DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED C
		345370	B. WING			11/03/2016
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY,	STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARI PINEHURST, NC 2837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 272 SS=D			F 2	72		12/1/16
	resident assessment by the State. The ass least the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be Physical functioning a Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments an Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	dent's needs, using the instrument (RAI) specified sessment must include at nographic information; atterns; ing; and structural problems; and structural problems; d health conditions; status; and procedures; mmary information regarding ment performed on the care e completion of the Minimum				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITL	E	(X6) DATE

Electronically Signed

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.

11/21/2016

STATEMENT (S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) D/	NO. 0938-039 ATE SURVEY OMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING _			
		345370	B. WING			C 11/03/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST HEALTHCARE & REH	148		3(00 BLAKE BOULEVARD		
FINEHOR				P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 272	Continued From page	e 1	F	272			
	This REQUIREMEN	Γ is not met as evidenced					
	by:	· · · · · · · ·					
		iew and staff interview, the			For the residents found to have been offered by the alleged deficient pro		
		letely assess residents on ssessment in the area of			affected by the alleged deficient pra (#171 and #202) a minimum data se		
	•	1) and weight (Resident			(MDS) correction was submitted on		
	÷ .	pled residents. The findings			11/4/2016 by the Minimum data set		
	included:				coordinator.		
	1 Desident #171 wa	s admitted to the facility on			For those residents having the pote be affected by the alleged deficient	ntial to	
		liagnoses including chronic			practice the Dietary Manager was		
	-	admission Minimum Data			educated on 11/7/2016 by Director	of	
	Set (MDS) assessme				Nursing (DON) on facility procedure		
		cognition. Section K, the			coding MDS assessments properly.		
	•	al Status section, was not			MDS nurses were educated on 11/2		
		estion K0200A required sident #171's height in			by Director of Nursing on coding MI assessments properly. 100% of cur		
		on was coded with a dash			residents were audited on 11/7/201		
	· ·	estion was not answered.			heights and weights entered into the	Э	
					system by the DON. There were 20		
		ducted with the Dietary			residents noted to not have heights		
		/1/16 at 5:03 PM. She eted Section K of the MDS			weights in system and they were ac All residents now have a current he		
	and the MDS Coordin				and weight entered into the system.	•	
		M revealed that if there was			most recent yearly, quarterly or adm		
	÷	ht in the medical record for a			assessment for 100% of residents v	vere	
		he completed Section K then			audited by Director of Nursing and		
		(K0200A) blank or entered a e had not asked anyone to			Assistant director of nursing on 11/2 As a result of the audit 25 MDS	5/16.	
	-	eight for her if it was not			assessments were found to not hav	е	
	readily available.				either a height and /or weight entere		
					MDS assessments with missing		
		nducted on 11/2/16 at 5:13			information will be corrected by the	MDS	
		ordinator. She indicated			nurses by 12/1/2016. To ensure this alleged deficient prac	tice	
		ss and accuracy. The			does not reoccur, the following mea		
		d 7/6/16 for Resident #171			will be put into place: Heights and		
		ght was not assessed was			weights will be entered in computer		

Facility ID: 923403

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		OMPLETED
						С
		345370	B. WING			11/03/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE	
	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD		
	1			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 272	Continued From page	2	F 21	72		
	reviewed with the MD			system within 72 hou	rs of admission to	
		vas required to be entered		facility by the admittir		
		ported if a height had not		admissions will be re-	•	
	been documented in	the resident's medical		administrative nurses	which include the	
		he MDS assessment that		Director of nursing, A		
		be obtained prior to the		Nursing, the Clinical		
	-	S. The MDS Coordinator		MDS Coordinator in t	0	
		eeded a system to obtain a le time of admission. She		the next business day completion of heights		
	-	o system in place at this		will be performed dur		
	time.			at Risk meeting by Pa		
				committee team men		
	An interview was con	ducted on 11/3/16 at 8:21		Director of Nursing, C		
		of Nursing (DON). She		or Assistant Director	of Nursing, the MDS	
	indicated it was her expectation that all MDS assessments were fully completed.			coordinator and the D		
				Dietary Manager is re	-	
	0. De side et #000			completing section K		
		s admitted to the facility on diagnoses including heart		Coordinator will ensu completed prior to sig		
		ion Minimum Data Set		complete. Five MDS		
		ated 10/12/16 indicated he		audited weekly for he		
	was cognitively intact			four weeks and five N	•	
	Swallowing/Nutritiona	al Status section, was not		will be audited biweel	kly for one month	
		stion K0200B required		then monthly for four		
		sident #202's weight in		different residents in		
		on was coded with a dash		assessment review p		
		estion was not answered.		these audits will be keep	-	
	An interview was con	ducted with the Dietary		Quality Assurance me		
		(1/16 at 5:03 PM. She		to be reviewed and d		
		ted Section K of the MDS		of Correction will be r		
	and the MDS Coordir	nator reviewed the		needed will be altered	d to ensure that	
		M revealed that if there was		compliance is met. C		
		ht in the medical record for a		be performed based	on results of the	
		he completed Section K then		previous audits.		
	-	(K0200B) blank or entered a				
		e had not asked anyone to eight for her if it was not				
	readily available.	FIGHT IOF HET IT IL WAS HOL				

If continuation sheet Page 3 of 58

	S FOR MEDICARE &					O. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345370	B. WING		11	C / 03/2016
IAME OF PF	OVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP COD	θE	
	T HEALTHCARE & REF		3	00 BLAKE BOULEVARD		
	I HEALINGARE & REI		P	PINEHURST, NC 28374		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 272	Continued From page	e 3	F 272			
	PM with the MDS Co that she reviewed the signed them for comp The admission MDS #202 that indicated h was reviewed with the indicated the weight v on the MDS. She rep been documented in record at the time of the the weight needed to completion of the MD revealed the facility n resident's weight at the	ducted on 11/2/16 at 5:13 ordinator. She indicated e MDS assessments and oleteness and accuracy. dated 10/12/16 for Resident is weight was not assessed e MDS Coordinator. She was required to be entered ported if a weight had not the resident's medical the MDS assessment that be obtained prior to PS. The MDS Coordinator eeded a system to obtain a ne time of admission. She posystem in place at this				
F 273 SS=D	AM with the Director	PREHENSIVE	F 273			11/25/16
	after admission, exclu there is no significant physical or mental co	dent within 14 calendar days uding readmissions in which change in the resident's ndition. (For purposes of ssion" means a return to the nporary absence for				
	This REQUIREMENT	is not met as evidenced				

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
			-			С
		345370	B. WING			1/03/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 273	Continued From page	e 4	F 27	73		
		iew and staff interview the		F273		
	facility failed to compl			. 2. 0		
	-	e first 14 days of admission		The resident found to hav	e been affected	
	for 1 of 14 sampled re	esidents (Resident #194).		by the alleged deficient pr		
	The findings included	1:		had comprehensive asses		
	D			completed within the first	•	
		dmitted to the facility on		admission. Being that the	•	
	failure and chronic kid	e diagnoses including heart		had the assessment comp within the required time fra		
		uney disease.		minimum data set (MDS)		
	A review of Resident	#194's medical record		educated on timely compl		
		n Minimum Data Set (MDS)		assessments by the Direc		
		Assessment Reference Date		(DON) and MDS consulta	-	
	(ARD) of 10/17/16. T	he MDS assessment was		For those residents having	g the potential to	
		y the MDS Coordinator on		be affected by the alleged	deficient	
		500B). This was 22 days		practice the Minimum data		
	after Resident #194's	admission to the facility.		Coordinators were educat		
	A			by Director of Nursing on		
		ducted on 11/2/16 at 5:13 ordinator. She indicated		completion of Minimum Da assessments. An audit wa		
		S assessments and signed		Director of Nursing and as	•	
		She reported the MDS		of nursing on all residents		
		nts were required to be		the past 90 days to identif		
		first 14 days of a resident's		completion of admission 1		
	-	Coordinator stated she		assessments within 14 da	•	
		facility in the end of April		11/25/2016. There were m	nultiple MDS	
	2016. She reported t			admission assessments id		
		the MDS assessments had		completed within the requ		
		dicated when she started at		To ensure this alleged def		
	•	issessments were "about a ind" and they were currently		does not reoccur, the follo will be put into place. MDS		
		b". The MDS assessment		be reviewed for upcoming		
		/16 and a completion date of		assessments during morn		
		#194 was reviewed with the		each business day to eval		
	MDS Coordinator. T			admission assessment du		
		a surprise to her that the		Director of Nursing and As	ssistant Director	
		ted within the first 14 days		of Nursing will assist to co		
	of admission for Resi	dent #194.		assessments timely as inc calendar.	dicated by MDS	

Facility ID: 923403

	-	ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/02/201 RM APPROVE IO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345370	B. WING		_ 1 [,]	C 1/03/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
						0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
F 273	Continued From page		F 2			
	AM with the Director	iducted on 11/3/16 at 8:21 of Nursing (DON). She expectation that all MDS completed timely.		Patients at Risk (F members to includ Nursing, Assistant Clinical Coordinate admission assess weekly for comple four weeks and fiv admission assess biweekly for one n four months altern in each MDS asse These audits will b with immediate act identified. Results maintained by the will bring them to the Assurance meeting reviewed and disco	t Director of Nursing and or. Five MDS 14 day ments will be audited ation and accuracy for	
F 276 SS=D	483.20(c) QUARTER LEAST EVERY 3 MC A facility must assess		F 2	previous audits.		11/25/16
	quarterly review instr	ument specified by the State S not less frequently than				
	by: Based on record rev facility failed to comp Set (MDS) assessme Assessment Referen	is not met as evidenced iew and staff interviews, the lete quarterly Minimum Data ents within 92 days of the ce Date (ARD) for 2 of 12 residents #28 and #171).		affected by the all (#28 and #171) ha Data Set assessm within 92 days of t	found to have been eged deficient practice ad quarterly Minimum nents not completed the assessment period. d quarterly assessment	

Event ID: JMTI11

Facility ID: 923403

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	D: 12/02/2016 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345370	B. WING			11	C / 03/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINICUUD				3	00 BLAKE BOULEVARD		
PINEHUK	ST HEALTHCARE & REF	IAD		P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 276	Continued From page	e 6	F	276			
	1a. Resident #28 was 11/25/09 with multiple cerebrovascular dises A review of Resident revealed a quarterly I assessment with an A (ARD) of 3/17/16. Resident #28 had a c with an ARD of 6/16/7 required a signature of Assessment Coordina This quarterly MDS a was indicated to be c (Question Z0500B). T was completed 117 d MDS assessment's A An interview was con PM with the MDS Co she reviewed the MD them for completion. quarterly assessment completed within 92 of assessment's ARD. S working at the facility She reported that sim facility the MDS asses She indicated when s were "about a month were currently still "pl assessment with an A completion date of 7/ reviewed with the MDS was	as admitted to the facility on e diagnoses that included ase. #28's medical record Minimum Data Set (MDS) Assessment Reference Date quarterly MDS assessment 16. The MDS assessment of a Registered Nurse (RN) ator to verify its completion. ssessment for Resident #28 ompleted on 7/11/16 This quarterly assessment ays after the most recent RD (3/17/16). ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed She reported the MDS ts were required to be days of the previous MDS She stated she began in the end of April 2016. ce she started working at the ssments had been behind. she started at the facility they and a half behind" and they laying catch up". The MDS			completed on 11/3/16 by Minimum Da set Coordinator. Being that the reside #28 already had the assessment completed but not within the required frame, the minimum data set (MDS) nurses were educated on timely completion of MDS assessments by th Director of Nursing (DON) and MDS consultant on 11/4/2016. For those residents having the potent be affected by the alleged deficient practice the MDS nurses, Dietary Manager, Social Services Director, Activities Director and Wound Care N were educated by the Director of Nurs on 11/4/16 on timely completion and accuracy of MDS assessments. An au was performed by DON and assistant director of nursing on all residents wh had a quarterly assessment due within past 90 days to identify timely comple of Quarterly Assessments within 92 do on 11/25/2016. There were multiple N assessments identified as not comple within the required time frame. To ensure this alleged deficient practic does not reoccur, the following measu will be put into place: MDS calendar w be reviewed for upcoming quarterly assessments during morning meeting each business day to evaluate upcom assessment due dates. Director of Nursing and Assistant Director of Nurs will assist to complete quarterly MDS assessments timely as indicated by M calendar. Audits will be performed during week Patients at Risk meeting by team	nt time time al to urse sing udit on the tion ays DS ted ce ures <i>i</i> ll ing sing DS	

Facility ID: 923403

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		3 NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	B	· · · ·	COMPLETED
						С
		345370	B. WING			11/03/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD)E	
				300 BLAKE BOULEVARD		
PINEHUR	ST HEALTHCARE & REH	IAB		PINEHURST, NC 28374		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 276	Continued From page	e 7	F 27	76		
	AM with the Director indicated it was her e assessments were co 1b. Resident #28 was 11/25/09 with multiple cerebrovascular dise A review of Resident revealed a quarterly f assessment with an A (ARD) of 6/16/16. Resident #28 had a c with an ARD of 9/16// required a signature of Coordinator to verify quarterly MDS assess indicated to be comp Z0500B). This quarte completed 107 days assessment's ARD (6	s admitted to the facility on e diagnoses that included ase. #28's medical record Minimum Data Set (MDS) Assessment Reference Date quarterly MDS assessment 16. The MDS assessment of an RN Assessment its completion. This sment for Resident #28 was leted on 9/30/16 (Question erly assessment was after the most recent MDS 5/16/16).		members to include the Direct Nursing, the Assistant Direct and the Clinical Coordinator. quarterly MDS assessments audited weekly for completion accuracy for four weeks and MDS assessments will be au- biweekly for one month then assessments per month for for alternating different residents MDS assessment review peri audits will be reviewed in the with immediate action taken i identified. Results of these au- kept by the Director of Nursin bring them to the monthly Qu Assurance (QA) meeting wh- be reviewed and discussed. Of audits be performed based on the previous audits.	or of Nursing Five will be and five quarterly dited five quarterly our months in each od. These PAR meeting f issues are udits will be g who will ality ere they will Continued	
	An interview was conducted on 11/2/16 at 5:13 PM with the MDS Coordinator. She indicated she reviewed the MDS assessments and signed them for completion. She reported the MDS quarterly assessments were required to be completed within 92 days of the previous MDS assessment's ARD. She stated she began working at the facility in the end of April 2016. She reported that since she started working at the facility the MDS assessments had been behind. She indicated when she started at the facility they were "about a month and a half behind" and they were currently still "playing catch up". The MDS assessment with an ARD of 9/16/16 and a					

