STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide a dignified dining experience for 1 of 1 resident (Resident #6) who was served a meal in an environment with an offensive odor (feces odor) during a meal observation. The facility failed to provide glassware to residents who received milk in an 8 ounce (oz.) paper carton during 2 of 2 meal observations. Findings included: 1. Resident # 6 was admitted June 13, 2000 with diagnoses of Alzheimer's disease, chronic kidney disease, impulse disorder and major depression disorder. Review of Resident # 6's Minimum Data Set (MDS) dated 7/11/2017 revealed that resident was cognitively impaired. Bed mobility and transfers were scored as extensive assistance with two staff members. Resident #6 also required extensive assistance of one person with eating. An observation of Resident #6 on August 5, 2017 at 7:00 PM revealed that she was served her supper meal in her room while the room had a very offensive feces odor.	F 241	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F241 On August 24, 2017, Nurse #24 and Nurses Assistant #21 received in-service from the Director of Nursing on maintaining dignity and respect of	9/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/31/2017

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F 241	Continued From page 1 An interview with Nurse # 24 at 7:00 PM revealed that Resident #6's roommate had behaviors and had "messed with" her colostomy bag resulting in the feces odor in the room. She stated that the Nursing Assistant (NA# 21) had set up Resident # 6's dinner tray in the room for the resident to eat even with the offensive odor in the room. During an interview with Director of Nursing (DON) at 7:10 PM on August 5, 2017 she stated that she would not want to eat a meal in the room because "it stinks in there". The DON also indicated that Resident #6's roommate had behaviors and would frequently "mess" with her colostomy bag. During an interview with the Administrator on August 6, 2017 at 9AM she revealed she was aware of Resident # 6's roommate's behavior however she expected staff to take Resident #6 out of the room until the odor was gone and that Resident # 6 could have her dinner in the dining room. 2. During a meal service observation in the facility's main dining room on August 5, 2017 at 6:20 PM nine residents were served and consumed milk directly from the 8 oz. paper carton. Residents were served other beverages, such as iced tea, water, thickened liquids and coffee in a glass or cup, but were not offered the use of glass or cup for their milk. Straws were observed on the trays. An observation of the facility's main dining room for breakfast on August 6, 2017 at 8:20 AM revealed seven of nine residents were observed being served and consuming milk from the 8 oz.	F 241	residents residing in the facility to include activities of daily living during meal times, offensive odors, and proper tableware. On August 28, 2017,the Director of Nursing (DON), Minimum Data Set (MDS), and Quality Improvement (QI) nurse initiated a 100% licensed nurse, certified nursing assistant, and dietary staff in-service titled Dignity and Respect. The in-service instructs staff on the importance of maintaining dignity and respect of residents to include activities of daily living during meal times, offensive odors, and proper tableware. The in-service is to be completed by September 1, 2017. All newly hired licensed nurses, certified nursing assistants, and dietary staff will receive this in-service upon hire by the Director of Nursing and /or Registered Nurse during the orientation process. On August 28, 2017 the DON, QI nurse, MDS, Activities director, and Social Worker began resident care observations and interviewing alert and oriented residents along with resident representatives for cognitively impaired residents to ensure that they have been treated with dignity and respect, observation for cleanliness, and utilization of proper tableware. This information is being documented on a Dignity Audit Tool. The DON and/or QI nurse will complete Dignity/Respect Audits on 20% of residents weekly times 4 weeks, then once weekly times 8 weeks, then once monthly times one month.	

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F 241	Continued From page 2 paper carton without being offered the use of a glass or cup for their milk. Straws were observed on the trays. During a meal service observation on August 6, 2017 at 8:35 AM of the 400 hall ten of fourteen residents were served and consumed milk directly from the 8 oz. carton. No glass or cup was offered to them for their milk. Straws were observed on the trays. During a meal service observation on August 6, 2017 at 8:40 AM of the 300 hall ten of fifteen residents were served and consumed milk directly from the 8 oz. paper carton. No glass or cup was offered to them for their milk. Straws were observed on the trays. During a meal service observation on August 6, 2017 at 8:47 AM of the 200 hall twelve of twenty residents were served and consumed milk directly from the 8 oz. paper carton. No glass or cup was offered to them for their milk. Straw were observed on the trays. During a meal service observation on August 6, 2017 at 8:50 AM on the 100 hall ten of thirteen residents were served and consumed milk directly from the 8 oz. paper carton. No glass or cup was offered to them for their milk. Straw were observed on the trays. During a meal service observation on August 6, 2017 at 8:55 AM of the 500 hall and the main dining room sixteen of twenty-two residents were served and consumed milk directly from the 8 oz. paper carton. Residents were observed being served other beverages, such as juices, water, thickened liquids and coffee in a glass or a cup,	F 241	The DON and/or QA nurse will review with the monthly Quality Improvement (QI) committee the results of the audits for three months for identification of trends, actions taken, and to determine the need for an/or frequency of continued, monitoring for continued compliance. The QI nurse or DON will present the Audit tool findings and QI committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	

