PRINTED: 10/13/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
	345144	B. WING _			C <b>09/14/2016</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/11/2010
PINE RIDGE HEALTH AND REHA	BII ITATION CENTER		706 PINEYWOOD ROAD		
FINE RIDGE REALITIAND RETA	BILITATION CENTER		THOMASVILLE, NC 27360		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	
SS=E DEPENDENT RESII  A resident who is un daily living receives	ARE PROVIDED FOR DENTS  able to carry out activities of the necessary services to on, grooming, and personal	F3	12		9/30/16
This REQUIREMEN by: Based on record revesident, family and failed to provide sho (Residents # 1, #3, # residents who needed totally dependent with totally dependent with the resident #1 was a 9/1/16 with multiple Alzheimer's disease Data Set (MDS) assindicated that Reside impairment, totally dispairment, totally dispairment, totally dispairment, totally dispairment, totally dispairment, and Saturdays on the Care plan as of 9/13/16 receive a shower two and Saturdays on the On 9/13/16 at 10:30 Resident #1 was into member stated that She indicated that the weeks ago and her of short of staff. The fathad been asking the resident a shower. That the resident was every Wednesday and the resident was every Wednesday and the states.	The admission Minimum essment dated 9/8/16 ent #1 had severe cognitive ependent with bathing and due for a comprehensive 16 but he was scheduled to ce per week on Wednesdays		F312 resident #1 was provided a sho 9/17/16 resident #3 was provided shower 9/21/16 #4 was provided shower (full BE preference) on 9/21/16 residen provided a shower on 9/21/16. A 100% audit was completed o of all residents to determine ba preference by the facility consu of all residents were offered and a shower on date by title. A new schedule was designed by DOI initiated on 9/21/16. 100% in-service was initiated on by DON for all nursing staff reg bathing, and showers. After da nursing staff will be allowed to vin-service completed. All newly nursing staff will be trained on corientation. On 9/22/16 the DON, SDC, or I supervisor will audit 100% of all weekly x 4 weeks, then biweek weeks to ensure 2 showers we shower was not given, then readocumented in the resident chaaudits will be documented on the	ed a 3 per t #5 was n 9/20/16 thing lltant. 100 d provide w shower N and n 9/21/10 arding ate no work unti hired during RN I residen lly x 8 re given. ason is art. The	o% ed f 6 I ts

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

**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.

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED			
							С
		345144	B. WING			09	/14/2016
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND RE	HABILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 312	Continued From p	page 1	F;	312			
	there was only on	e nurse aide assigned on the			Audit tool. The results of the complete	ed	
	hall. When asked	for a shower, the nurse aide			audit tool will be reviewed weekly by tl	ne 💮	
	responded that th	ey were short of staff and they			Administrator and/or the Director of		
	-	shower if they have time. The			Nursing. The QI Committee will review	v	
	family member sta	ated that the resident had one			the audits monthly x 6 to determine the	Э	
	shower (9/10/16)	since he was admitted to the			continued need for and frequency of		
	facility after repea	ntedly asking for a shower.			monitoring. Any recommended chang	es	
	On 9/13/16 at 10:	45 AM, Resident #1 was			will be discussed and carried out as		
	observed in bed. The resident's hair was				agreed upon at that time.		
	uncombed.						
	The form where the nurse aide had documented						
	what type of bath						
	reviewed from September 1 - September 13,						
		ndicated that Resident #1 was					
		ower since admission.					
		05 AM, Nurse #1 was					
		stated that several NAs had					
		9/13/16). She was the Staff ordinator (SDC) and was					
		or to pass medications and					
	_	s because the facility had not					
	enough staff.	is because the facility had not					
	_	00 noon, NA #1 was					
		#1 stated that she worked 7-3					
		here Resident #1 resided. She					
	indicated that the	staffing for NAs was very short,					
		sidents on the hall plus the					
		sidents. 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	e a shower were provided a					
	partial bed bath.						
		0 PM, the actual staffing for NAs					
		oor for 7-3 shift was observed.					
		s observed on 100 (28					
		00 (27 residents) hall, 300 (22					
		d 400 (24 residents)hall. At 5:00					
		affing for the NAs working on the					
	floor for 3-11 shift	was observed. There was 1					

NAME OF PROVIDER OR SUPPLIER  PINE RIDGE HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  CAGNIFICATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 312  Continued From page 2  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.  On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that the worked 7-3 shift on the hall where Resident #1 resided and there were 2 NAs	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  PINE RIDGE HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 312  Continued From page 2  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.  On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that he worked 7-3 shift on the hall			3/51//	B WING				_	
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could get help from the other hall. She added that she had no time to give showers to residents scheduled to have a shower. On 9/14/16 at 8:25 AM, NA #4 was interviewed. NA #4 stated that he worked 7-3 shift on the hall		*							
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NA #4 stated that he worked 7-3 shift on the hall									
Whole Resident in President and there were 2 to te									
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		the time showers v	were not provided consistently						
because they did not have the time to do it.		I -							
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.									
resident, they could provide a full bed batti.		resident, they coul	a provide a full bed batti.						
2. Resident #3 was admitted to the facility on		2. Resident #3 was	s 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		6/8/16 indicated th	at 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.			esdays and Fridays on the 3-11						
The grievance forms from August 22, 2016 to September 13, 2016 were reviewed. There were									