Facility ID: 923403

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2016 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345370	B. WING				C 03/2016
NAME OF P	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	АВ			300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	CTION SHOULD BE COMPL D THE APPROPRIATE DA	
F 276	completion date of 9/3 reviewed with the MD Coordinator revealed her that the MDS was days of the previous N An interview was com AM with the Director of indicated it was her et assessments were co 2. Resident #171 was 7/6/16 with multiple di kidney disease. A review of Resident F revealed an admissio assessment with an A (ARD) of 7/13/16. Resident #171 had a with an ARD of 10/13, assessment required Assessment Coordina (Question Z0500A). MDS assessment for indicated to be incom RN Assessment Coor Z0500A) and no date Z0500B). This quarted days after the most re ARD (7/13/16) and it as of 11/2/16. An interview was com PM with the MDS Coo she reviewed the MD	30/16 for Resident #28 was S Coordinator. The MDS this was not a surprise to a not completed within 92 MDS ARD for Resident #28. ducted on 11/3/16 at 8:21 of Nursing (DON). She expectation that all MDS ompleted timely. a admitted to the facility on iagnoses including chronic #171's medical record n Minimum Data Set (MDS) assessment Reference Date quarterly MDS assessment /16. This quarterly MDS a signature of an RN ator to verify its completion As of 11/2/16 this quarterly Resident #171 was plete as evidenced by no dinator signature (Question of completion (Question of completion (Question of completion (Question of completion (Question erly MDS was already 113 ecent MDS assessment's had not yet been completed ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed She reported the MDS	F	276			

Facility ID: 923403

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/02/2016 RM APPROVED IO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345370	B. WING		1	1/03/2016
NAME OF PF	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
	T HEALTHCARE & REH	ΙΔB	300	BLAKE BOULEVARD		
			PIN	EHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 276	F 276 Continued From page 9 completed within 92 days of the previou assessment's ARD. She stated she be working at the facility in the end of Apri		F 276			
	facility the MDS asse She indicated when s were "about a month were currently still "pl assessment with an A completion date for R with the MDS Coordin Coordinator revealed her that the MDS was	ce she started working at the ssments had been behind. the started at the facility they and a half behind" and they aying catch up". The MDS ARD of 10/13/16 and no resident #171 was reviewed nator. The MDS this was not a surprise to a not completed within 92 MDS ARD for Resident				
F 278 SS=E	AM with the Director of indicated it was her e assessments were co 483.20(g) - (j) ASSES		F 278			12/1/16
	The assessment mus resident's status.	t accurately reflect the				
	A registered nurse mi each assessment with participation of health					
	A registered nurse ma assessment is complete	ust sign and certify that the eted.				
		completes a portion of the n and certify the accuracy of sessment.				
	Under Medicare and	Medicaid, an individual who				

Facility ID: 923403

If continuation sheet Page 10 of 58

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		C 11/03/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD	
TINEHON				PINEHURST, NC 28374	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 278	willfully and knowingly false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingly to certify a material a resident assessment penalty of not more th assessment. Clinical disagreement material and false sta This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) asse urinary catheters (Re weight (Resident # 12 #158, #12, #125, #10 range of motion and a and medications (Res sampled residents re 1. Resident #106 was 9/8/16 with multiple d pressure ulcer. The a dated 9/15/16 indicat cognition was intact a urinary catheter. Review of the physici #106 revealed that sh order for the indwellin 10/20/16 the catheter On 11/2/16 at 5:40 PI interviewed. The MDS #106 had an indwellin	y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each t does not constitute a tement. is not met as evidenced iew and staff interview, the ately code the Minimum issments in the areas of sidents # 106 & # 14), 25), height (Residents #74, 15, #202 & #72), limitation in ambulation (Resident #107) sident #12) for 10 of 25 viewed. Findings included: admitsed to the facility on iagnoses including sacral admission MDS assessment ed that Resident # 106's and she had no indwelling an's orders for Resident he was admitted with an ang urinary catheter and on	F 27	8 For the residents found to have I affected by the alleged deficient p residents (urinary catheters #106 (weight #125) (height #74,#158, #125, #105 , #202, #72) (limitation range of motion and ambulation # (medications #12). Resident #106 Minimum Data Set admission assessment was correc 11/4/16 to reflect that the resider catheter at that time. Resident #14 MDS admission assessment was corrected by MI coordinator on 11/4/16 to reflect to resident had a catheter at that tim Resident #74 MDS admission assessment was corrected by MI coordinator on 11/18/16 to reflect residents accurate height. Resident #158 MDS quarterly ass was corrected by MDS coordinate 11/18/16 to reflect residents accur height.	bractice i, #14) #12, bn in #107) et (MDS) ected on ht had a DS that the he. DS t the sessment or on

Facility ID: 923403

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/201 MAPPROVE D. 0938-039
STATEMENT OF DI AND PLAN OF COP	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		PLETED
		345370	B. WING				C 1 03/2016
NAME OF PROVI	DER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTHCARE & REH	IAB			0 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
CO Wa Or (D sh ac 2. fac ind MI Re no Re rev uri on Or ob ind Or (D sh ac 3. 9/2 sta ad	is not. 11/3/16 at 8:20 AN ON) was interviewe e expected the MD curate. Resident # 14 was cility on 6/25/16 with cluding stage IV pre- DS assessment dat esident #14's cognit indwelling urinary of eview of the physici- vealed that he was nary catheter due t his sacrum and bu 11/2/16 at 8:35 AN served in bed. He welling urinary cathe- erviewed. MDS Nu own Resident #14 f theter since admission DS assessment was 11/3/16 at 8:20 AN ON) was interviewe e expected the MD curate. Resident #74 was a 28/16 with multiple age renal disease a mission MDS asses	on MDS assessment but it M, The Director of Nursing ed. The DON stated that S assessments to be originally admitted to the h multiple diagnoses assure ulcers. The quarterly ted 9/30/16 indicated that tion was intact and he had catheter. an's orders for Resident #14 admitted with an indwelling o stage IV pressure ulcers ittocks. M, Resident #14 was was observed to have an heter. M, MDS Nurse #1 was urse #1 stated that she had to have an indwelling sion. She indicated that the	F 2	78	Resident #125 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and weight Resident #202 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #105 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height. Resident #12 MDS admission assessment was corrected by MDS coordinator on 11/18/16 to reflect residents accurate height and accurate coded 3 for anti-anxiety medication. Resident #107 MDS quarterly assess was corrected by MDS coordinator to ensure accurate coding of range of motion for assessment period of 8/20/ on 11/4/16. Resident #107 MDS assessment was coded inaccurately for documentation Certified Nursing Assistant (CNA) for Activities of daily living (ADL□s). MDS quarterly assessment was corrected b MDS coordinator to ensure accurate coding of activities of daily living for th assessment period of 8/20/16 on 11/4 Coding was reviewed with CNA involv the CNA was educated on proper documentation of accurate information the assistant Director of Nursing on	ment 16 by by e /16. ed,	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/201 MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345370	B. WING				03/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	IAB			00 BLAKE BOULEVARD INEHURST, NC 28374		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From page	e 12	F 2	278			
	she completed section assessments. She si- height when she corrishe left that area blar ask anyone for the height the resident's chart a the height blank on si- On 11/2/16 at 5:40 Pl interviewed. She stat (DM) was responsible MDS assessment ind Nurse further indicate be coded as 0, if ther the DM should have a the height of the resid On 11/3/16 at 8:20 Al (DON) was interview she expected the MD accurate. 4. Resident # 158 wa 5/27/16 with multiple Hypertension. The q dated 9/3/16 indicate memory and decision height was 0 inches. On 11/1/16 at 5:03 Pl conducted with the di she completed section assessments. She si- height when she corrishe left that area blar	 ietary manager. She stated in K of the MDS tated if she did not have the apleted the assessments, nk. She said she would not eight if she could not find it in nd would enter "0" or leave ection K0200 (height). M, MDS Nurse #1 was ed that the Dietary Manager e in coding section K on the cluding the height. The MDS ed that the height should not re was no height recorded, asked nursing to measure dent. M, The Director of Nursing ed. The DON stated that to be sadmitted to the facility on diagnoses including uarterly MDS assessment d that Resident #158 had n making problems and his M, an interview was ietary manager. She stated 			For those residents with potential to b affected by alleged deficient practice 100% of current residents were audite on 11/7/2016 by the Director of Nursin and Assistant director of nursing, for heights and weights entered into the system. 20 residents were found to m have heights and weights in the elect health system and those were added residents currently have a height and weight entered into the system. All residents who currently have a cathef had their MDS assessment audited a reviewed by Director of nursing and assistant director of nursing to ensure accurate coding of a catheter in place 11/18/2016. All residents with cathete were found to be correctly coded. All residents who are currently receiving psychotropic medication will have the MDS assessment audited by the DON and ADON and reviewed for accurate coding of psychotropic medications b 12/1/16.All current residents will have most current MDS assessment audite accurate range of motion and ambula by the DON and ADON by 12/1/16. A inaccurate coding will be corrected by MDS nurses by 12/1/2016. To ensure this alleged deficient practi does not reoccur, the following measu will be put into place. The Dietary Manager was educated on 11/7/2016 Director of Nursing on facility procedu on coding MDS assessments properly specifically regarding height and weig MDS nurses, Dietary Manager, Socia Services Director, Activities Director a	ed ng ot ronic All er nd er nd e on rs a ir N y the d for tion II y the ce ures by ures y ht.	

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	S FOR MEDICARE &				OMB NO. 093	8-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345370	B. WING		C 11/03/20	16
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COM	(X5) IPLETIC DATE
F 278	Continued From page	e 13	F 278	3		
	the resident's chart a the height blank on si On 11/2/16 at 5:40 Pl interviewed. She stat (DM) was responsible MDS assessment inc Nurse further indicate be coded as 0, if ther the DM should have a the height of the resid On 11/3/16 at 8:20 Al (DON) was interview she expected the MD accurate. 5a. Resident #125 wa 6/22/16 and readmitte diagnoses including r admission Minimum I dated 7/9/16 indicate Section K, the Swallo section, indicated Re inches (Question K02 An interview was com Manager (DM) on 11/ indicated she comple and the MDS Coordir assessments. She re documented height in resident at the time s she left the question "0". She reported sho	nd would enter "0" or leave ection K0200 (height). M, MDS Nurse #1 was ed that the Dietary Manager e in coding section K on the cluding the height. The MDS ed that the height should not re was no height recorded, asked nursing to measure dent. M, The Director of Nursing ed. The DON stated that DS assessments to be as admitted to the facility on ed on 7/2/16 with multiple respiratory failure. The Data Set (MDS) assessment d her cognition was intact. owing/Nutritional Status sident #125's height was 0 200A). ducted with the Dietary /1/16 at 5:03 PM. She ted Section K of the MDS		Wound Care Nurse were educat Director of Nursing on 11/4/16 of completion and accuracy of MD assessments. Heights and weig entered in computer system with hours of admission to facility by nurse. All new admissions will b reviewed by administrative nurse include DON, ADON, and clinicat coordinator in the clinical meetir business day after admission for completion of heights and weigh services will be provided to all C Nurses to include weekend and on accurate coding of ADL docu by December 1, 2016 by either A MDS nurses or Director of Nursi Audits will be performed during of Patients at Risk meeting by tear members to include the Director Nursing, the Assistant Director of and the Clinical Coordinator. Fiv assessments will be audited for and weight, psychotropic medicat urinary catheters and accurate A documentation weekly for four w MDS assessments will be audited biweekly for one month then mo four months alternating different in each MDS assessment review After review of the audits correct be done immediately if noted. Fit these audits will be maintained fit Director of Nursing who will brin the monthly Quality Assurance r and they will be discussed. Con- audits will be performed based of	n timely S hts will be hts will be hts will be hts will be hts will be hts will be hts will be help n of f Nursing e MDS height https://weekly h of f Nursing e MDS height https://weekly. h of f Nursing e MDS height https://weekly. height	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345370	B. WING				C 103/2016	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
PINEHUR	ST HEALTHCARE & REH	IAB			300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 278	she reviewed the MD them for completeness admission MDS dated that indicated the heig reviewed with the MD indicated the height w on the MDS. She rep been documented in f record at the time of the the height needed to completion of the MD needed a system to of the time of admission no system in place at An interview was con AM with the Director of indicated it was her e assessments were co 5b. Resident #125 wa 6/22/16 and readmitted diagnoses including r admission Minimum E dated 7/9/16 indicated Section K, the Swallo section, indicated Res pounds (Question KO An interview was con Manager (DM) on 11/ indicated she comple and the MDS Coordin assessments. She re documented weight in resident at the time sh she left the question ("0". She reported she	S assessments and signed as and accuracy. The d 7/9/16 for Resident #125 ght was 0 inches was VS Coordinator. She vas required to be entered borted if a height had not the resident's medical he MDS assessment that be obtained prior to the S. She revealed the facility obtain a resident's height at . She reported there was this time. ducted on 11/3/16 at 8:21 of Nursing (DON). She xpectation that all MDS ompleted accurately. as admitted to the facility on ed on 7/2/16 with multiple espiratory failure. The Data Set (MDS) assessment d her cognition was intact. wing/Nutritional Status sident #125's weight was 0 200B). ducted with the Dietary 1/16 at 5:03 PM. She ted Section K of the MDS	F	278				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345370	B. WING				C 03/2016	
NAME OF PF	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHURS	NEHURST HEALTHCARE & REHAB				300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 278	PM with the MDS Coo she reviewed the MD them for completeness admission MDS dated that indicated her wei reviewed with the MD indicated the weight w on the MDS. She rep been documented in f record at the time of the the height needed to completion of the MD needed a system to of the time of admission no system in place at An interview was con AM with the Director of indicated it was her e assessments were co 6. Resident #202 was 10/5/16 with multiple disease. The admiss (MDS) assessment day was cognitively intact Swallowing/Nutritiona Resident #202's heigh K0200A). An interview was con Manager (DM) on 11/ indicated she comple and the MDS Coordin	ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed as and accuracy. The d 7/9/16 for Resident #125 ght was 0 pounds was OS Coordinator. She was required to be entered borted if a weight had not the resident's medical the MDS assessment that be obtained prior to the S. She revealed the facility obtain a resident's weight at . She reported there was this time. ducted on 11/3/16 at 8:21 of Nursing (DON). She xpectation that all MDS ompleted accurately. a admitted to the facility on diagnoses including heart ion Minimum Data Set ated 10/12/16 indicated he . Section K, the al Status section, indicated th was 0 inches (Question	F	278				
		evealed that if there was no the medical record for a						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345370	B. WING				C /03/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	AB			300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 278	she left the question ("0". She reported she obtain a resident's he readily available. An interview was con PM with the MDS Coo she reviewed the MD them for completeness admission MDS dated #202 that indicated the reviewed with the MD indicated the height w on the MDS. She rep been documented in record at the time of the the height needed to completion of the MD needed a system to of the time of admission no system in place at An interview was con AM with the Director of indicated it was her e assessments were co 7. Resident #105 was 7/29/16 with multiple (thighbone) fracture. 8/5/16 indicated she w Section K, the Swallo section, indicated Res inches (Question KO2	he completed Section K then (K0200A) blank or entered a e had not asked anyone to ight for her if it was not ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed as and accuracy. The d 10/12/16 for Resident he height was 0 inches was VS Coordinator. She vas required to be entered borted if a height had not the resident's medical he MDS assessment that be obtained prior to the S. She revealed the facility obtain a resident's height at . She reported there was this time. ducted on 11/3/16 at 8:21 of Nursing (DON). She xpectation that all MDS ompleted accurately. a admitted to the facility on diagnoses including a femur The admission MDS dated was cognitively intact. wing/Nutritional Status sident #105's height was 0 c00A).	F	278			
	•	ted Section K of the MDS					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345370	B. WING				C 03/2016
NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	HURST HEALTHCARE & REHAB				300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 278	and the MDS Coordin assessments. She re documented height in resident at the time sl she left the question ("0". She reported she obtain a resident's he readily available. An interview was con PM with the MDS Coo she reviewed the MD them for completeness admission MDS dated that indicated the height reviewed with the MD indicated the height w on the MDS. She rep been documented in record at the time of the the height needed to completion of the MD needed a system to of the time of admission no system in place at An interview was con AM with the Director of indicated it was her e assessments were co 8. Resident #72 was a 6/6/16 with multiple d fracture. The admiss indicated she was con the Swallowing/Nutrit	ator reviewed the evealed that if there was no the medical record for a ne completed Section K then K0200A) blank or entered a e had not asked anyone to ight for her if it was not ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed as and accuracy. The d 8/5/16 for Resident #105 ght was 0 inches was S Coordinator. She vas required to be entered orted if a height had not the resident's medical he MDS assessment that be obtained prior to the S. She revealed the facility btain a resident's height at . She reported there was this time. ducted on 11/3/16 at 8:21 of Nursing (DON). She xpectation that all MDS ompleted accurately. admitted to the facility on iagnoses including a pelvic ion MDS dated 6/13/16 gnitively intact. Section K,	F	278			