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F 241	Continued From page 3 but were not offered the use of a glass or cup for their milk. Straws were observed on the trays. An interview on August 6, 2017 at 11:30 AM, the Dietary Manager (DM) revealed that she was informed to only use a glass or a cup when serving thickened liquids. The DM indicated that she was never informed that she needed to provide a glass or a cup when serving milk. She stated that as soon as the washer was fixed she would provide a glass for the resident's milk. Straws were observed on the trays. An interview on August 6, 2017 at 3:30 PM, the Administrator revealed it was her expectation that a cup be available for every disposable beverage container that was served on a resident's tray.	F 241		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and family interview the facility failed to provide incontinent care to 2 of the 3 sampled residents (resident #5 and Resident #8) reviewed for activities of daily living (ADL) who were completely dependent on staff for incontinent care. The Facility failed to provide assisted with feeding for 1 of 3 sampled residents (Resident #12) reviewed for activities of daily living (ADL) who were completely dependent on staff for assistance with meals.	F 312	F312 On August 24 & 28, 2017, The Director of Nursing (DON), Minimum Data Set (MDS), and Quality Assurance/Improvement (QA/QI) nurse initiated a 100% licensed nurse and certified nursing assistants in-service titled Dignity and Respect. The in-service instructs staff on the importance of maintaining dignity and respect of residents to include activities of daily	9/4/17

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F 312	Continued From page 4 1: Resident #5 was admitted to the facility on 9-19-16 and readmitted on 3-24-17. The resident was admitted with multiple diagnoses including Alzheimer's, encephalopathy and CVA with Aphasia. A review of the Minimum Data Set (MDS) dated 6-6-17 revealed resident #5 was cognitively impaired. The MDS also revealed resident #5 was an extensive assist with 2+ persons in the area of bed mobility, transfers and toileting. A review of the Care Plan dated 6-20-17 revealed the following; the resident will be neat, clean and odor free. The resident received showers on Tuesday and Friday. The staff will provide a male NA when possible to shower the resident. The resident will accept care. Staff will allow flexibility in ADL (Activity of Daily Living) routine. Pericare occurred after each incontinent episode and staff will prompt and remind resident to toilet. An observation of resident #5 occurred on 8-5-17 at 3:35pm. The resident was in the dining room. The resident was non communicative other than grunting. Food and liquid were noted on the front of the resident's shirt and the resident's pants were noted to be wet in the crotch area. An observation of the continent care for resident #5 on 8-5-17 at 5:00pm revealed that resident #5 had 2 briefs in place that were both wet. The resident's wife was present during the care and told the NA her husband is to only have "one pull up" on. The NA stated she did not know and that "someone" from first shift was the last to change her husband. The wife also asked why the resident was wearing a dirty shirt.	F 312	living. This in-service instructs the staff on proper application of adult briefs and perineum care. The in-service is to be completed by September 1, 2017. All newly hired licensed nurses and certified nursing assistants will receive this in-service upon hire by the Director of Nursing during the orientation process. On August 29, 2017 the DON, QI nurse, MDS, Activities Director, and Social Worker began resident care observations and interviewing alert and oriented residents along with resident representatives for cognitively impaired residents to ensure that they have been treated with dignity and respect, observation for cleanliness, and to ensure that they are appropriately dressed. This information is being documented on a Dignity Audit Tool. The DON and/or QA nurse will complete Dignity/Respect Audits on 20% of residents weekly times 4 weeks, then once weekly times 8 weeks, then once monthly times three months. The DON and/or QA nurse will review with the monthly Quality Improvement (QI) committee, the results of Dignity Audit tool for three months for identification of trends, actions taken, and to determine the need for and/or frequency of continues monitoring for continued compliance. The QA nurse or DON will present the Dignity Audit Tool findings to the quarterly quality assessment and assurance (QAA) Committee for further	