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		
		345144	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343144		STR	EET ADDRESS, CITY, STATE, ZIP CODE	09/	14/2016
NAME OF T	TO VIDER OR OUT FEILER				PINEYWOOD ROAD		
PINE RIDGE HEALTH AND REHABILITATION CENTER				DMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	2 residents who filed their showers regular Resident #3 had a gr not getting showers rethe previous interim E were to monitor future with the involved nurs need for a shower wa On 9/13/16 at 10:05 // interviewed. She star called out today (9/13 Development Coordin working on the floor to provide treatments be enough staff. On 9/13/16 at 2:30 Pl working on the floor for There were 2 NAs ob residents) hall, 200 (2 residents) hall and 40 5:00 PM, the actual son the floor for 3-11 swas 1 NA working on halls. On 9/13/16 at 4:05 Pl	a grievance for not getting ly including Resident #3. ievance dated 8/24/16 for egularly. The response from Director of Nursing (DON) e showers and discussion se and NAs regarding the as conducted on 8/25/16. AM, Nurse #1 was ted that several NAs had 8/16). She was the Staff nator (SDC) and was o pass medications and ecause the facility had not M, the actual staffing for NAs or 7-3 shift was observed.	F3	312	DEFICIENCY)		
	that she had filed a g not getting her showed she was provided a s she did not receive a by the staff that they a shower. Resident # was only 1 NA assign shift. Resident #3 states shower last night (9/1 in the building. On 9/13/16 at 4:00 Plobserved. The reside	rievance last month about er regularly. She stated that hower that day but last week shower again. She was told did not have time to give her #3 further stated that there hed on the hall on the 3-11 ted that she was given a 3/16) because the state was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	1 00.	2010	
PINE RIDGE HEALTH AND REHABILITATION CENTER			706 PINEYWOOD ROAD				
PINE RIDGE HEALTH AND REHABI	LITATION CENTER		THOMASVILLE, NC 27360				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE	
F 312 Continued From page	4	F3	312				
was interviewed. She the importance of show on the hall where Resistated that she had no showers but she had won the board to remind shower days.  The form where the number of bath was reviewed from August The form indicated that a shower three times of There was no shower 8/30, 9/6 and 9/9/16.  On 9/13/16 at 12:00 no interviewed. NA #1 stashift on the hall where indicated that the staff 2 NAs with 28 resident assisted living resident the residents needed thave to wait until she of stated that she had to no time to do showers residents scheduled to provided a partial bed On 9/13/16 at 3:50 PM NA #2 stated that she hall where Resident #5 that only 1 NA assigner residents on the 3-11 signst did the best she coneeded 2 person assist could get help from the that she had no time to scheduled to have a sign 9/14/16 at 8:25 AM	stated that she discussed wer with the NAs and nurse dent #3 resided. She also formal monitoring of the written the shower schedule if the staff of the resident 's urse aide had documented given to the resident was 22- September 13, 2016. It Resident #3 was provided on 8/27, 9/2 and 9/13/16. provided on 8/23, 8/26, con, NA #1 was ated that she worked 7-3 Resident #3 resided. She ing for NAs was very short, its on the hall plus the ts. She stated that most of two person assist and they can get help. NA #3 further do her best but there was . NA #2 further stated that to have a shower were bath. If NA #2 was interviewed. Worked 3-11 shift on the 3 resided. She indicated and on the hall with 28 shift. She stated that she ould and residents who st had to wait until she a other hall. She added to give showers to residents		312				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345144	B. WING _				C / <b>14/2016</b>	
	ROVIDER OR SUPPLIER  GE HEALTH AND REHAL	BILITATION CENTER		706	PINEYWOOD ROAD  OMASVILLE, NC 27360	1 03/	14/2010	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 312	assigned on the hall indicated that the 2 N the best they could. the time showers we because they did not On 9/14/16 at 9:35 A interviewed. She staleast one NA, and on assigned on each ha indicated that she ha that if they could not they could provide a  3. Resident #4 was a 11/23/15 with multiple cerebro vascular dischemiparesis. The quidated 8/8/16 indicated memory and decision totally dependent with There was no specific Resident #4, however a shower every Mondshift.  The form where the rewhat type of bath was reviewed from August The form indicated the provided a shower. On 9/13/16 at 10:05 interviewed. She staled out today (9/13) Development Coordi working on the floor the provide treatments beenough staff. On 9/13/16 at 11:00 at 11:00 and 1	most of the time. NA #4 IAs worked together and did NA #4 added that most of re not provided consistently have the time to do it. M, the administrator was ted that she expected at e nurse or a medication aide II and on each shift. She d discussed with the NAs give a shower to residents, full bed bath.  dmitted to the facility on e diagnoses including ease with hemiplegia and arterly MDS assessment d that Resident #4 had making problems and was h bathing. c care plan for bathing for r he was scheduled to have day and Thursday on the 7-3  nurse aide had documented s given to the resident was t 22- September 13, 2016. at Resident #4 was not  AM, Nurse #1 was ted that several NAs had B/16). She was the staff nator (SDC) and was o pass medications and ecause the facility had not	F	312				