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	12/02/2016 APPROVED 0938-039
STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	IPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345370	B. WING		C 11/0	3/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP		
	ST HEALTHCARE & REH	1AB		300 BLAKE BOULEVARD		
T INCENSION	I HEAEINOARE & REI			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C PROVIDER'S PLAN OF C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	Manager (DM) on 11/ indicated she complete and the MDS Coordin assessments. She re- documented height in resident at the time si- she left the question of "0". She reported she obtain a resident's her readily available. An interview was com- PM with the MDS Co- she reviewed the MD them for completeness admission MDS dated that indicated the height wo on the MDS. She rep been documented in record at the time of a the height needed to completion of the MD needed a system to co the time of admission no system in place at An interview was com- AM with the Director indicated it was her e assessments were co 9 a. Resident #12 wa	ducted with the Dietary (1/16 at 5:03 PM. She ted Section K of the MDS nator reviewed the evealed that if there was no in the medical record for a he completed Section K then (K0200A) blank or entered a e had not asked anyone to eight for her if it was not ducted on 11/2/16 at 5:13 ordinator. She indicated S assessments and signed as and accuracy. The d 8/5/16 for Resident #72 ght was 0 inches was 0S Coordinator. She vas required to be entered borted if a height had not the resident's medical the MDS assessment that be obtained prior to the S. She revealed the facility obtain a resident's height at a. She reported there was this time. ducted on 11/3/16 at 8:21 of Nursing (DON). She expectation that all MDS ompleted accurately. s admitted to the facility diagnoses included anxiety e disorder.	F 2			
		6/16 indicated Resident #12				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345370 B. WING 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD			ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
345370 B. WING 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD	STATEMENT				(X3) DATE COMF	E SURVEY PLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PINEHURST HEALTHCARE & REHAB 300 BLAKE BOULEVARD			345370	B. WING				-
PINEHURST HEALTHCARE & REHAB	NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINEHURST, NC 28374	PINEHUR	ST HEALTHCARE & REH	IAB			300 BLAKE BOULEVARD PINEHURST, NC 28374		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
F 278 Continued From page 19 was cognitively intact. Under section K (Swallowing/ Nutritonal status), K0200 A. height was documented as "0". F 278 On 11/1/16 at 5:03PM, an interview was conducted with the dietary manager. She stated she completed the admission assessments on all residents and completed section K of the MDS assessments. She stated if she did not have the height and/or weight when she completed the assessments. She batted if she would not ask anyone for the height if she could not find it in the resident's Chart and would enter "0" or leave the height blank on section K0200 (height). On 11/2/16 at 5:25PM, an interview was conducted with the MDS. If the height was not available, the dietary manager should have asked for the height of the resident so it could be coded accurately on the MDS. If the height was not available, the dietary manager should have asked for the height of the resident so it could be coded accurately on the MDS. On 11/03/2016 at 8:18AM, an interview was conducted with the Director of Nursing who stated she expected the MDS for be coded accurately. 9 b. Resident #12 was admitted to the facility 6/2816. Cumulative diagnoses included anxiety and major depressive disorder. A Quarterly MDS dated 10/6/16 indicated resident #12 was cognitively intact. A review of the medications received during the seven day look back period (9/30/16-10/6/16) indicated Resident #12 received ant-anxiety medication two days	F 278	was cognitively intact (Swallowing/ Nutrition was documented as On 11/1/16 at 5:03PM conducted with the di she completed the ac residents and comple assessments. She st height and/or weight assessments, she lef dietary manager state update her informatio were completed. She anyone for the height resident ' s chart and the height blank on se On 11/2/16 at 5:25PM conducted with the M the height should hav accurately on the MD available, the dietary for the height of the re accurately on the MD On 11/03/2016 at 8:10 conducted with the D she expected the MD 9 b. Resident #12 wa 6/28/16. Cumulative and major depressive A Quarterly MDS date #12 was cognitively in medications received back period (9/30/16-	 Under section K hal status), K0200 A. height "0". <i>A</i>, an interview was etary manager. She stated section assessments on all eted section K of the MDS tated if she did not have the when she completed the t that area blank. The ed she did not go back and in after the assessments e said she would not ask if she could not find it in the would enter "0" or leave ection K0200 (height). <i>A</i>, an interview was DS coordinator who stated re been documented S. If the height was not manager should have asked esident so it could be coded S. 8AM, an interview was irector of Nursing who stated S for be coded accurately. s admitted to the facility diagnoses included anxiety e disorder. ed 10/6/16 indicated resident ntact. A review of the during the seven day look 10/6/16) indicated Resident 	F	278	3		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345370	B. WING				C 03/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	АВ			300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	during the assessment A review of physician and October 2016 rev clonazepam (anti-anx milligrams by mouth the A review of the Septe Medication Administration look-back period of 6/ Resident #12 receive on 9/30/16, 10/2/16 at On 11/2/16 at 5:20PM conducted with the M reviewed the MARs' for the look back period stated the MDS shoul for anti-anxiety medic miscounted. On 11/03/2016 at 8:11 conducted with the Di she expected the MD 10 a. Resident #107 to on 4/3/13 and readmin Cumulative diagnoses accident (CVA) with he right dominant side at hand. An Admission MDS d Resident #107 had sh memory impairment at decision-making skills (Functional limitation	nt period. orders for September 1016 ealed an order for iety medication) 0.5 wice a day as needed. mber and October ation Sheets (MAR) for the 30/16-10/6/16 revealed d clonazepam 0.5 milligrams nd 10/6/16 (three days). 1, an interview was DS Coordinator. She for September and October od of 9/30/16-10/6/16 and d have been coded as "3" ation. It must have been BAM, an interview was rector of Nursing who stated S for be coded accurately. was admitted to the facility tted on 11/19/15. s included cerebrovascular emiplegia (paralysis) in the nd contracture of the right ated 11/26/15 indicated nort term and long term and was severely impaired in s. Section G0400 in range of motion) indicated	F	278			
	Resident #107 had no	o range of motion) indicated o range of motion limitations ies and impairment on one					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345370	B. WING				C 03/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	АВ			300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	side for range of moti Observations conduct 11/3/16 revealed Ress facility in her wheelch her left leg and arm to Her right arm and leg motion. On 11/2/16 at 5:36PM conducted with the M section G0400 for rar inaccurately and shou impairment of range of upper and lower extre not sure why it was in MDS Coordinator on On 11/03/2016 at 8:18 conducted with the Di she expected the MD 10 b. Resident #107 v on 4/3/13 and readmi Cumulative diagnoses accident (CVA) with h right dominant side at hand. A Quarterly MDS date Resident #107 had sh memory impairment a decision-making skills (Functional limitation Resident #107 had in	on for the lower extremities. ted from 10/31/16 through ident #107 moving about the air independently. She used o manipulate the wheelchair. were impaired in range of 1, an interview was DS Coordinator. She stated uge of motion was coded uld have indicated of motion on one side for emities. She said she was iaccurate as she was not the 11/26/15. 8AM, an interview was irector of Nursing who stated S for be coded accurately. was admitted to the facility tted on 11/19/15. s included cerebrovascular memiplegia (paralysis) in the nd contracture of the right ed 8/20/16 indicated nort term and long term and severely impaired in s. Section G0400 in range of motion) indicated mairment on one side for e upper extremities and no	F	278			

Facility ID: 923403

If continuation sheet Page 22 of 58

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345370	B. WING				C 03/2016
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	АВ	300 BLAKE BOULEVARD PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Observations conduct 11/3/16 revealed Res facility in her wheelch her left leg and arm to Her right arm and leg motion. On 11/2/16 at 5:36PM conducted with the M that section G0400 fo coded incorrectly and impairment on one sid extremities. On 11/03/2016 at 8:18 conducted with the Di she expected the MD 10 c. Resident #107 v on 4/3/13 and readmi Cumulative diagnoses accident (CVA) with h right dominant side ar hand. A Quarterly MDS date Resident #107 had sh memory impairment a decision-making skills Resident #107 require ambulation in the root Observations conduct 11/3/16 revealed Res facility in her wheelch her left leg and arm to Her right arm and leg	ted from 10/31/16 through ident #107 moving about the air independently. She used o manipulate the wheelchair. were impaired in range of 1, an interview was DS Coordinator. She stated r range on motion was should have indicated de for the upper and lower BAM, an interview was rector of Nursing who stated S for be coded accurately. was admitted to the facility tted on 11/19/15. s included cerebrovascular emiplegia (paralysis) in the nd contracture of the right ed 9/30/16 indicated hort term and long term and severely impaired in s. It was documented that ed extensive assistance with	F	278			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED C
		345370	B. WING		11/	/03/2016
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278 F 279 SS=D	On 11/2/16 at 9:00AW conducted with NA #2 was unable to use he non-ambulatory. On 11/2/16 at 3:44PW conducted with Nursin stated she had been approximately eleven She stated she had n walk and Resident #1 On 11/02/2016 at 5:30 conducted with the M they had provided edu regarding the need fo for activities of daily li would be accurate. S #107 did not ambulate 9/30/16 should have I not occurring during t On 11/03/2016 at 8:10 conducted with the Di she expected the MD 483.20(d), 483.20(k)(COMPREHENSIVE O A facility must use the to develop, review an comprehensive plan of the facility must develop objectives and timeta medical, nursing, and	 A, an interview was She stated Resident #107 r left hand and arm and was A, an interview was ng Assistant (NA) #1. She employed at the facility months on evening shift. ever seen Resident #107 07 was non-ambulatory. 6PM, an interview was DS Coordinator. She stated ucation for nursing staff r accurate documentation ving (ADL) so the MDS 6he stated that Resident e and the MDS dated been coded as ambulation he assessment period. 8AM, an interview was irector of Nursing who stated S for be coded accurately. 1) DEVELOP CARE PLANS e results of the assessment d revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial 	F 2			11/25/16
	objectives and timeta medical, nursing, and	bles to meet a resident's				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02 FORM APPR(OMB NO. 0938-	OVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING		C 11/03/2016	3
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
				300 BLAKE BOULEVARD		
FINEHUK	ST HEALTHCARE & REF			PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5 TE ACTION SHOULD BE COMPLE D TO THE APPROPRIATE DAT CIENCY)	ETION
F 279	Continued From page	e 24	F 2	79		
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's of §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on record rev interview, and family develop a plan of car comprehensive asses reviewed for nutrition findings included: Resident #194 was a 10/10/16 with multiple heart failure and chro A physician's order da Resident #194 was o The admission Minim assessment for Resid cognition was intact. and she was 65 inche	ing as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment is not met as evidenced iew, staff interview, resident interview, the facility failed to e based on a resident's essment for 1 of 3 residents (Resident #194). The dmitted to the facility on e diagnoses that included onic kidney disease. ated 10/10/16 indicated n a mechanical soft diet. um Data Set (MDS) dent #194 indicates her Her weight was 92 pounds es tall. She was assessed		For the residents four affected by the alleged resident (#194) incom percutaneous endosce tube (PEG) for nutritio removed from residen 11/3/16 by Minimum d (MDS)coordinator. For the residents with affected by alleged de residents who have a audited by the Directo Assistant Director of N accurate care plans to tube on 11/7/16, all re tubes had a current ca To ensure this alleged does not reoccur, the will be put into place; a	d deficient practice plete care plan for opic gastrostomy nal intake was t⊡s care plan on iata set the potential to be ficient practice all PEG tube were r of Nursing and Jursing to ensure or effect use of PEG esidents with PEG are plan for the tube. deficient practice following measures	
	MDS review period (0 #194 was additionally received no nutritional during the MDS revie The Care Area Asses	being utilized during the Question K0510B). Resident / assessed as having al intake by a feeding tube w period (Question K0710). sment (CAA) for Nutritional ident #194 had a feeding		who are admitted with reviewed at the next F meeting by team mem Director of Nursing, th of Nursing and the Cli ensure accurate care	a PEG tube will be Patients at Risk obers to include the e Assistant Director nical Coordinator to	