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F 312	Continued From page 5 An interview with resident #5's wife occurred on 8-5-17 at 5:45pm. The wife stated the resident was only changed once on the day shift. The wife stated she usually came near shift change and her husband's pants would be wet from urine. The wife stated she felt staff double briefs her husband so staff does not need to change her husband as often. An observation of incontinent care occurred on 8-6-17 at 2:45pm. The resident had not been changed since 10:00am that morning. The resident was noted to have only one brief on which had dry yellow markings mixed with current wetness. The wife was present again for the care and asked the NA when the last time her husband was changed. The NA stated she last changed the resident around 10:00am. The wife asked why her husband had not been changed since that morning. The NA replied she had been pulled to another floor for "awhile" and did not have time to change everyone. 2: Resident #8 was admitted on 2-28-14 the readmitted on 3-20-14. The resident was admitted with multiple diagnoses including Dementia, Peripheral Vascular Disease, and pain and muscle weakness. A review of the Minimum Data Set (MDS) dated 5-25-17 revealed the resident was cognitively impaired. The MDS also revealed the resident was an extensive assist with one person for dressing, toileting and hygiene. A review of the Care Plan dated 6-9-17 revealed the following; "Pericare after each incontinent episode".	F 312	recommendations and oversight.	

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F 312	Continued From page 6	F 312		

An observation of the incontinent care of resident #8 occurred on 8-6-17 at 9:40am. The resident was noted to have on 2 briefs which were both wet. Pericare was performed correctly. The NA was noted to place 2 new briefs on the resident.

An interview with the nursing assistant (NA#14) occurred on 8-6-17 at 10:00am. The NA stated she normally does not work first shift so she was not familiar with the residents morning care. The NA also stated she double briefs the resident to protect the resident and their clothing from possible leakage.

An interview with resident #8 occurred on 8-7-17 at 1:00pm. The resident stated he received a bed bath every morning but only received incontinent care 1-2 times a shift. The resident stated once a shift was normal. The resident stated he has asked to be changed when he had an incontinent episode but that there were no staff available to help him. Resident #8 also revealed he was unaware that he had on 2 briefs.

An interview with the Director of Nursing (DON) occurred on 8-7-17 at 12:45. The DON stated she expected staff to provide "timely" incontinent care for the residents who could not toilet on their own or needed assistance. The DON described "timely" as "whenever a resident needs changed or within 5 minutes of a call light".

3. Resident #12 was admitted to the facility on 10-27-08, with diagnoses that included anxiety disorder, major depressive disorder and degenerative disease of nervous system.

A review of a quarterly minimum data set (MDS) dated July 7, 2017 revealed that Resident # 12

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had some memory problems with both short and long term. Resident # 12 required extensive assistance with eating one person physical assist. This resident requires staff to feed her during all his meals.

A review of Resident # 12, care plan review, revealed that Resident #12 needed assistance with all meals.

During an observation Resident # 12's tray was placed in her room at 1:15 PM for staff to assist Resident #12 with her meal.

During this meal observation, Resident #12 holler out several times "I am hungry will somebody feed me please, just feed me".

During this mal observation NA # 41 observed walking down the hall on August 6, 2017 about 1:55 PM, NA # 41 indicated that she would assist Resident #12 with her lunch. NA # 41 washed her hands and set up Resident #14 to help with feeding.

Tray was not reheat nor was the Resident #12 asked if her food was ok or cold. Resident # 12 tray had been sitting in her for 50 minutes or longer.

An interview with NA # 41 on August 6, 2017 at 2:30 PM revealed that most of the time during the weekend there was only one NA for each hall and it took time to pass out the trays and feed the residents. NA # 41 revealed that they were always short of staff. NA #41 revealed that dinner trays were always late and when she was by herself it took time to pass out the trays but today we have some help and it still taken time to get to the

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F 312	Continued From page 8 Resident # 12. NA #41 also revealed that they can't reheat resident's food; they are required to go to the kitchen and get a new plate of food and that takes longer. NA #41 indicated that Resident # 12 loves to eat. NA #41stated that "she was glad families comes out to help but the facility really do need more staff". An interview with on August 6, 2017 at 3 PM, the Administrator revealed it was her expectation that staff assistance residents immediately with all meals, that 30 minutes was to long for any resident to be assistance with their meals, her expectation that food is served hot.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		9/4/17

