STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING ______ B. WING ______	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: A review of the yearly minimum data set dated 4/5/17 revealed Resident #4 was severely cognitively impaired, had no behaviors, and meals were coded as independent with set up. The resident ' s diagnoses were Alzheimer ' s disease without behaviors and diabetes. A review of the physician ' s order dated 5/23/17 revealed a regular diet. A review of Resident #4 ' s care plan dated 4/5/17 revealed interventions for potential weight loss. There were goals for 50% of meal consumption, to allow ample time, to provide choices, and family brought in favorites. A review of Resident #4 ' s weight log for the past six months revealed that her weight was stable. A review of Resident #4 Nurses ' note dated 4/21/17 revealed Metformin was discontinued and a cat scan of the abdomen reported a large abdominal mass in the upper right quadrant. The resident was being medicated for pain from the mass. On 6/8/17 at 11:10 am an observation was conducted of Resident 4 (only resident in the room). The resident was confused to situation. The resident ' s breakfast was on the tray table and food and drinks were covered. The resident	F 311	Resident number one had her tray removed from her room by the C.N.A. on 06/08/2017. Resident number one had the extra sets of silverware removed from her room by the hall charge nurse on 06/08/2017.Resident number one had the care plan updated to reflect her cognitive decline as evidenced by hording behaviors by the MDS Nurse on 06/08/2017. A 100 % audit was completed by Administrative Staff on meal trays to make sure all containers were opened and that the trays were removed from residents rooms timely on 06/26/2017. The Assistant Director of Nursing completed a 100% in-service with the nursing department on setting up meal trays by making sure all containers were opened and that when residents are finished eating that trays are removed from their room. A QI Tool will be used to monitor that all containers are opened when a residents meal tray is set up and that the tray is removed from the room when they are finished eating. The department heads	7/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2017

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

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F 311	Continued From page 1 stated she did not know what was on the tray table. The resident was directed to remove the plate cover and breakfast had not been touched. The silverware was not present on the tray. The resident asked what is that? The resident then proceeded to eat the breakfast with a straw. After looking around the room, 7 sets of silverware in the original paper wrap, which included knives, were lying on the spare bed. The resident stated thank you and began to eat with a fork. On 6/8/17 at 11:15 am Nurse #3 was made aware by observation in Resident #4 ' s room of the breakfast that was not set up and the collection of silverware on the spare bed. Nurse #3 removed the silverware and stated that the nursing assistant was responsible to set up the meal, take the breakfast tray and ascertain how much the resident had eaten. All nursing assistants were in resident rooms providing care. Nurse #4 stated he would inform the Assistant Director of Nursing (ADON) and speak to the nursing assistants assigned to the 400 Hall. On 6/8/17 at 11:45 am an interview was conducted with NA #4. NA #4 stated she was assigned to Hall 400 to pick up trays. NA #4 noticed that Resident #4 did not eat her meal and the lids were in place. NA #4 noticed that Resident #4 had not touched her breakfast this morning at 9:30 am and left the tray. NA #4 stated she did not inform anyone that the resident had not eaten. NA #4 had a break and then was busy with personal care with other residents. NA #4 stated she returned to pick up trays again around 11:30 am. NA #4 stated she was informed by NA #5 that the resident was known to hoard dishes and cups. NA #4 was not aware that the resident was hoarding silverware. NA #4	F 311	will complete the QI tool daily and turn them into the Director of Nursing and / or the Assistant Director of Nursing for review. Any identified area of concern will be addressed as it is identified. The weekly QI Committee will review the QI audits weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The montly QI Committee will review the results of the weekly QI minutes for the continued need and frequency of monitoring for 2 months.	