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STATEMENT AND PLAN O	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI). 0938-0391	
			A. BUILDIN		ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		345370	B. WING				C 103/2016	
PINEHUR	ROVIDER OR SUPPLIER	•		STREE	TADDRESS, CITY, STATE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		IAB	300 BLAKE BOULEVARD PINEHURST, NC 28374					
	1			PINER			1	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Continued From page	e 25	F2	79				
F 279	tube that was not bein mechanical soft diet. The plan of care for F recent documented d A problem/need was "[Resident #194] requendoscopic gastrosto adequate nutritional i included maintaining position after each fer #194's placement bein checking for residual #194's feeding. A Registered Dieticia indicated Resident #1 soft diet. An interview was con on 11/1/6 at 4:35 PM. received any nutrition feeding tube since her (10/10/16). An interview was con family member on 11. confirmed Resident # had not received any	Resident #194, with the most late of 11/1/6, was reviewed. noted that indicated uires a [Percutaneous omy (PEG)] tube for ntake." The interventions Resident #194 in an upright eding, checking Resident fore initiating feeding, and before initiating Resident n (RD) note dated 10/20/16 194 was on a mechanical educted with Resident #194 . She indicated she had not hal intake through her er admission to the facility	F 2	PE ha on Du witi for ac mo by the au Nu bri As rev will	EG tubes. Any resident found to no ave a care plan for PEG tube will have placed immediately by MDS nursule to the limited number of resident th a PEG tube, audits will be perfor r all residents with a PEG tube for courate care plans monthly for six onths. These audits will be perform the Assistant Director of Nursing a e Clinical Coordinator. Results of the udits will be kept by the Director of ursing who will be responsible for inging them to the monthly Quality ssurance meeting where they will be viewed and discussed. Continued a ill be performed based on results of evious audits.	ed nd/or ed ed ed ed ese e		
	Manager on 11/1/16 a							

		MEDICAID SERVICES			OMB N	M APPROVE 0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345370	B. WING		C 11/03/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE		
PINEHUR	ST HEALTHCARE & REF	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 279 F 280 SS=D	plans of care for all re related to Resident # nutritional intake was Coordinator. She rev Resident #194 was in Resident #194 was in Resident #194 had no intake through the PE Coordinator explained had added this proble plan of care. She inco probably trying to hel Coordinator reported had added this proble plan of care. She sta remove the problem// nutritional intake on F An interview was com Nursing (DON) on 11 indicated her expects be comprehensive bas assessment. 483.20(d)(3), 483.100 PARTICIPATE PLANI The resident has the incompetent or other incapacitated under t participate in planning changes in care and A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a registere	for the completion of initial esidents. The plan of care 194's PEG tube for reviewed with the MDS vealed this plan of care for naccurate. She indicated ot received any nutritional EG tube. The MDS d that another staff member em/need to Resident #194's dicated the staff member was p her out. The MDS she was unable to tell who em/need to Resident #194's ated she was going to need for the PEG tube for Resident #194's plan of care. ducted with the Director of /3/16 at 8:21 AM. She ation was for plans of care to ased on each resident's MDS (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment.	F 27			11/28/16	

Facility ID: 923403

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345370	B. WING				C 03/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PINEHUR	ST HEALTHCARE & REH	AB		F	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE COMPL HE APPROPRIATE DAT		
F 280	and, to the extent pra the resident, the resid legal representative; a	e 27 ined by the resident's needs, cticable, the participation of lent's family or the resident's and periodically reviewed n of qualified persons after	F	280				
	by: Based on review revi facility failed to revise (Resident #14) of 3 sa for pressure ulcers an sampled residents rev medications. Finding 1. Resident 14 was ou facility on 6/25/16 with including stage IV pre Minimum Data Set (N 9/30/16 indicated that was intact and he had The physician's order reviewed. Resident # nutritional supplemen on 8/31/16 to promote On 9/15/16, there was discontinue the nutriti Resident #14.	ampled residents reviewed ad for 1 (Resident #12) of 5 viewed for unnecessary s included: riginally admitted to the n multiple diagnoses assure ulcers. The quarterly IDS) assessments dated Resident #14's cognition 4 stage IV pressure ulcers. s for Resident#14 were 14 had an order for a t to be given 3 times a day e wound healing. s a physician's order to			For the residents found to have been affected by the alleged deficient practic resident (#14) care plan was updated accurately to reflect Physician □s order discontinue nutritional supplement by Minimum Data Set coordinator (MDS)o 11/4/2016. Resident (#12) care plan for anti-psychotic medication was discontinued by MDS coordinator on 11/4/16. For the residents with the potential to be affected by alleged deficient practice 100% of all residents have their care plans compared with current orders to ensure accuracy of ca plans by November 28,2016. The audit will be completed by the Director of Nursing, Assistant Director of Nursing a the Clinical Coordinator and wound car nurse. All care plans will updated by the MDS nurses based on results of audits performed at the time of the audit. To ensure this alleged deficient practice do not reoccur, the following measures wil	to n will are s and re e		
	was reviewed. The c	are plan approaches e nutritional supplement 3			be put into place; all new orders will be brought the next business day to daily clinical meeting to have the care plan			

Facility ID: 923403

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/02/2016 RM APPROVEE IO. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	PLE CONSTRUCTION		E SURVEY IPLETED
		345370	B. WING		1'	C 1/03/2016
NAME OF PR	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				300 BLAKE BOULEVARD		
PINEHURS	T HEALTHCARE & REH	IAB		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	interviewed. MDS Nu plans were reviewed MDS assessment and She added that the nu discontinued before th assessment was com- been removed when the On 11/3/16 at 8:20 AP (DON) was interviewed she expected the card revised based on the physician's orders. 2. Resident #12 was 6/28/16. Cumulative depressive disorder and A review of physician dated 6/30/16 for Ser- medication) 50 milligr An Admission Minimu assessment dated 7/6 was cognitively intact were noted. Medicati 7 day look back perio received antipsychotic the assessment perio A review of the care p 7/15/16 and last revie Resident #12 was at antipsychotic drug us	M, MDS Nurse #1 was arse #1 stated that care after the completion of the d new physician's orders. utritional supplement was he quarterly MDS upleted and should have the care plan was reviewed. M, the Director of Nursing ed. The DON stated that e plan to be reviewed and MDS assessments and admitted to the facility on diagnoses included major and anxiety. 's orders revealed an order oquel (antipsychotic ams by mouth twice daily. Im Data Set (MDS) 6/16 indicated Resident #12 . No mood or behaviors ions administered during the d indicated Resident #12 c medication 7 days during	F 28		e Director of of Nursing of S e plan residents e month four or effected in adjusted Results of d by the ing them to e meeting ad	

Facility ID: 923403

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345370	B. WING		11/03/2016	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
PINEHUR	ST HEALTHCARE & REH	IAB		000 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 280	Continued From page	29	F 280			
	A physician's order da Seroquel 25 milligram fourteen (14) days, th was discontinued on	ns nightly by mouth x en discontinue. Seroquel				
	the care plan was rev 10/13/16 and the care	I, an interview was DS Coordinator. She stated riewed and updated on e plan for antipsychotic ve been discontinued.				
	stated she expected t and revised based or physician's orders. 483.20(k)(3)(ii) SERV	irector of Nursing. She the care plan to be reviewed the MDS assessment and ICES BY QUALIFIED	F 282		11/28/16	
SS=D	The services provided must be provided by	d or arranged by the facility				
	by: Based on record revi interview, and family follow the plan of care supplement for 1 of 3 nutrition (Resident #1 Resident #194 was a	residents reviewed for 94). The findings included: dmitted to the facility on e diagnoses that included		For the resident found to have been affected by the alleged deficient practic resident (#194) had the care plan upda and removed the intervention to provid nutritional supplement on 11/2/16 by th Minimum Data Set coordinator (MDS). For the residents with the potential to b affected by alleged deficient practice 100% of all residents will have their can plans compared with current orders to	ited e ie ie	

Event ID: JMTI11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2016 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345370	B. WING				03/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	АВ			00 BLAKE BOULEVARD INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	cognition was intact. and she was 65 inches The plan of care for F recent documented d reviewed. A problem, indicated "[Resident # tear/laceration." The offering Resident #19 support. The physician's order reviewed. There was nutritional supplement An interview was con Manager on 11/1/16 a Resident #194 receiv supplement. An interview was con on 11/2/6 at 3:35 PM. received or been offe since her admission t Resident #194 report nutritional shake once her home. She indica pounds was under he Resident #194 stated accepting of a nutritio been offered. An interview was con family member on 11/ confirmed Resident # not received or been	um Data Set (MDS) lent #194 indicated her Her weight was 92 pounds es tall. Resident #194, with the most ate of 11/1/16, was (need was noted that 4194] has a skin intervention included 4 supplemental nutritional s for Resident #194 were no physician's order for a t for Resident #194. ducted with the Dietary at 5:03 PM. She indicated ed no nutritional ducted with Resident #194 She revealed she had not red a nutritional supplement o the facility (10/10/16). ed she had taken a e daily when she resided at ated her current weight of 92 r normal body weight. she would have been nal supplement if one had	F2	282	ensure accuracy of care plans by November 28,2016 by Director of nur assistant director of nursing, clinical coordinator and wound care nurse. The ensure this alleged deficient practice not reoccur, the following measures will be brought the next business day to daily clinical meeting to have the care plan updated by the MDS nurse at that tim Audits will be performed by The Direct of Nursing, the Assistant Director of Nursing and the Clinical Coordinator of residents to compare new and discontinued orders to the care plan weekly for four weeks and five reside will be audited biweekly for one month then five residents monthly for four months. Any orders either new or discontinued found not to be reflected care plan during audits will be adjuste immediately by MDS nurses. Results these audits will be maintained by the Director of Nursing who will bring the the monthly Quality Assurance meeting where they will be reviewed and discussed. Continued audits be perfor based on results of the previous audit	o does vill pe y le. ctor on 5 nts h d in ed s of e m to ng rmed	

Facility ID: 923403

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMF	E SURVEY PLETED
		345370	B. WING			C / 03/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	AB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	given her one nutrition resided at home and her normal body weig An interview was con Coordinator on 11/2/1 she was responsible plans of care for all re- related to a skin tear// supplemental nutrition offered to Resident # MDS Coordinator. SH #194 had not been of supplement and this p followed. The MDS C another staff member problem/need and int plan of care. She ind probably trying to hell Coordinator reported had added this proble Resident #194's plan was going to update to the intervention "offer nutritional support" be not been offered a nut	onally confirmed that he had nal shake daily when she that she was currently under that she was currently under tht. ducted with the MDS 6 at 5:13 PM. She reported for the completion of initial esidents. The plan of care laceration that indicated hal support was to be 194 was reviewed with the ne revealed that Resident fered a nutritional blan of care was not Coordinator explained that had added this ervention to Resident #194's icated the staff member was b her out. The MDS she was unable to tell who em/need and intervention to of care. She stated she the plan of care and remove resident supplemental ecause Resident #194 had	F 24	82		
F 325 SS=D	indicated her expecta be followed. 483.25(i) MAINTAIN I UNLESS UNAVOIDA	BLE	F 3:	25		11/25/16
	Based on a resident's assessment, the facili resident -	-				

Facility ID: 923403

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2016 1 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345370	B. WING				C 03/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	00 BLAKE BOULEVARD		
PINEHUR	ST HEALTHCARE & REH	АВ		Р	INEHURST, NC 28374		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
F 325	25 Continued From page 32		F	325			
	(1) Maintains accepta	ble parameters of nutritional					
		weight and protein levels,					
	unless the resident's						
	demonstrates that this	s is not possible; and					
	(2) Receives a therap	eutic diet when there is a					
	nutritional problem.						
		is not met as evidenced					
	by:						
		n, medical record review			For the resident found to have alleged		
		e facility failed to notify the			deficient practice (resident #107)		
	-	significant weight loss and			The resident was referred and evaluat	ed	
		as ordered for one of three			by the Registered Dietitian (RD) on		
		r nutrition (Resident #107).			11/3/16. The RD ordered weekly weigh		
	The findings included				for four weeks. Weights were noted to		
	1a Decident #107 wa	a admitted to the facility			stable past 3 months. Resident's weigh		
	4/3/13 and last readm	as admitted to the facility			will be reviewed weekly in Patients at r		
					Meeting for four weeks as recommended	eu	
	Cumulative diagnoses				by RD.	od	
		, hemiplegia (paralysis) on nd Alzheimer ' s disease.			For residents with potential to be affect all weights were reviewed by RD on	eu	
	ngin dominant side al				11/3/2016 to identify any weight loss		
	A care plan dated 2/2	5/16 with last approaches			trends. During RD review, six residents		
	-	dicated Resident #107 was			were noted with weight loss trends with		
	at risk for weight loss				appropriate interventions added to inclu		
		deficits. Approaches			obtaining labs, weekly weights,		
		utritional supplement) as			supplements, and resident dietary		
	-	(4 ounces) four times daily			preferences. All interventions had orde	rs	
		evaluate nutritional status			placed by physician and were added to		
	prn (as needed).				the residents care plans by Minimum D		
	,				Set (MDS) coordinator on 11/4/2016.		
	A Quarterly Minimum	Data Set (MDS) dated			To ensure the alleged deficient practice	•	
		sident #107 had short and			does not reoccur all weights will be		
		pairment and was severely			reviewed in Patient's At Risk meeting h	eld	
	impaired in decision r				on Wednesdays. Any resident who has		
		ed with eating. Weight was			had a 5 pound or greater weight loss w		