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F 323	Continued From page 9 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and resident interview the facility failed to provide supervision to prevent repeated falls for 1 of 3 (resident #10) sampled residents reviewed for accidents. Findings include: Resident #10 was admitted to the facility on 8-4-16 then readmitted on 11-8-16. The resident was admitted with multiple diagnoses including Malignant Neoplasm of the left Kidney and Renal Pelvis, Alzheimer's, Chronic Kidney Disease stage 3. The admission information revealed the resident was admitted under hospice care. A review of the Minimum Data Set (MDS) dated 7-19-17 revealed that the resident was cognitively impaired. The areas of bed mobility and transfers were scored extensive with a two person assist. The areas of toileting and hygiene were scored extensive with one person assist while bathing was total dependence with one person assist. A review of the nurse's note dated 6-13-17 revealed that resident #10 had a fall at 3:25am. The note revealed a NA found the resident face down on top of the fall mat. The nurse documented she found a bruise and a slight skin elevation on the left side of the residents forehead. The note revealed the resident said he was going to the bathroom. No other injuries were documented.	F 323	F323 On August 7, 2017, The Director of Nursing (DON), placed a urinal in Resident #10□s room. Beginning August 28, 2017 and complete by September 1, 2017, The DON and Quality Improvement (QI) nurse will in-service all licensed nurses and certified nursing assistants on providing supervision to prevent falls and care guides to include appropriate interventions. On August 30, 2017, The DON, Minimum Data Set (MDS) nurse, and QI nurse initiated a 100% room versus care plan/care guide audit to ensure that appropriate interventions were in place for each resident. The audit revealed less than 10% of interventions were needing to be corrected. These items will be corrected by September 4, 2017, by the DON, Maintenance Director, and/or QI nurse. Beginning on September 1, 2017, the QI nurse, DON, and/or MDS nurse will monitor 20% of residents weekly x 4 weeks, then once weekly times 8 weeks, then once monthly times one month.	

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F 323	Continued From page 10 A review of the nurse's note on 6-17-17 revealed that resident #10 had a fall at 11:18pm. The note revealed the resident was found by a med aide on his knees with his forehead on his scooter. The note denied any injury. The incident log revealed the resident said he was using the bathroom. A review of the care plan dated 6-13-17 with a revision on 7-31-17 revealed the following: The resident will not sustain serious injury through the next review. Staff will analyze previous falls to determine whether a pattern/trend can be addressed, chair evaluation by nursing to determine best chair for resident, provide resident with urinal and offer/ assist him to use it frequently, educate staff that resident can and will use a urinal, added chair alarm, bed in lowest position, fall mat on floor when in bed, fall risk protocol, articles within reach, urinal within reach, keep call lite within reach, monitor and intervene for factors causing falls i.e. bowel/bladder needs, mobility transfers, check for incontinence and provide incontinence care frequently and as needed. An observation of resident #10's room on 8-6-17 at 11:00am revealed there was no urinal by the resident's bed or in the bathroom. An interview with a nursing assistant (NA13) occurred at 11:05am on 8-6-17. The NA stated she usually does not work resident #10's hall but that she "tries" to check the residents every 2 hours. The NA stated she was unaware that resident #10 needed to be checked more frequently or that he used a urinal. An interview with a nurse (RN31) occurred on 8-7-17 at 1:35pm. The nurse stated "resident gets	F 323	The DON and/or QA nurse will review with the monthly Quality Improvement (QI) committee the results of the audits for three months for identification of trends, actions taken, and to determine the need for an/or frequency of continued, monitoring for continued compliance. The QI nurse or DON will present the Audit tool findings and QI committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	

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F 323	Continued From page 11 up and down on his own but should have assistance". The nurse revealed that staff reminded resident to ask for help but he does not. She revealed that resident #10 was getting up on his own because he has to go to the bathroom. The nurse stated the resident does not use the call light because he does not remember how. She stated the resident should have a urinal in his room and the resident is checked every 2 hours An observation of resident #10's room occurred on 8-7-17 at 1:40pm. The resident was in the bed in a standard position. There was no urinal noted to be within reach of the resident. An interview with the resident #10 occurred on 8-7-17 at 1:45pm. The resident stated he got up on his own from his wheelchair and laid down. The resident stated his falls happened in the evening when he had to go to the bathroom. The resident stated he does know to ask for help but then stated "if I waited for someone to help me I would have a bucket full". The resident revealed he had not seen a urinal in his room but that he would try to use it if he had one. An interview with the Director of Nursing (DON) occurred on 8-7-17 at 12:45. The DON revealed that staff had a morning meeting every morning to discuss falls and interventions. The DON stated if there were changes in the interventions, this was then verbally communicated with the rest of the staff. The DON stated she expected staff to follow the interventions put in place to prevent the falls.	F 323		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		9/4/17