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F 311	Continued From page 2 stated she had not seen the silverware on the spare bed when she entered the resident ' s room. NA #4 stated she had not checked to see if all dishes and silverware were on the tray before she had taken the tray from the room. NA #4 had not informed anyone that the resident had not eaten. NA #4 stated she sets up the resident ' s meals by opening all lids and by adding salt, pepper, or butter as desired and by unwrapping the paper form the silverware. NA #4 was educated during orientation to inform nursing if there were changes or concerns with the resident. On 6/8/17 at 2:00 pm an interview was conducted with NA #5. NA #5 stated that she did not open the lids and covers to the resident ' s breakfast today. She thought the resident could open them herself. NA #5 stated that she was aware that Resident #4 was hoarding dishes and silverware. NA #5 stated that the family had a sign in the room about the hoarding and all the nursing assistants were aware. NA #5 stated that she had not informed the nurse about the resident ' s hoarding. NA #5 stated she checked for dishes and silverware before taking the tray. On 6/8/17 at 4:30 pm an interview was conducted with the Administrator and the ADON (Assistant Director of Nursing). The ADON stated that she expected staff to have opened all containers when meals were required to be set up and to have removed the tray, checked for its contents, and documented how much was eaten within an hour or so.	F 311		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		7/1/17

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F 514	Continued From page 3 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to document the nursing evaluation and status each shift of the PICC Line (intravenous catheter) in 1 of 1	F 514	Resident number one had her picc line assessed and her orders updated to assess and document every shift by the Assistant Director of Nursing on	

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F 514	Continued From page 4 resident (Resident #3). Findings included: A review of Resident #3 ' s 14-day minimum data set dated 3/23/17 revealed an intact cognition and her diagnoses were diabetes mellitus type 2 and an infected wound of the right knee. A review of the Nurses ' note dated 5/31/17 revealed Resident #3 was admitted on 3/9/17 after a fall at home and injury to the right knee. The injury had become infected and the resident had become septic. The resident was transferred back to the facility on 5/31/17 for rehabilitation after the hospital visit. A review of the hospital-placed PICC Line vendor information dated 5/31/17 revealed the PICC Line was inserted on 5/31/17. The care plan dated 5/31/17 revealed interventions and goals for PICC Line (intravenous catheter) change dressing per physician ' s order, surgical incision dressing and intravenous antibiotics. A review of the nurses ' notes and treatment record from 5/31/17 to 6/7/17 revealed an evaluation and status of the PICC Line site and dressing were not documented on each shift. On 6/7/17 at 12:10 am an interview was conducted with Nurse #1. Nurse #1 stated that Resident #3 ' s PICC Line dressing was not dated because it was placed at the hospital. Nurse #1 stated that he assessed the PICC Line each time he administered the intravenous antibiotic medication. Nurse #1 stated that the PICC Line was required to be assessed and condition documented on each shift.	F 514	06/23/2017. On 06/23/2017the MDS Nurse audited 100% of residents for picc lines or IV sites on 06/23/2017. Any resident that was found to have a picc line or an IV site had their orders reviewed and new orders written for an order to assess, document every shift, and notify the doctor of any acute changes on 06/23/2017. The Assistant Director of Nursing completed a 100% in-service with Nurses on assessing picc lines and / or IV sites, documenting any area of concern, and notifying the doctor on 07/01/2017. A QI Tool will be completed by the Director of Nursing / Assistant Director of Nursing or their designee to monitor assessing, monitoring, and calling the doctor 3 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The weekly QI will review the QI tools weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The monthly QI Committee will review the weekly QI minutes for the continued need and frequency of monitoring.	

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F 514	Continued From page 5 On 6/8/17 at 3:40 pm an interview was conducted with the Clinical Supervisor. The Clinical Supervisor stated that nursing staff was to evaluate and document every shift on the status of an intravenous catheter for signs and symptoms of infection, dislodgement and infiltration in the nurses ' notes narratives. The Clinical Supervisor also stated that the assessment of an intravenous site could be documented in the treatment record, but that was not the current process. On 6/8/17 at 4:30 pm an interview was conducted with the Administrator and the ADON (Acting Director of Nursing). The ADON stated that she expected staff to evaluate the intravenous site and document the findings each shift.	F 514		