Facility ID: 923403

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							2
		345370	B. WING			11/03/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REF	IAB			00 BLAKE BOULEVARD INEHURST, NC 28374		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 325	Continued From page	e 33	F 32	25			
		oounds with weight loss	1 02		be referred to the Registered Dietitian r	10	
	noted.				later than the next business day by the		
					Director of Nursing. All new admission		
	A review of the medic	cal record revealed the			will have a face sheet placed in the		
	following weights: 2/	1/16-121.8 pounds;			Registered Dietitian's folder by the		
	3/3/16-104 pounds; 3	8/23/16-108.2 pounds;			Director of Nursing for notification of all		
		s; 6/29/16-94.4 pounds;			new admissions for his review of charts		
		7/13/16-108.2 pounds;			when he visits facility. Any new admiss		
	10/3/16-109.8 pounds	s and 11/3/16-107.8 pounds.			that needs to be seen for issues such a	-	
					wounds, tube feedings, diagnosis such	as	
		nts at Risk (PAR) notes			failure to thrive, etc. will be referred via		
	committee on 3/9/16.	07 was reviewed by the PAR			telephone to the RD by the DON no late	er	
					than the next business day. An RD referral log will be kept by the Director of	of	
	On 11/2/16 at 9:00AN	1 an interview was			Nursing with referral to RD date, date		
		2. She stated Resident #107			seen by RD and any interventions note	h	
		uid intake. She stated			DON will monitor log weekly to ensure		
		onsumed 75% of breakfast			timely assessment by RD. An audit of a	all	
		was her usual amount			residents with a 5 pound or greater wei		
	consumed for breakfa				loss will be conducted weekly for four	-	
					weeks to ensure an RD referral was		
		PM, Resident #107 was			placed, RD was notified, any new		
	-	h. She was fed by nursing			interventions and care plan was update	ed.	
	staff and consumed 1	100% of food and fluids.			These audits will be performed by the		
	On 11/02/2016 at 4.5	5PM an interview was			administrative nurses to include the	or	
		5PM, an interview was #3. She stated the PAR			Director of Nursing the Assistant Director of Nursing and the Clinical Coordinator		
		of the dietary manager, the			These audits will continue weekly times		
		he clinical supervisor (Nurse			four weeks, biweekly times one month		
		ordinator. The committee			and monthly for four months. Audits wil		
		wed resident weights. If			be performed by Patients at Risk team		
		d, a list of those residents			members weekly during meeting.		
		to the registered dietician			Continued audits will be based on result	lts	
	(RD) for review and r	ecommendations. Nurse #3			of previous audits. Results of all audits	will	
		ure who gave the RD the list			be maintained by the Director of Nursin	ng	
		w. Nurse #3 said if weight			who will bring them to monthly quality		
		esident #107 on 3/9/16, a			assurance meetings where they will be		
		een made to the RD for			reviewed and discussed.		
	evaluation. Nurse #3	said she expected that the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2016 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345370	B. WING				C 03/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00/2010
				30	00 BLAKE BOULEVARD		
PINEHUR	ST HEALTHCARE & REH	AB		PI	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG F 325	Continued From page Director of Nursing (w facility) would have in to see the resident. A nutrition note dated dietician stated Resid documented at 123.6 eating well and fed he Continue to monitor. documentation from th he had evaluated/ see January. On11/03/2016 at 9:13 conducted with the RI the facility once a mor calls from the facility r have been reviewed of recommendations. Th facility about residents concerns, wound com also sees new admiss he does not review all residents on an " as stated there might not if he had made recom phone. The RD state he had received a pho #107 in March for wei would review his Marc #107 had been referred	 34 tho no longer worked at the formed the RD of the need 1/14/16 by the registered ent #107 's weight was pounds. Resident was pounds. Resident was erself after tray set-up. There was no further ne registered dietician that en Resident #107 since AM, an interview was D. He stated he comes to nth and also gets phone regarding residents that during the PAR meetings for ne RD stated he asks the s who have weight cerns, tube feeders and sions as needed. He stated in ew admissions and sees needed " basis. The RD to be RD notes on a resident 	F 3	25		AIE	
	said he should have h the weight loss and a weights documented part of July were inco	ad a referral in March for dded that he thought the at the end of June and first					

Facility ID: 923403

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345370	B. WING				C 03/2016	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEHUR	ST HEALTHCARE & REH	АВ			300 BLAKE BOULEVARD PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 325	facility obtain a currer and her current weigh was a loss of two pour 2b. Resident #107 wa 4/3/13 and last readm Cumulative diagnoses (difficulty swallowing) right dominant side an A care plan dated 2/2 updated on 8/31/16 in at risk for weight loss paresis and cognitive included Med Pass (m ordered 120 milliliters (5/18/16). Dietician to prn (as needed). A Quarterly Minimum 9/30/16 indicated Res long term memory im impaired in decision m assistance was requir documented as 108 p noted. A review of the medic following weights: 2/7 3/3/16-104 pounds; 3 6/15/16-107.4 pounds; 7/6/16-94.4 pounds; 7 10/3/16-109.8 pounds A review of physician revealed an order for	ht weight for Resident #107 ht was 107.8 pounds which inds since October. As admitted to the facility hitted on 11/19/15. Is included dysphagia , hemiplegia (paralysis) on hd Alzheimer 's disease. 5/16 with last approaches indicated Resident #107 was related to right sided deficits. Approaches nutritional supplement) as (4 ounces) four times daily be evaluate nutritional status Data Set (MDS) dated sident #107 had short and pairment and was severely naking skills. Limited red with eating. Weight was bounds with weight loss al record revealed the 1/16-121.8 pounds; /23/16-108.2 pounds; is; 6/29/16-94.4 pounds; /13/16-107.8 pounds. orders for September 2016	F	325				
	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
--------------------------	---	--	---------------------	-----	---	-------------------	----------------------------	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		345370	B. WING				C 03/2016	
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
PINEHURS	ST HEALTHCARE & REH	AB			00 BLAKE BOULEVARD INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 325	Pass 120 milliliters (m documented as having received by Resident remainder of the Sept through 9/30/16 revea Med Pass 120 ml was A review of the physic and November 2016 was not a physician ' four times daily. Med there was not a physic the Med Pass. Medical review of the November MAR revea documentation that M daily had been admin November. On 11/2/16 at 5:30PM conducted with the Di stated the facility char the MAR 's and phys Apparently the order if four times daily did no orders nor was in on if Nursing said the nurs error because they we MAR and physician of	mber Medication d (MAR) revealed that Med nl) four times daily was g been administered and #107 through 9/5/16. The tember MAR from 9/6/16 aled no documentation that is administered. cian orders for October 2016 was completed and there s order for Med Pass 120 ml ical record review revealed cian ' s order to discontinue October MAR and aled there was no led Pass 120 ml four times istered in October or 1, an interview was irector of Nursing. She nged systems that printed ician orders in September. for the Med Pass 120 ml. ot carry over to the October the MAR. The Director of es should have caught the ere supposed to review the rders in the old system and s in the new system to make	F3	325				
F 329 SS=D	•	IMEN IS FREE FROM	F	329			11/28/16	
	Each resident's drug	regimen must be free from						

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/02/2010 MAPPROVED O. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING		C 11/03/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEHUR	ST HEALTHCARE & REF	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	drug when used in ex duplicate therapy); or without adequate mo indications for its use adverse consequence should be reduced or combinations of the r Based on a compreh resident, the facility n who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	An unnecessary drug is any accessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical s who use antipsychotic I dose reductions, and	F 32	29		
	by: Based on record rev facility failed to comp involuntary movemen to obtain the weight a 2 of 5 sampled reside unnecessary medicat The facility's policy of (undated) was review that AIMS test will be dyskinesia which may	F is not met as evidenced iew and staff interview, the lete an AIMS (abnormal its) test (Resident #153) and as ordered (Resident #12) for ents reviewed for tions. Findings included: in antipsychotic medications yed. The policy indicated used to monitor for tardive y develop from antipsychotic cy further indicated that AIMS		For the resident affected by the deficient practice resident (#15 was a DISCUSS completed on by the Assistant Director of Nur form monitors for negative effect psychotropic drugs to include ta dyskensia which monitors for th movements as the AIMS (abno involuntary movements scale). resident (#12) a weight was obt 11/4/16 and entered into compu- by Director of Nursing. The ord	3) there 11/4/2016 sing. This cts of ardive he same rmal For the tained on uter system	

Event ID: JMTI11

Facility ID: 923403

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. 0	PPROVE
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLET	
		345370	B. WING		C 11/03/	2016
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE C	(X5) OMPLETION DATE
F 329	current resident with antipsychotic medica months. 1. Resident # 153 wa 7/29/16 with multiple hallucinations and de Parkinson's disease. Data Set (MDS) asse indicated that Reside decision making prob antipsychotic drug in The physician's order reviewed. On 8/22/10 Seroquel (antipsycho and to give 1 and ½ t for hallucinations and On 9/6/16, there was Seroquel. On 9/7/16, there was (antipsychotic drug) 1 times a day for halluc The monthly drug reg #153 were reviewed. had requested for an The medical records electronic records we no AIMS test complet On 11/2/16 at 4:10 Pl	 d 72 hours after new chotic medication and initiation of new order of tion and then every 6 s admitted to the facility on diagnoses including lusions secondary to The quarterly Minimum essment dated 9/23/16 nt #153 had memory and blems and had received an the last 7 days. rs for Resident #153 were 6, there was an order for tic drug) 25 milligrams (mgs) ablet by mouth 3 times a day 1 delusions. an order to discontinue the an order to give Nuplacid 17 mgs. 1 tablet by mouth 2 cinations and delusions. gimen reviews for Resident 0n 8/25/16, the pharmacist AIMS test. of Resident #153 including the reviewed and there was ted. M, Nurse #1 was 	F 32	weights to be obtained weekly w scheduled to be discontinued or and was discontinued as ordere For those resident with the pote affected by the alleged deficient on 11/7/16 an audit for a comple DISCUSS of all residents was p by the Director of Nursing and the Clini Coordinator. There were three r found to not have a DISCUSS performed and entered into the health record on 11/7/16. All res were audited by the DON to ens current weight was entered into electronic system and were enter already done so by DON comple 11/7/2016. 100% of resident s or weights by 11/26/16 by staff nur assigned to residents on this da ensure there is an area to docur weight on the medication admin record. There were no orders fo weights as it relates to adjusting medication dosage.For all reside to have an order for weights it w with the restorative aide on 11/2 the weight was being obtained a To ensure this practice does n reoccur, audits of residents will performed using the MDS calen ensure the DISCUSS is being p on all residents quarterly. All ner will be reviewed in daily Clinical that are attended by the DON, A	n 11/1/16 d. ntial to be practice eted erformed sssistant ical esidents ompleted, be electronic idents sure a the ered if not eted on orders ders for ses te to ment istration und for a ents found vas verified 8/16 that as ordered. ot be dar to erformed w orders Meetings ADON,	
	interviewed. Nurse #	M, Nurse #1 was 1 stated that the admission e in completing the AIMS		that are attended by the DON, A MDS Coordinator and the Clinic Coordinator any orders that are	al	

Facility ID: 923403

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/02/2016 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345370	B. WING				C / 03/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST HEALTHCARE & REH			30	00 BLAKE BOULEVARD		
FINEHOR	ST HEALTHCARE & REP			P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	test on admission if a antipsychotic medica indicated that she did was not completed for On 11/3/16 at 8:20 Al (DON) was interview she expected AIMS to facility policy. 2. Resident #12 was 6/28/16. Cumulative congestive heart failu A Quarterly Minimum 10/6/16 indicated Res intact. Medications ad assessment period in received diuretic med A care plan dated 7/1 updated 10/13/16 sat potential for fluid volu use. Approaches inco resident as ordered a and report weight var dietician. Physician's orders fo and revealed an orded diuretic medication) 2 8 AM. If 5 pounds we 40 milligrams daily. check weight every F increase 5 pounds, g daily. A review of the Septe Administration record	 resident was admitted on tion. Nurse #1 further In't know why the AIMS test or Resident #153. M, the Director of Nursing ed. The DON stated that est to be completed per the admitted to the facility on diagnoses included ure and diabetes. Data Set (MDS) dated sident #12 was cognitively dministered during the adicated Resident #12 had ure deficit due to diuretic duded, in part, weigh and prn (as needed. Record riance to physician and r September were reviewed and the deficit for Lasix (a 20 milligrams by mouth daily eight gain, increase back to There was also an order to triday 2 PM; if weight o back to 40 milligrams 	F	329	the weekend are reviewed in the next business day meeting. Any new phys orders for weights to be obtained will reviewed by the DON, ADON, clinical coordinator and MDS coordinator in t electronic health record to ensure that area to record weight is available. A co of the weight log for daily, weekly and monthly weights will be kept by the Director of Nursing and a copy for the restorative aides who are responsible obtaining weights. The DON will revie weights weekly prior to Patients at Ri meeting to ensure all weights have be obtained as ordered. Review of log w ongoing as to ensure weights are obtained as ordered. Audits will be performed by the MDS nurses weekly 4 weeks, biweekly for one month and monthly for four months. Results of th audits will be kept by the Director of Nursing and will be brought to monthl Quality assurance meeting to review discuss. Continued audits will be performed based on the outcome of t audits previously performed.	ician be he t an copy t e for ew all sk een ill be / for he y and	