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F 353	Continued From page 12 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as	F 353		

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F 353	Continued From page 13 identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with staff, resident and families and observation the facility failed to provide staffing of sufficient quantity and quality to provide incontinence care, for residents who required assistance with meals. This affected 7 out of 12 residents (Resident # 1, Resident #5, Resident #6, Resident #8, Resident #9, Resident #10, and Resident #12). This tag is cross referenced tags F241, F 364, F 312, and F 323. Findings included: F-241 Based on observations, record review and staff interview the facility failed to provide a dignified dining experience for 1 of 1 resident (Resident #6) who was served a meal in an environment with an offensive odor (feces odor) during a meal observation. The facility failed to provide glassware to residents who received milk in an 8 ounce (oz.) paper carton during 2 of 2 meal observations. F-364 Based on observations, record reviews, resident interviews and staff interviews the facility failed to serve food at an acceptable temperature and provide palatable food for 2 of 2 residents (Resident #1 and Resident # 9) that were reviewed for food palatability.	F 353	F 353 On August 30, 2017 a 100% audit was completed by the Administrator looking back at the last 14 days of staff records to ensure sufficient staffing was in place to provide adequate care. No sufficient staffing issues were identified in the audit. On August 28, 2017, the Director of Nursing (DON) and Quality Improvement (QI) nurse initiated a 100% in-service for all licensed nurses and certified nursing assistants regarding maintaining dignity and respect, offensive odors during meal times, proper tableware, and notification to the administrator and/or DON for staffing challenges during a shift. On August 29, 2017, the DON, QI nurse, Minimum Data Set nurse (MDS), Activities director, and Social Worker began resident care observations and interviewing alert and oriented residents along with resident representatives for cognitively impaired residents to ensure that they have been treated with dignity and respect, observation for cleanliness, and utilization of proper tableware. This information is being documented on a	

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F 353	Continued From page 14 F-312 Based on observation, staff interview, record review and family interview the facility failed to provide incontinent care to 2 of the 3 sampled residents (resident #5 and Resident #8) reviewed for activities of daily living (ADL) who were completely dependent on staff for incontinent care. The Facility failed to provide assisted with feeding for 1 of 3 sampled residents (Resident #12) reviewed for activities of daily living (ADL) who were completely dependent on staff for assistance with meals. F-323 Based on observation, record review, staff interview and resident interview the facility failed to provide supervision to prevent repeated falls for 1 of 3 (resident #10) sampled residents reviewed for accidents. Observation during tour on August 5, 2017 from 3:30 pm revealed one NA on the 100 Hall, one NA on the 200 hall, one NA on the 300 Hall, one NA on the 400 hall and one NA who indicated that she worked both 200 and 300 halls from 3pm until 7am on Sunday morning. An interview with NA # 23 on August 5, 2017 at 7:30 PM revealed that most of the time during the weekend there was only one NA for each hall and it took time to pass out the trays and feed the residents. NA #23 revealed that they were always short of staff. NA #23 revealed that dinner trays were always late and when she was by herself it took time to pass out the trays. NA #23 also revealed that they can't reheat resident's food; they are required to go to the kitchen and get a new plate of food and that takes longer. An interview with NA # 24 on August 5, 2017 at	F 353	Dignity Audit Tool. On August 29, 2017, The Administrator and DON continued discussing the topic of sufficient staffing in the morning department head meeting to ensure the scheduler was providing the Administrator and/or DON the opportunity to review the staffing schedule three days in advance. On August 29, 2017, the schedule reflected sufficient staff signed up to allow for staff to carry out their assignments. On August 29, 2017, the Administrator and DON initiated the Staffing Assignment Tool to ensure appropriate staffing and identify staffing needs, including staffing on evenings, weekends, and holidays. The goal of the Staffing Assignment Tool is to ensure sufficient staff are listed on the daily assignment sheet for the number of residents and ensure the staff working are given appropriate assignments to meet the needs of the residents, to include pericare and application of adult briefs. The DON will utilize the Staffing Assignment Tool 5 times weekly for 4 weeks, twice weekly for 4 weeks, and weekly x 4 weeks. Any identified areas of concerns will be addressed immediately by the DON. The DON and/or QI nurse will review with the monthly Quality Improvement (QI) committee, the results of the Dignity Audit Tool for three months for identification of trends, actions taken, and to determine the need for and/or frequency of continues monitoring for continued	

