13/16 at 3:50 PM, NA #2 was interviewed. NA #2 stated that she worked 3-11 shift on the hall where Resident #1 resided. She indicated that only 1 NA assigned on the hall with 28 residents on the 3-11 shift. She stated that she just did the best she could and residents who needed 2 person assist had to wait until she could get help from the other hall. She added that she had no time to give showers to residents scheduled to have a shower.</p> <p>On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that he worked 7-3 shift on the hall where Resident #1 resided and there were 2 NAs assigned on the hall most of the time. NA #4 indicated that the 2 NAs worked together and did the best they could. NA #4 added that most of the time showers were not provided consistently because they did not have the time to do it.</p> <p>On 9/14/16 at 9:35 AM, the administrator was interviewed. She stated that she expected at least one NA, and one nurse or a medication aide assigned on each hall and on each shift. She indicated that she had discussed with the NAs that if they could not give a shower to the resident, they could provide a full bed bath.</p> <p>2. Resident #3 was admitted to the facility on 3/2/16 with multiple diagnoses including pelvic fracture. The quarterly MDS assessment dated 6/8/16 indicated that Resident #3 had moderate cognitive impairment, needed extensive assist with bathing and had no behavior. There was no specific care plan for bathing for Resident #3, however she was scheduled to have a shower every Tuesdays and Fridays on the 3-11 shift.</p> <p>The grievance forms from August 22, 2016 to September 13, 2016 were reviewed. There were</p>	F 312			

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F 312	<p>Continued From page 3</p> <p>2 residents who filed a grievance for not getting their showers regularly including Resident #3. Resident #3 had a grievance dated 8/24/16 for not getting showers regularly. The response from the previous interim Director of Nursing (DON) were to monitor future showers and discussion with the involved nurse and NAs regarding the need for a shower was conducted on 8/25/16. On 9/13/16 at 10:05 AM, Nurse #1 was interviewed. She stated that several NAs had called out today (9/13/16). She was the Staff Development Coordinator (SDC) and was working on the floor to pass medications and provide treatments because the facility had not enough staff.</p> <p>On 9/13/16 at 2:30 PM, the actual staffing for NAs working on the floor for 7-3 shift was observed. There were 2 NAs observed on 100 (28 residents) hall, 200 (27 residents) hall, 300 (22 residents) hall and 400 (24 residents) hall. At 5:00 PM, the actual staffing for the NAs working on the floor for 3-11 shift was observed. There was 1 NA working on 100, 200, 300 and 400 halls.</p> <p>On 9/13/16 at 4:05 PM and on 9/14/16 at 8:30 AM, Resident #3 was interviewed. She stated that she had filed a grievance last month about not getting her shower regularly. She stated that she was provided a shower that day but last week she did not receive a shower again. She was told by the staff that they did not have time to give her a shower. Resident #3 further stated that there was only 1 NA assigned on the hall on the 3-11 shift. Resident #3 stated that she was given a shower last night (9/13/16) because the state was in the building.</p> <p>On 9/13/16 at 4:00 PM, Resident #3 was observed. The resident 's hair looked clean.</p> <p>On 9/13/16 at 4:08 PM, the previous interim DON</p>	F 312			

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F 312	<p>Continued From page 4</p> <p>was interviewed. She stated that she discussed the importance of shower with the NAs and nurse on the hall where Resident #3 resided. She also stated that she had no formal monitoring of the showers but she had written the shower schedule on the board to remind the staff of the resident ' s shower days.</p> <p>The form where the nurse aide had documented what type of bath was given to the resident was reviewed from August 22- September 13, 2016. The form indicated that Resident #3 was provided a shower three times on 8/27, 9/2 and 9/13/16. There was no shower provided on 8/23, 8/26, 8/30, 9/6 and 9/9/16.</p> <p>On 9/13/16 at 12:00 noon, NA #1 was interviewed. NA #1 stated that she worked 7-3 shift on the hall where Resident #3 resided. She indicated that the staffing for NAs was very short, 2 NAs with 28 residents on the hall plus the assisted living residents. She stated that most of the residents needed two person assist and they have to wait until she can get help. NA #3 further stated that she had to do her best but there was no time to do showers. NA #2 further stated that residents scheduled to have a shower were provided a partial bed bath.</p> <p>On 9/13/16 at 3:50 PM, NA #2 was interviewed. NA #2 stated that she worked 3-11 shift on the hall where Resident #3 resided. She indicated that only 1 NA assigned on the hall with 28 residents on the 3-11 shift. She stated that she just did the best she could and residents who needed 2 person assist had to wait until she could get help from the other hall. She added that she had no time to give showers to residents scheduled to have a shower.</p> <p>On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that he worked 7-3 shift on the hall where Resident #3 resided and there were 2 NAs</p>	F 312			