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-					FORM	APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
	345370	B. WING				C 03/2016
ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
ST HEALTHCARE & REH	IAB					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION DATE
9/20-9/30/16. A physician's order da Lasix 20 milligrams by every Fridayif weigh back to Lasix 40 millig A review of the Octob no weights document A review of resident # weekly weights had b record. On 11/1/16 at 4:30PM conducted with Nurse the computer to obtai every Friday. She sta nursing assistant to o recorded the weight of Nurse #1 stated she ov report from the previce Resident#12 had a w always wrote it down and the weight should on the MAR. She ind it was not recorded on On 11/2/16 at 3:53PM conducted with the Di stated she had review sheets and could only 10/14, 10/21 and 10/2 hour report sheets rev 10/14-228 pounds: 10 10/28-230 pounds. T her expectation was f documented in the co	ated 10/31/16 indicated y mouth daily. Check weight it increase 5 pounds, go grams daily. The MAR revealed there were ed for the month of October. The MAR revealed no been documented in the the Mark revealed no revealed she would ask the btain the weight and she on the 24 hour report sheet. Would review the 24 hour bus Friday to determine if eight gain. She said she on the 24 hour report sheet d also have been recorded licated she did not know why in the MAR. A, an interview was irrector of Nursing. She wed the 24 hour report y find the report sheets for 28/16. A review of the 24 wealed the following weights: D/21227.2 pounds and the Director of Nursing said for the weights to be omputer under weights so	F	329			
	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION SUMMARY ST. (EACH DEFICIENCIES CONTINUED FROM DEFICIENCIES CONTINUED FROM DEFICIENCIES CONTINUED FROM DEFICIENCIES CONTINUED FROM DEGICIENCIES Q/20-9/30/16. A physician's order da Lasix 20 milligrams b every Fridayif weigh back to Lasix 40 millig A review of the Octob no weights document A review of resident # weekly weights had b record. On 11/1/16 at 4:30PM conducted with Nurse the computer to obtai every Friday. She sta nursing assistant to o recorded the weight c Nurse #1 stated she w report from the previce Resident#12 had a w always wrote it down and the weight should on the MAR. She ind it was not recorded of On 11/2/16 at 3:53PM conducted with the D stated she had review sheets and could only 10/14, 10/21 and 10/2 hour report sheets ref 10/14-228 pounds: 10 10/28-230 pounds. T her expectation was f documented in the co	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345370 ROVIDER OR SUPPLIER ST HEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 9/20-9/30/16. A physician's order dated 10/31/16 indicated Lasix 20 milligrams by mouth daily. Check weight every Fridayif weight increase 5 pounds, go back to Lasix 40 milligrams daily. A review of the October MAR revealed there were no weights documented for the month of October. A review of resident #12's record revealed no weekly weights had been documented in the	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345370 B. WING 345370 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 40 F : 9/20-9/30/16. A physician's order dated 10/31/16 indicated Lasix 20 milligrams by mouth daily. Check weight every Fridayif weight increase 5 pounds, go back to Lasix 40 milligrams daily. F : A review of the October MAR revealed there were no weights documented for the month of October. A review of resident #12's record revealed no weekly weights had been documented in the record. On 11/1/16 at 4:30PM, an interview was conducted with Nurse #1. She stated it was in the computer to obtain Resident #12's weight every Friday. She stated she would ask the nursing assistant to obtain the weight and she recorded the weight on the 24 hour report sheet. Nurse #1 stated she would review the 24 hour report from the previous Friday to determine if Resident#12 had a weight gain. She said she always wrote it down on the 24 hour report sheet and the weight should also have been recorded on the MAR. She indicated she did not know why it was not recorded on the MAR. On 11/2/16 at 3:53PM, an interview was conducted with the Director of Nursing. She stated she had reviewed the 24 hour report sheets and could only find the report sheets for 10/14, 10/21 and 10/28/16. A review of the 24 hour report sheets revealed the following weights: 10/14-228 p	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES POORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 9/20-9/30/16. A physician's order dated 10/31/16 indicated Lasix 20 milligrams by mouth daily. Check weight every Fridayif weight increase 5 pounds, go back to Lasix 40 milligrams daily. A review of the October MAR revealed there were no weights documented for the month of October. A review of resident #12's record revealed no weekly weights had been documented in the record. On 11/1/16 at 4:30PM, an interview was conducted with Nurse #1. She stated it was in the computer to obtain Resident #12's weight every Friday. She stated she would ask the nursing assistant to obtain the weight and she recorded the weight on the 24 hour report sheet. Nurse #1 stated she would review the 24 hour report from the previous Friday to determine if Resident#12 had a weight gain. She said she always wrote it down on the 24 hour report sheet and the weight should also have been recorded on the MAR. She indicated she did not know why it was not recorded on the MAR. On 11/2/16 at 3:53PM, an interview was conducted with the Director of Nursing. She stated she had reviewed the 24 hour report sheets and could only find the report sheets for 10/14, 10/21 and 10/28/16. A review of the 24 hour report sheets revealed the following weights: 10/14-228 pounds: 10/21-227.2 pounds and 10/28-230 pounds. The Direc	SPOR MEDICARE & MEDICAID SERVICES OF DEFINICIENCIES (1) PROVIDERSUPPLIERCLIA DERIFICATION NUMBER: (2) MULTIPLE CONSTRUCTION A BUILDING 345370 B WING ROVIDER OR SUPPLIER STREETADDRESS, GITY, STATE, ZIP CODE 300 BLACE BOULEVARD PINEHURST, NC 28374 ST HEALTHCARE & REHAB STREETADDRESS, GITY, STATE, ZIP CODE 300 BLACE BOULEVARD PINEHURST, NC 28374 Continued From page 40 9/20-9/30/16. PROVIDERS PLAN OF CORRECTION (EACH ORRECTIVE ATIONS HOLD DE CONSTRUCTIVE ATIONS AND TO CORRECTIVE REQUILING A physician's order dated 10/31/16 indicated Lasix 20 milligrams by mouth daily. Check weight every Friday-if weight increase 5 pounds, go back to Lasix 40 milligrams daily. F 329 A review of the October MAR revealed three were no weights documented for the month of October. A review of resident #12's record revealed no weekly weights had been documented in the record. Not 11/1/16 at 4:30PM, an interview was conducted with Nurse #1. She stated it was in the computer to obtain Resident #12's weight every Friday. She stated she would review the 24 hour report from the previous Friday to determine if Resident#12 had a weight gain. She said she atimays worke it down on the 24 hour report sheet. On 11/12/16 at 3:352PM, an interview was conducted with the Director of Nursing. She stated she had review the 24 hour report sheets nevaled the following weights: 10/14, 10/21 at 10/22/15, a review of the 24 hour report sheets revealed the following weights: 10/14, 20/21 at 10/22/15, a review of the 24 h	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICAD SERVICES OMB NC SFOR MEDICARE & MEDICAD SERVICES OMB NC A BULDING 345370 E.VINIC

Facility ID: 923403

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/201 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345370	B. WING			11/03/2016	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEHUR	ST HEALTHCARE & REH	IAB			0 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 41	F	329			
F 332 SS=D		needed to be increased. OF MEDICATION ERROR IORE	F	332			12/1/16
	The facility must ensumedication error rates	ure that it is free of s of five percent or greater.					
	by: Based on record revi interview, the facility f medication error rate following the physicia errors of 29 opportun 6.9% error rate. Find 1. Resident #60 had a 10/19/16 for Morphine reliever) 15 milligrams for pain. On 11/2/16 at 7:40 AI during the medication to prepare and to adm Morphine Sulfate to F bottle of Morphine Su ml." On 11/2/16 at 9:30 AI interviewed. Nurse # had administered 10 Resident #60. After r bottle of Morphine Su should have given 7.5	at 5%% or below by not in's orders. There were 2 ities for error resulting in a lings included: a physician's order dated e Sulfate (a narcotic pain s (mgs) via tube twice a day M, Nurse #2 was observed ninister 10 Millie liter (ml) of Resident #60 via tube. The ulfate read "10 mgs. per 5 M, Nurse #2 was 2 acknowledged that she ml of Morphine Sulfate to reading the direction on the ulfate, she stated that she			For the resident affected by the allege deficient practice resident (#60) order morphine was clarified with the physici (MD) and the order was corrected with clarification from MD. The resident was assessed by the Director of Nursing (DON) immediately and no negative outcomes were noted. The nurse administering medications to the reside was educated by DON immediately on proper administration of medications p policy with return demonstration. For those resident with the potential to affected by the alleged deficient practic all licensed nurses and medication aid will be in serviced of the five rights of medication administration and proper administration of medications per polic by 12/1/2016 by Clinical Coordinator a Assistant Director of Nursing. Audits o medication administration on 100% of licensed nurses and medication aides be performed on 2 different nurses for weeks, biweekly for one month and monthly for 4 months. These audits wi include all weekend and PRN staff. Au will be performed by Clinical Coordinator	for an a s ent er be ce es y nd f will 4 ults	

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/02/2016 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING _			C /03/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEHURS	ST HEALTHCARE & REH	AB		300 BLAKE BOULEVARD		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 332	Continued From page	2 42	F 3	32		
	. ,	ed. The DON stated that		and Assistant Director of Nursing		
	she was informed of t			weekend registered nurse super Results of the audits will be kep		
		ne Sulfate. She indicated Resident #60 was informed		DON and who will bring them to	•	
		or and a new order for		Quality assurance meeting to re	view and	
		received. The DON further ted the nurses to administer		discuss. Continued audits will be performed based on the outcom		
	medications as order			audits previously performed.		
		a physician's order dated				
		m Chloride (KCL) 40 Millie ml via tube and to dilute with ater before giving for				
	during the medication	M, Nurse #2 was observed pass. She was observed ninister 30 ml of KCL by tube water.				
	On 11/2/16 at 9:30 Al interviewed. She ack dilute the KCL with wa	nowledged that she did not				
F 333 SS=D		ted that she expected the the medications as ordered. ENTS FREE OF	F 3	33		12/1/16
	The facility must ensu any significant medica	are that residents are free of ation errors.				
	by:	is not met as evidenced				
		ew, observation and staff ailed to administer the		For the resident affected by the deficient practice resident (#60)		