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F 312	On 9/13/16 at 12:00 interviewed. NA #1 shift on the hall wher indicated that the sta 2 NAs with 28 reside assisted living reside the residents needed have to wait until she stated that she had to no time to do shower residents scheduled provided a partial beresident scheduled provided a partial beresident #4 was sch today but she had givinstead. On 9/13/16 at 2:30 Pworking on the floor of There were 2 NAs obresidents) hall, 200 (2 residents) and 400 (2 PM, the actual staffin floor for 3-11 shift wan NA working on 100, 2 On 9/13/16 at 3:50 PNA #2 stated that she hall where Residents that only 1 NA assign residents on the 3-11 just did the best she needed 2 person assigned on the hall indicated that the 2 NA #4 stated that he where Resident #4 reassigned on the hall indicated that the 2 Na with the stated that the where Resident #4 reassigned on the hall indicated that the 2 Na with the stated t	stated that she worked 7-3 e Resident #4 resided. She effing for NAs was very short, ints on the hall plus the ints. She stated that most of two person assist and they e can get help. NA #3 further to do her best but there was s. NA #1 further stated that to have a shower were d bath. NA #1 added that eduled to have a shower ven him a partial bed bath M, the actual staffing for NAs for 7-3 shift was observed. Diserved on 100 (28 27 residents) hall, 300 (22 24 residents) hall. At 5:00 g for the NAs working on the s observed. There was 1 200, 300 and 400 halls. M, NA #2 was interviewed. E worked 3-11 shift on the E worked 3-11 shift on	F	312			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From page	e 7	F3	312				
F 312	the time showers were because they did not On 9/14/16 at 9:35 A interviewed. She state least one NA, and on assigned on each hall indicated that she had that if they could provide at they could provide at 4. Resident #5 was at 7/22/11 with multiple Parkinson's disease assessment dated 7/2 Resident #5 had most totally dependent with behavior.  The care plan dated reviewed. The care plan did not add she was scheduled to Tuesday and Friday of The form where the reviewed from Augus The form indicated the provided a shower. On 9/13/16 at 10:05 // interviewed. She state called out today (9/13) Development Coordin working on the floor to provide treatments be enough staff.	re not provided consistently have the time to do it.  M, the administrator was ted that she expected at e nurse or a medication aide II and on each shift. She discussed with the NAs give a shower to residents, full bed bath.  dmitted to the facility on diagnoses including The quarterly MDS 31/16 indicated that Iterate cognitive impairment, in bathing and had no 17/25/16 for Resident #5 was plan indicated that the ist with bath at the sink. The ress the shower, however, on have a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the ist with bath at the sink. The ress the shower, however, on have a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the ist with bath at the sink. The ress the shower, however, on have a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink. The ress the shower is a shower every on 3-11 shift.  The quarterly MDS 31/16 indicated that the sink indica	F	312				
	working on the floor f There were 2 NAs ob	or 7-3 shift was observed.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		N 	(X3) DATE SURVEY COMPLETED				
		345144	B. WING				C / <b>14/2016</b>
	ROVIDER OR SUPPLIER  GE HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS 706 PINEYWOOD THOMASVILLE		1 03/	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD I S-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	residents) hall and 4 5:00 PM, the actual on the floor for 3-11 was 1 NA working or halls. On 9/13/16 at 5:10 F NA#3 stated that she where Resident #5 r assigned on the hall stated that she did the not have time to give scheduled to have a further stated that Rehave a shower today be able to give her a On 9/13/16 at 5:15 F observed. The residuciothes and her hair On 9/14/16 at 9:35 A interviewed. She state least one NA, and or assigned on each hair dicated that she had	on (24 residents) hall. At staffing for the NAs working shift was observed. There in 100, 200, 300 and 400 on the NAS was interviewed. When we worked 3-11 shift on the hall esided. There was only 1 NA with 22 residents. NA #3 he best she could and she did in showers to residents shower on 3-11 shift. NA #3 esident # 5 was scheduled to work (Tuesday) but she would not shower. When Resident #5 was ent was dressed on street was combed. When the administrator was atted that she expected at the nurse or a medication aide all and on each shift. She ad discussed with the NAs give a shower to residents,	F	312			