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F 312	<p>Continued From page 5</p> <p>assigned on the hall most of the time. NA #4 indicated that the 2 NAs worked together and did the best they could. NA #4 added that most of the time showers were not provided consistently because they did not have the time to do it. On 9/14/16 at 9:35 AM, the administrator was interviewed. She stated that she expected at least one NA, and one nurse or a medication aide assigned on each hall and on each shift. She indicated that she had discussed with the NAs that if they could not give a shower to residents, they could provide a full bed bath.</p> <p>3. Resident #4 was admitted to the facility on 11/23/15 with multiple diagnoses including cerebro vascular disease with hemiplegia and hemiparesis. The quarterly MDS assessment dated 8/8/16 indicated that Resident #4 had memory and decision making problems and was totally dependent with bathing. There was no specific care plan for bathing for Resident #4, however he was scheduled to have a shower every Monday and Thursday on the 7-3 shift. The form where the nurse aide had documented what type of bath was given to the resident was reviewed from August 22- September 13, 2016. The form indicated that Resident #4 was not provided a shower. On 9/13/16 at 10:05 AM, Nurse #1 was interviewed. She stated that several NAs had called out today (9/13/16). She was the staff Development Coordinator (SDC) and was working on the floor to pass medications and provide treatments because the facility had not enough staff. On 9/13/16 at 11:00 AM, Resident #4 was observed in bed. The resident's hair looked unkempt.</p>	F 312			

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F 312	<p>Continued From page 6</p> <p>On 9/13/16 at 12:00 noon, NA #1 was interviewed. NA #1 stated that she worked 7-3 shift on the hall where Resident #4 resided. She indicated that the staffing for NAs was very short, 2 NAs with 28 residents on the hall plus the assisted living residents. She stated that most of the residents needed two person assist and they have to wait until she can get help. NA #3 further stated that she had to do her best but there was no time to do showers. NA #1 further stated that residents scheduled to have a shower were provided a partial bed bath. NA #1 added that Resident #4 was scheduled to have a shower today but she had given him a partial bed bath instead.</p> <p>On 9/13/16 at 2:30 PM, the actual staffing for NAs working on the floor for 7-3 shift was observed. There were 2 NAs observed on 100 (28 residents) hall, 200 (27 residents) hall, 300 (22 residents) and 400 (24 residents) hall. At 5:00 PM, the actual staffing for the NAs working on the floor for 3-11 shift was observed. There was 1 NA working on 100, 200, 300 and 400 halls.</p> <p>On 9/13/16 at 3:50 PM, NA #2 was interviewed. NA #2 stated that she worked 3-11 shift on the hall where Resident #4 resided. She indicated that only 1 NA assigned on the hall with 28 residents on the 3-11 shift. She stated that she just did the best she could and residents who needed 2 person assist had to wait until she could get help from the other hall. She added that she had no time to give showers to residents scheduled to have a shower.</p> <p>On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that he worked 7-3 shift on the hall where Resident #4 resided and there were 2 NAs assigned on the hall most of the time. NA #4 indicated that the 2 NAs worked together and did the best they could. NA #4 added that most of</p>	F 312			

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F 312	<p>Continued From page 7</p> <p>the time showers were not provided consistently because they did not have the time to do it. On 9/14/16 at 9:35 AM, the administrator was interviewed. She stated that she expected at least one NA, and one nurse or a medication aide assigned on each hall and on each shift. She indicated that she had discussed with the NAs that if they could not give a shower to residents, they could provide a full bed bath.</p> <p>4. Resident #5 was admitted to the facility on 7/22/11 with multiple diagnoses including Parkinson ' s disease. The quarterly MDS assessment dated 7/31/16 indicated that Resident #5 had moderate cognitive impairment, totally dependent with bathing and had no behavior.</p> <p>The care plan dated 7/25/16 for Resident #5 was reviewed. The care plan indicated that the resident required assist with bath at the sink. The care plan did not address the shower, however, she was scheduled to have a shower every Tuesday and Friday on 3-11 shift.</p> <p>The form where the nurse aide had documented what type of bath was given to the resident was reviewed from August 22- September 13, 2016. The form indicated that Resident # 4 was not provided a shower.</p> <p>On 9/13/16 at 10:05 AM, Nurse #1 was interviewed. She stated that several NAs had called out today (9/13/16). She was the Staff Development Coordinator (SDC) and was working on the floor to pass medications and to provide treatments because the facility had not enough staff.</p> <p>On 9/13/16 at 2:30 PM, the actual staffing for NAs working on the floor for 7-3 shift was observed. There were 2 NAs observed on 100 (28 residents) hall, 200 (27 residents)hall, 300 (22</p>	F 312			

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F 312	Continued From page 8 residents) hall and 400 (24 residents) hall. At 5:00 PM, the actual staffing for the NAs working on the floor for 3-11 shift was observed. There was 1 NA working on 100, 200, 300 and 400 halls. On 9/13/16 at 5:10 PM, NA #3 was interviewed. NA#3 stated that she worked 3-11 shift on the hall where Resident #5 resided. There was only 1 NA assigned on the hall with 22 residents. NA #3 stated that she did the best she could and she did not have time to give showers to residents scheduled to have a shower on 3-11 shift. NA #3 further stated that Resident # 5 was scheduled to have a shower today (Tuesday) but she would not be able to give her a shower. On 9/13/16 at 5:15 PM, Resident #5 was observed. The resident was dressed on street clothes and her hair was combed. On 9/14/16 at 9:35 AM, the administrator was interviewed. She stated that she expected at least one NA, and one nurse or a medication aide assigned on each hall and on each shift. She indicated that she had discussed with the NAs that if they could not give a shower to residents, they could provide a full bed bath.	F 312			