Event ID: JMTI11

Facility ID: 923403

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STATURENT OF DERIGENCIES AND PLAN OF CORRECTION Importance supplies addition of contractions international distributions of the stated that and plant is supplied and stated that a diministration of modeling and stated that a diministration of a diministered 10 millio liter (mil) of Morphine Sulfate read "10 mgs per 5 ml." Importance stated that a diministration of the discustor of Nursing the medication a dives that a diministration of the discustor of Nursing the medication a dives that a diministration of the discustor of Nursing the discusse. Continued addition and a diministration of the discusse of the discusse of the a different nurses and medication addition addition addition a diministration of the discusse of the discusse of the a different nurses and medication addition addition addition a different nurses and medication addition addition addition a different nurses and medication addition addition addition addition a different nurses and medication addition additis a dintenesthated addition addition the bothe of Morphine Sulfa			ND HUMAN SERVICES			PRINTED: 12/02/201 FORM APPROVE OMB NO. 0938-039
346370 B. WNO 11/03/2016 NAME OF PROVIDER OR SUPPLIER SIMEWAY SATURENT OF DEFICIENCY MAD BE PRECIDED BY FULL PREFIX SIMEWAY SATURENT OF DEFICIENCIES (EACH OPERS PLAN OF CORRECTIVE ACTON SIGULAR PREFIX SIMEWAY SATURENT OF DEFICIENCIES (EACH OPERS PLAN OF CORRECTIVE ACTON SIGULAR PREFIX OPENDES PLAN OF CORRECTIVE ACTON SIGULAR PREFIX OPENDES PLAN OF CORRECTIVE ACTON SIGULAR PREFIX OPENDES PLAN OF CORRECTIVE ACTON SIGULAR (EACH OPENDES PLAN OF CORRECTIVE ACTON SIGULAR PREFIX OPENDES PLAN OF CORRECTIVE ACTON SIGULAR (EACH OPENDES PLAN OF CORRECTIVE ACTON SIGULAR PREFIX OPENDES PLAN OF CORRECTIVE ACTON SIGULAR (EACH OPENDES) PLAN OF CORECTIVE ACTON SIGULAR (EACH OPENDE	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,		(X3) DATE SURVEY COMPLETED
PNEHURST HEALTHCARE & REHAB 300 BLAKE BOULEVARD PREFIX 300 BLAKE BOULEVARD PREFIX 049.10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED ST FULL REGULATORY ON LSC IDENTIFYING MFORMATION) 0 PREFIX TAG 0 PREFIX TROUVERTS FLAN OF CORRECTION (EACH OPRICE/TIX ACTION SHOULD BE CROSS-REFERENCE) TO THE AMPROPRIATE DEFICIENCY) 0 PREFIX TAG 0 PREFIX 0 PRE			345370	B. WING		-
PINEHURST HEALTHCARE & REHAB PINEHURST, NC 28374 [94] ID PREFIX TAG Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN OF CORRECTIVE ACTON SHOULD BE (EACH DEFICIENCY MUST EF PLAN ACTON SHOULD BE (EACH DEFICIENCY ACTON SHOULD BE (EACH DEFICIENCY ACTOR SHOULD ACTOR (MITTING ACTOR SHOULD ACTOR (MITING ACTOR AC	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WH ID PRETIX TAG SUMMARY STREMENT OF DEFICIENCING (EACH DEFICIENCY MADE REPRECEEDED BY FULL REQUILTORY OR LSC DEDITIVING INFORMATION) D PRETIX TAG PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MADE REPRECEEDED BY FULL REQUILTORY OR LSC DEDITIVING INFORMATION) D Deficition PRETIX TAG DEFICIENCY (EACH DEFICIENCY MADE REPRECEEDED BY FULL RECENCY) D Deficition (EACH DEFICIENCY MADE REPRECEEDED BY FULL RECENCY) D DEFICIENCY (EACH DEFICIENCY) D DEFICIENCY (EACH DEFICIENCY) D DEFICIENCY F 333 Continued From page 43 Morphine Sulfate (a narcotic pain reliever) as ordered by the physician for 1 (Resident #60) of 7 sampled residents observed during the medication pass. Findings included: F 333 morphine was clarified with the MD and the order was corrected with a clarification from Physician. The resident was durated by DON immediately by the Director of Nursing. The nurse administering medications the resident was durated by T/31'16 indicated that Resident #60's cognition was intact. F 333 Morphine Sulfate 16 ministration of medications per policy with return demonstration. On 11/2/16 at 7.40 AM, Nurse #2 was observed during the medication pass. She was observed during the medication administered 10 millie itter (mil) of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The worker addition administred 10 millie itter (mil					300 BLAKE BOULEVARD	
Predry Tvg (EACH DERIGENCY AGLES DEBTRYING INFORMATION) Predry Tvg (EACH DERIGENCY and CLOBER CROSS-REFERENCE TO IN SHOULD BE CROSS-REFERENCE TO IN BAPPROPRIATE DEFICENCY) COMMET DEFICENCY F 333 Continued From page 43 Morphine Sulfate (a narcotic pain reliever) as ordered by the physician for 1 (Resident #60) of 7 sampled resident sobserved during the medication pass. Findings included: F 333 F 333 Resident #60 was originally admitted to the facility on 7/6/16 and was readmitted on 10/18/16 with multiple diagnoses including pain. The admission Minimum Data Set (MDS) assessment dated 7/13/16 indicated that Resident #60's cognition was intact. F 333 F 333 The physician's orders for Resident #80 were reviewed. On 10/19/16, there was a physician order for Morphine Sulfate 15 milligrams (mgs) via tube twice a day for pain. The admissization on 10/19/16, there was a physician order for Morphine Sulfate 15 milligrams (mgs) via tube twice a day for pain. The physicianis orders for Resident #80 were reviewed. On 10/19/16, there was a physician order for Morphine Sulfate 15 milligrams (mgs) via tube twice a day for pain. The admissization on 100% of licensed nurses and medication aides to include weekend and PRN staff will be performed to include weekend registered nurse supervisor. Results of the audits will be kept by the DON who will bring them to the monthly Ouality assurance meeting to review and discuss. Continued audits will be performed based on the outcome of the audits previously performed. On 11/2/16 at 11.28 AM, the Director of Nursing (DON) was interviewed. The DON stated that she schedcth the nurses to follow the physician's orders.	FINEITOIX				PINEHURST, NC 28374	
Morphine Sulfate (a narcotic pain reliever) as ordered by the physician for 1 (Resident #60) of 7 sampled residents observed during the medication pass. Findings included:morphine was clarified with the MD and the order was corrected with a clarification from Physician. The resident was assessed immediately by the Director of Nursing. The nurse administering medications per policy with return demonstration.Resident #60 was originally admitted to the facility on 7/6/16 and was readmitted on 10/18/16 with multiple diagnoses including pain. The admission Minimum Data Set (MDS) assessment dated 7/13/16 indicated that Resident #60's cognition was intact.The physician's orders for Resident #60 were reviewed. On 10/19/16, there was a physician order for Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate read "10 mgs per 5 ml."morphine was clarified with the MD and the order was corrected with a clarification from Physician. The resident was assessed util the morthly fourily particular to administer 10 milling target (morphine Sulfate to Resident #60 via tube. The bottle of Morphine Sulfate read "10 mgs per 5 ml."morphine was clarified with the MD and the order was corrected with a clarification administration or medication per policy with return demonstration. For those resident with the potential to be affected by the alleged deficient practice all licensed nurses and medication aides to include weekend and PRN staff will be performed to include weekend registered nurse supervisor. Results of the audits will be performed to morthly Gaulity assurance meeting to review and assistant Director of Nursing and weekend registered nurse supervisor. Results of the audits will be performed to moutome of the audits previously p	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
she expected the nurses to follow the physician's orders.	F 333	Morphine Sulfate (a r ordered by the physic sampled residents of medication pass. Fir Resident #60 was ori on 7/6/16 and was re- multiple diagnoses in Minimum Data Set (N 7/13/16 indicated tha was intact. The physician's order reviewed. On 10/19/ order for Morphine Si via tube twice a day f On 11/2/16 at 7:40 Al during the medication to prepare and to adr Morphine Sulfate to F bottle of Morphine Su- ml." On 11/2/16 at 9:30 Al interviewed. She ach administered 10 ml o Resident #60. After r bottle of Morphine Su- she should have adm Sulfate instead of 10 On 11/2/16 at 11:28 A	harcotic pain reliever) as cian for 1 (Resident #60) of 7 perved during the adings included: ginally admitted to the facility admitted on 10/18/16 with cluding pain. The admission <i>IDS</i>) assessment dated t Resident #60's cognition rs for Resident #60 were 16, there was a physician ulfate 15 milligrams (mgs) for pain. M, Nurse #2 was observed ninister 10 Millie liter (ml) of Resident #60 via tube. The ulfate read "10 mgs per 5 M, Nurse #2 was knowledged that she had f Morphine Sulfate to reading the instruction on the ulfate, Nurse #2 stated that ninistered 7.5 ml of Morphine ml. AM, the Director of Nursing	F 33	 morphine was clarified with the MD the order was corrected with a clarifrom Physician. The resident was assessed immediately by the Direct Nursing. The nurse administering medications to the resident was ed by DON immediately on proper administration of medications per p with return demonstration. For those resident with the potentia affected by the alleged deficient pra all licensed nurses and medication will be in serviced of the five rights medication administration and prop administration of medications per p by 12/1/2016 by Clinical Coordinate Assistant Director of Nursing. Audit medication administration on 100% licensed nurses and medication aid include weekend and PRN staff will performed to include all shifts week different nurses for 4 weeks, biwee one month and monthly for 4 month Audits will be performed by Clinical Coordinator and Assistant Director Nursing and weekend registered nurses with the potential coordinator and discuss. Continued aud be performed based on the outcom 	fication tor of ucated olicy al to be actice aides of of or and s of of les to l be dy of 2 kly for ns. of urse II be m to eting to its will
E 371 483 35(i) FOOD PROCURE E 571 11/28/16		(DON) was interview she expected the nur orders.	ed. The DON stated that sees to follow the physician's			
	F 371	483.35(i) FOOD PRC	OCURE,	F 37	1	11/28/16

Facility ID: 923403

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORI	D: 12/02/2016 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	E SURVEY PLETED
		345370	B. WING			/03/2016
NAME OF P	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
PINEHUR	ST HEALTHCARE & REH	IAB		300 BLAKE BOULEVARD		
				PINEHURST, NC 28374		
(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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371 SS=E	Continued From page STORE/PREPARE/S		F 37	1		
	considered satisfacto authorities; and	n sources approved or ory by Federal, State or local stribute and serve food ions				
	by: Based on observation interview, the facility and discard expired for refrigerator, maintain temperatures for the during the morning models clean refrigerator in the included: An undated facility por and dating openend for "All food items that are and cooked to be used properly labeled and the date the item was the time frame in which discarded." 1. On 10/31/16 at 9:3 kitchen was conducted The following was no refrigerator: an open	pureed eggs and bacon leal and failed to maintain a he kitchen. The findings blicy titled "Properly labeling food items" stated, in part, re opened and/or prepped ed at a later time must be dated. The label must state is ether opened or made and ch it must be used and 30AM, an initial tour of the ed with the dietary manager.		For the current residents have affected, an inspection of the dietary department was cond 11/3/16 by the Dietary Manage ensure that all items were pro- and dated and that all items of discarded prior to expiration of ensured that all appliances we immediately. In addition, DM food temps to ensure all were appropriate ranges. For all residents having the p affected, 100% of all Dietary educated on 11/14/2016 by the Administrator on the following Proper labeling, safe food ter zone standards (proper holdi sanitation/cleaning standards review of the cleaning checkli temperature logs and newly of audit tools. All newly hired d will receive this education du	entire lucted on ger (DM) to operly labeled were date. DM vere cleaned l observed e within votential to be staff were he g areas: mps, safe ng temps), s and a list, food developed ietary staff	

Facility ID: 923403

If continuation sheet Page 45 of 58

						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · /	ATE SURVEY OMPLETED
			A. BUILDING	3		
		345370	B. WING			C
	ROVIDER OR SUPPLIER	545570		STREET ADDRESS, CITY, STATE, ZIP CO		11/03/2016
NAME OF F	ROVIDER OR SUFFLIER			300 BLAKE BOULEVARD	DE	
PINEHUR	ST HEALTHCARE & REH	IAB		PINEHURST, NC 28374		
				-		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 371	Continued From page	e 45	F 37	71		
	barbeque sauce, an o	on opened undated jar of dill		for obtaining food temperatu	res for each	
		ndated container of tuna		food item immediately prior t		
		ed jar of Italian dressing and		service. All food temps will b		
	an open undated con	tainer of mayonnaise.		will include temperature, dat cook's initials and time.	e, product,	
	On 10/31/16 at 9:30A	M, an interview was				
		ietary manager stated any		To ensure ongoing complian	ce, the DM or	
	item should be dated	when it was opened.		dietary assistant manager w audits throughout all shifts a		
	On 11/2/16 at 10:30A	M, a second observation of		a minimum of 5 days a week		
	the kitchen was cond	ucted. There was a		to include weekends to ensu		
	container of chopped	slaw in the refrigerator with		are properly dated and label	ed and that all	
	a use by date of 10/2	7/16.		products are discarded prior In addition, a cleaning Inspe	•	
	On 11/2/16 at 10:30A	M, an interview was		Checklist will be used by sta	ff to ensure	
	conducted with the di	ietary manager who stated		ongoing compliance with sar	nitation	
	she thought the use t	by 10/27 date was incorrect		standards. An audit tool will	be developed	
	but she would discare	d it.		and used by DM or assistant manager a minimum of five of		
	2. On 11/2/16 at 6:50	DAM, an observation of the		throughout all shifts and mea		
		is conducted. The cook		months to include weekends	to determine	
	calibrated the thermo			staff compliance with the cle	•	
		temperature of the food.		inspection checklist. In addition		
		ture of the pureed eggs was		temperature logs will be aud		
	observed to be 130 d			assistant dietary manager a		
	-	ooked bacon was observed		days a week for 6 months to		
	-	he cook did not reheat the		weekends to ensure ongoing		
	pureed eggs or bacor			DM or assistant dietary man observe cook obtaining food		
	On 11/2/16 at 7.004	<i>I</i> , the dietary manager		a minimum of five days a we		
		d on the trays to be served		all shifts including weekends		
		e was observed to be serving		mealtimes for 6 months.		
		dent trays. When asked at				
		e would reheat the bacon,		All findings from audits will b	e kept and	
		reheat the bacon to a		brought to monthly Quality A		
		of 140 degrees. She was		(QA) meeting by the dietary		
		ad a holding temperature of		be reviewed and discussed l		
		moved the bacon from the		team monthly for 6 months.	-	
		d the bacon x 2. The last		findings, the team will detern		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2016 MAPPROVED D: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING				C 103/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				3	00 BLAKE BOULEVARD		
PINEHUKS	ST HEALTHCARE & REF	IAD		Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From page	e 46	F	371			
	holding temperature of degrees.			57 1	necessary to continue audits and respective review of audits in QA mee	ting.	
	began plating the foo to the residents. What temperature she wou she stated the holding degrees. The dietary pureed eggs, recheck obtained a temperatur placed the pureed egg served the pureed egg of 140 degrees. On 11/2/16 at 10:30A conducted with the di she expected the hold to be as noted on the reviewed a copy of the stated bacon should 1 degrees for a minimu cooked to hold should minimum of 15 secon should have reheated holding temperature. 3. On 11/2/16 at 10:3 was conducted. The area was observed to stuck on the right side large amount to white material was noted co the refrigerator conta particles on the botto the refrigerator.	Id reheat the pureed eggs, g temperature should be 145 manager reheated the ked the temperature and the of 140 degrees. She gs on the tray line and tigs at a holding temperature M, an interview was letary manager. She stated ding temperatures of foods food safety sheet. She the food safety sheet that have a temperature of 145 m of 15 seconds and eggs d be at 155 degrees for a ads. She stated the cook d the foods to the proper BOAM, a tour of the kitchen refrigerator in the kitchen o have dirt and food particles e of the refrigerator and a e streaks of unknown overing the bottom half of efrigerator. The inside of ined food crumbs and m and sides of the inside of					
	On 11/2/16 at 10:30A	M, an interview was					

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					OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345370	B. WING		C 11/03/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHUR	ST HEALTHCARE & REH	IAB	:	300 BLAKE BOULEVARD	
				PINEHURST, NC 28374	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 371		e 47 etary manager. She stated eaned every Wednesday	F 371		
	and as needed. Here refrigerator to be clear stated the person tha Wednesday also had meal carts, deep frye said she did not keep	expectation was for the in. The dietary manager t put up supplies on the duty of cleaning the r and all equipment. She			
F 372 SS=E	PROPERLY	E GARBAGE & REFUSE ose of garbage and refuse	F 372		11/28/16
	by: Based on observatio facility failed to maint of two dumpsters free keep the grease barry reduce the chance of infestation. The findin 1. On 11/2/16 at 10:2 area was conducted There were cooked n ground beside one of was also a tomato, a foam sectional plate the dumpster. On 11/2/16 at 10:20A stated it was everyon the dumpster area cle			The entire dumpster area was immediately cleaned by the Maintena Department to include the grease bar on 11/2/16. The Dietary Manager (DM) will deve Dumpster and grease barrel Checkli which the dumpster and grease barre must be observed every hour from 6 until 8PM to ensure that the dumpster grease barrel is free of all debris and the dumpster doors and grease barre are closed. The cook will be respons for completing the inspection each h If dumpster area or grease barrel ne to be cleaned, the cook will ensure s cleaning is completed immediately b dietary staff. The Dumpster area an grease barrel will be placed on a dee	arrel lop a st in el AM er and d that el lids sible our. eds such y d

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TEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · ·	IO. 0938-039 E SURVEY
		A. BUILDING	A. BUILDING			
		B. WING	1	C 1/03/2016		
			STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/03/2010	
			300 BLAKE BOULEVARD			
				PINEHURST, NC 28374		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIC DATE
F 372	Continued From page	e 48	F 37	2		
F 431 SS=E	expected the dumpst 2. On 11/2/16 at 10:2 area was conducted barrel was observed area just behind the ob barrel with the lid oper inches. The top of th of black thick materia black material. The of the grease barrel whe grease. She stated s barrel looked like that the barrel to be clean On 11/2/16 at 10:45A area was conducted food items and foam removed from the gro The Administrator ob stated he expected d closed and clean and	20AM, a tour of the dumpster with the dietary manager. A at the back of the dumpster dumpsters. It was a black ened approximately 1-11/2 e barrel had large amounts I with leaves mixed in the dietary manager stated it was ere they dumped the old the did not realize that the t and her expectation was for and without debris. M, a tour of the dumpster with the Administrator. The sectional plate had been bund beside the dumpster. served the grease barrel and dietary staff to keep the barrel for maintenance personnel ean the barrels if necessary. BUG RECORDS,	F 43	 cleaning schedule for every Wedne by maintenance department. All distaff were educated by the Dietary Manager regarding these intervention 11/14/16. To ensure ongoing compliance, the will develop an audit tool to ensure compliance with the Dumpster and barrel checklist as well as the deep cleaning schedule. The DM or assidietary manager will conduct the auleast five days per week to include weekends throughout both shifts for months. All findings from audits will be kept brought to monthly Quality Assuran meeting by DM to be discussed and reviewed by the QA team monthly fmonths. Based on the findings, the will determine if it is necessary to caudits and respective review of aud QA meeting. 	DM DM grease stant dits at r 6 and ce d or 6 team pontinue	12/1/16
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all aintained and periodically				
		s used in the facility must be e with currently accepted				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	ION NUMBER: A. BUILDI				LETED
345370		B. WING				C 03/2016	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
DINELUD				3	300 BLAKE BOULEVARD		
PINERUK	ST HEALTHCARE & REH	IAD		F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 431	professional principle appropriate accessor instructions, and the applicable. In accordance with St facility must store all locked compartments controls, and permit of have access to the ke The facility must prov permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribut	s, and include the y and cautionary expiration date when tate and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to	F	431			
	by: Based on observatio record review, the fac spray, one insulin per medications carts. The discard two bottles ex solution on 1 of the 4 bottle of fecal occult b 1 of the 4 medication A review of the undate Expiration Date Guide Director of Nursing in expire 30 days after of would expire 42 days	is not met as evidenced ns, staff interviews and cility failed to date one nasal n and four inhalers on 3 or 4 the facility also failed to copired glucometer testing medication carts and one blood developer solution on carts. Findings included: ed Drug Storage and elines provided by the dicated inhaled medications opening and Levemir Insulin after opening. A review of facture instructions for the			No residents were specifically identifie as having been affected by this allege deficient practice. For those residents the potential to be affected by the sam alleged deficient practice, all nursing of were audited by Director of Nursing (DON) and Clinical Coordinator on 11/ to ensure all medications were labeled and dated correctly and all expired medications were discarded properly. medications found to be expired or no labeled with date opened were immediately discarded on 11/4/16 by l and clinical coordinator. To ensure the	d with le arts 4/16 t All t DON	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/02/20 RM APPROVE IO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		345370	B. WING			1	C 1/03/2016
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEHURST HEALTHCARE & REHAB					0 BLAKE BOULEVARD NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	control solution shoul three months past the manufacturer instruct Developer read do no date. On 11/2/16 at 4:00 Pl medication cart was no was one bottle of Flur 9/6/16 but not dated was a Levemir Insulin the label and not date There was also an Ar dated when it was op observed Assure Pris vial and a Level 2 via accuracy of the gluco blood sugar levels. Th and the level 2 vial ex- interview with Nurses discovered undated s when they were oper when they would nee Nurse #1 stated both for the glucometer sh used to determine ac machine. On 11/2/16 at 4:30 Pl 400 odd rooms and 5 Dulera Inhaler filled of when it was opened. Stated it should have opened. On 11/2/16 at 4:45 Pl 400 even rooms and Advair Inhaler filled 1 it was opened and a	eter check system read the d be discarded no later than e expiration date and ions for the Coloscreen ot use past the expiration	F	431	alleged deficient practice does not r all licensed nurses and medication a to include weekend and PRN staff w in serviced on the proper dating/ lab and disposal of out-of-date medicati by 12/1/2016 by the Assistant Direct Nursing (ADON) and/or Clinical Coordinator. The licensed nursing s first shift will perform weekly inspect for 4 weeks, biweekly inspections for month and monthly inspections for f month is to ensure all medications labeled with date opened and to ensi- that all medications are checked for expiration dates and disposed of pro- if applicable. ADON, DON and clinic coordinator will make random medic cart audits weekly to ensure all medications are labeled and dated correctly and all expired medications discarded properly. Results of the a will be kept by the DON who will brit them to the monthly Quality Assurar meeting to review and discussed. Continued audits will be performed I on the outcome of the audits previou performed.	aides vill be eling ons tor of taff on ions r one our are sure operly cal cation s are udits ng nce pased	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING _				C 03/2016
	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEHURS	ST HEALTHCARE & REH	AB		PI	NEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI> TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431 F 520 SS=E	the presence of blood 10/16. Nurse #2 state have been dated whe determine expiration of On 11/2/16 at 5:37 PM stated her expectation dating inhaled medica dated when opened to biological solutions us the glucometers and 1 be used past their exp 483.75(o)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS A facility must maintai assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activiti develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as such compliance of such co requirements of this s	r solution used to assess in a stool sample expired d opened inhalers should in they were opened to date. A, the Director of Nursing in that the facility policy on ations and insulin should be o determine expiration. Also sed to test the accuracy of for occult blood should not biration date. ERS/MEET in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of iffied quality deficiencies. ary may not require rds of such committee h disclosure is related to the committee with the	F 4	520			12/1/16

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/2 FORM APPRO OMB NO. 0938-0
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345370	B. WING		C 11/03/2016
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINEHURST HEALTHCARE & REHAB				300 BLAKE BOULEVARD PINEHURST, NC 28374	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLET
F 520	Continued From page and correct quality de a basis for sanctions.	ficiencies will not be used as	F 520	0	
	by: Based on record rev facility 's Quality Ass (QAA) Committee fail procedure and to mo the committee put int recertification survey, assessment (F278) a plan (F280) were cite survey of 12/3/15 and recertification/compla continued failure of th federal surveys of rec facility 's inability to s program. The finding This tag is cross refe F278 - Accuracy of th record review and sta to accurately code the assessments in the a (Residents # 106 & # 125), height (Resider #105, #202 & #72), li and ambulation (Resisted During the recertificat facility was cited F27 assessments accurated	nd review and revise care d during the recertification d was cited again during the int survey of 11/3/16. The ne facility during the two cord show a pattern of the sustain an effective QAA gs included: renced to: ne assessment - Based on aff interview, the facility failed e Minimum Data Set (MDS) reas of urinary catheters 14), weight (Resident # nts #74, #158, #12, #125, mitation in range of motion idents #107) for 10 of 25 viewed. tion survey of 12/3/15, the 8 for not coding the MDS reat of motion attent, range of motion ag and the use of		For the residents found to have affected by the alleged deficient residents (urinary catheters #100 (weight #125) (height #74,#158 #125, #105, #202, #72) (limitati range of motion and ambulation (medications #12). Resident #106 Minimum Data Sc admission assessment was corr 11/4/16 to reflect that the reside catheter at that time. Resident #14 MDS admission assessment was corrected by M coordinator on 11/4/16 to reflect resident had a catheter at that the Resident #74 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height. Resident #158 MDS quarterly as was corrected by MDS coordina 11/18/16 to reflect residents accu- height. Resident #125 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height. Resident #125 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height. Resident #202 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height and w Resident #202 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height and w Resident #202 MDS admission assessment was corrected by M coordinator on 11/18/16 to reflect residents accurate height. Resident #105 MDS admission	practice 6, #14) ,#12, ion in #107) et (MDS) ected on int had a IDS that the me. IDS that the me. IDS to the ssessment tor on urate IDS ct eight IDS ct

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			PRINTED: 12/02/201 FORM APPROVE OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X3) DATE SURVEY COMPLETED	
345370	B. WING		C 11/03/2016	
•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		300 BLAKE BOULEVARD		
		PINEHURST, NC 28374		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
of 11/3/16, the facility was boding the MDS rely in the areas of urinary right, limitation in range of on. care plan - Based on record view, the facility failed to or 1 (Resident #14) of 3 viewed for pressure ulcer 12) of 5 sampled residents asary medications. tion survey of 12/3/15, the 0 for not revising the care rition. On the current of 11/3/16, the facility was evising the care plan for e use of the psychotropic M, the Administrator was The Administrator stated QA committee that epartment heads and the revealed that the committee e stated that he had started as an Administrator 5 rated that the Director of onitoring the MDS e care plan but the MDS y newone MDS Nurse and the other MDS Nurse	F 52	 coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by ME coordinator on 11/18/16 to reflect residents accurate height. Resident #12 MDS admission assessment was corrected by ME coordinator on 11/18/16 to reflect residents accurate height and acc coded 3 for anti-anxiety medicat Resident #107 MDS quarterly ass was corrected by MDS coordinato ensure accurate coding of range motion for assessment period of 8 on 11/4/16. Resident #107 MDS assessment coded inaccurately for documenta Certified Nursing Assistant (CNA) Activities of daily living (ADL s). M quarterly assessment was correct MDS coordinator to ensure accur coding of activities of daily living f assessment period of 8/20/16 on Coding was reviewed with CNA in the CNA was educated on proper documentation of accurate inform the assistant Director of Nursing of 11/4/2016. For those residents with potential affected by alleged deficient pract 100% of current residents were a on 11/7/2016 by the Director of N and Assistant director of nursing, heights and weights entered into system. 20 residents were found have heights and weights in the e 	DS DS curately ion. sessment or to of B/20/16 was ation by o for 1DS ted by ate or the 11/4/16. ivolved, for ito be tice udited ursing for the to not dectronic	
	IDENTIFICATION NUMBER:	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345370 B. WING	MEDICAID SERVICES (x1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 345370 B. WING 345370 B. WING ARB STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SEC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHALL (RACH CORRECTIVE ACTION SHALL SEC IDENTIFYING INFORMATION) a 53 F 520 coordinator on 11/18/16 to reflect residents accurate height. Resident #72 MDS admission assessment was corrected by ML coordinator on 11/18/16 to reflect residents accurate height. Resident #12 MDS admission assessment was corrected by ML coordinator on 11/18/16 to reflect residents accurate height. Resident #10 MDS agarterity ass was corrected by MDS coordinator or 1 (Resident #14) of 3 viewed for pressure ulcer 12) of 5 sampled residents ssary medications. Resident #10 MDS agarterity ass was corrected by MDS coordinator ensure accurate height and acc coded 3 for anti-anxiety medicat Resident #107 MDS guarterity ass was corrected by MDS coordinator ensure accurate odding of range motion for assessment period of 4 on 11/4/16. Resident #107 MDS assessment coding of activities of daily living (ADL s). Activities of daily living (A	

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345370	B. WING _		11/03/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	
PINEHUR	ST HEALTHCARE & REH	НАВ		300 BLAKE BOULEVARD PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S P X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLETION EED TO THE APPROPRIATE DATE FICIENCY)
F 520	Continued From page	e 54	F	accurate range of mo by the DON and ADO inaccurate coding wi MDS nurses by 12/1. To ensure this allege does not reoccur, the will be put into place Manager was educat Director of Nursing o on coding MDS asse specifically regarding MDS nurses, Dietary Services Director, Ao Wound Care Nurse w Director of Nursing o completion and accu assessments. Height entered in computer hours of admission to nurse. All new admiss include DON, ADON	he system. All http://www.acatheter asment audited and of nursing and nursing to ensure catheter in place on ents with catheters rectly coded. All urrently receiving a tion will have their dited by the DON wed for accurate bic medications by esidents will have the assessment audited for bion and ambulation DN by 12/1/16. All Il be corrected by the /2016. d deficient practice e following measures . The Dietary ted on 11/7/2016 by in facility procedures assents properly g height and weight. / Manager, Social ctivities Director and were educated by the in 11/4/16 on timely iracy of MDS ts and weights will be system within 72 of facility by admitting asions will be trative nurses , which

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Facility ID: 923403

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
	345370		B. WING	C 11/03/2016		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2016	
			3	00 BLAKE BOULEVARD		
PINEHUR	ST HEALTHCARE & REH	IAB	F	PINEHURST, NC 28374		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
F 520	Continued From page	e 55	F 520		ts. In NA s and PRN staff mentation ADON, ng. veekly n of f Nursing e MDS neight ations, DL eeks, five d nthly for residents period. ions will esults of py the g them to neeting inued n results peen practice lated order to nt by	

Event ID: JMTI11

Facility ID: 923403

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345370	B. WING		C 11/03/2016	
		STREET ADDRESS, CITY, STATE, ZIP C		·		
PINEHURS	T HEALTHCARE & RI	ЕНАВ		300 BLAKE BOULEVARD PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI	
F 520	Continued From pa	ige 56	F 520	potential to be affected by alleged deficient practice 100% of all resid have their care plans compared w current orders to ensure accuracy plans by November 28,2016. The will be completed by the Director Nursing, Assistant Director of Nur the Clinical Coordinator and wour nurse. All care plans will updated MDS nurses based on results of a performed at the time of the audit ensure this alleged deficient pract not reoccur, the following measur be put into place; all new orders w brought the next business day to clinical meeting to have the care p updated by the MDS nurse at that Audits will be performed by the Di Nursing, the Assistant Director of and the Clinical Coordinator on 5 residents to compare new and discontinued orders to the care pl weekly for four weeks and five res will be audited biweekly for one m then five residents monthly for fou months. Any orders either new or discontinued found not to be refle care plan during audits will be adj immediately by MDS nurses. Res these audits will be reviewed and discussed. Continued audits will b performed based on results of the previous audits.	dents will vith v of care audits of sing and nd care by the audits . To tice does es will vill be daily blan t time. irrector of Nursing an sidents nonth ur cted in usted ults of v the them to eeting be	
				All findings from MDS assessmen care Plan audits will be brought to		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/201 APPROVEI). 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345370	B. WING				C 03/2016
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEHURS	T HEALTHCARE & REH	AB			00 BLAKE BOULEVARD		
				P	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 520	Continued From page	÷ 57	F	520	committee meeting each month for s months. The results of the audits wil determine whether or not the QA committee needs to continue the aud review past the originally decision of months. The QA committee will at th time determine if changes in the curr monitoring system need to occur. If the appropriate staff will receive educ regarding such changes to monitorin system.	l lit six is ent so, cation	
	7(02-99) Previous Versions Obs	olete Event ID: JM			cility ID: 923403 If cont	inuation shee	

Facility ID: 923403

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