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F 353	Continued From page 15 8:15 PM revealed that most of the time during the weekend that was only one NA for each hall. NA # 24 indicated that she had about 15 total care residents and it hard to the meet the needs of all the residents. NA # 24 indicated that residents do wait a long time for care and treatment up to 30 minutes and sometimes longer, NA # 24 indicated that we have been asking for staff and "No one would listen to us". An interview with NA # 32 on August 6, 2017 at 5:45 AM revealed that she had worked on the hall with 23 to 30 residents by herself and it's very hard to meet the needs of the resident during this shift. NA # 32 indicated that most of the residents are asleep but she still had several residents up during the night that need assisted with ADL care. NA #32 stated she still had to give about three to five showing during this shift and get about four to five residents up before the first shift coming. NA #32 indicated she has residents who needs assistance with the lift and she indicated she will not use the lift any resident by herself. NA # 32 asked "Can you please get us some help at the Facility' NA #32 had tears in her eyes. An interview with family member (FM) on August 6, 2017 at 11 AM revealed that the facility are short staff on all shifts. FM indicated that he had waited up two hours before his family member was assisted with care and this has been going on for months. FM indicated during this interview this was why he comes daily to care for his member. An interview with the resident #10 occurred on 8-7-17 at 1:45pm. The resident stated he got up on his own from his wheelchair and laid down. The resident stated his falls happened in the	F 353	compliance. The QI nurse or DON will present the Dignity Audit Tool findings to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	

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F 353	Continued From page 16 evening when he had to go to the bathroom. The resident stated he does know to ask for help but then stated "if I waited for someone to help me I would have a bucket full". The resident revealed he had not seen a urinal in his room but that he would try to use it if he had one. An interview with the Director of nursing on August 7, 2017 at 3 PM indicated that she "got one NA that can give 25 baths in one day." DON also indicated that the facility had a plan in place to hire more staff since June 2017. However DON could not answer to how many staff had been hired since June. DON revealed the facility got nine new employees for orientation on August 8, 2017 An interview with the Administrator on August 7, 2017 at 3:00 PM she only been at the facility for about two months and the facility had a plan in place to hire more staff. Administrator indicated this was identified before she got to the facility.	F 353		
F 356 SS=D	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		9/4/17

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F 356	Continued From page 17 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to post daily nurse staffing information during one (1) of three (3) days and the facility failed to post correct number	F 356	F356 On August 6, 2017, the regional vice president(RVP) in-serviced the	

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F 356	Continued From page 18 of resident census during one (2) of three (3) days during the survey. Findings Included: An observation on August 5, 2017 at 3:30 PM revealed an empty clipboard in the hall that normally has the Daily Nursing Staffing posted for Pine Ridge Health and Rehabilitation Center. An interview with the Admission staff on August 5, 2017 at 3:30pm revealed that the resident census was 139. An interview with the Admission staff at 3:50PM revealed that she had to contact the staffing person, because she did not know where to locate this information. An observation on August 5, 2017 at 5:00 PM revealed an empty clipboard on the hall that normally has the Daily Nursing Staff posted for Pine Ridge Health and Rehabilitation. An observation on August 5, 201 at 7:15 PM revealed the August 4, 2017 "Daily Nursing Staffing Facility Pine Ridge HRC 7am-3pm 132 Resident Census, 3pm-11pm Resident Census nothing and Resident Census nothing for 11pm-7am. Under August 4, 2017 was August 5, 2017 revealed August 5, 2017 "Daily Nursing Staffing, Facility Pine Ridge HRC 7am-3pm had 125 Resident Census and for 3pm-11pm no census residents listed. The time that the survey begin revealed no Resident Census in was nothing listed. An interview with the Director of Nursing on August 5, 2017 at 7:30 PM revealed that the	F 356	administrator, director of nursing (DON), and scheduler regarding posting the Daily Nursing Staffing Sheet including non-licensed and non-certified staff (non-resident care staff) on the required Daily Nursing Staffing sheet, according to the regulatory guidelines. On August 8, 2017, the director of nursing (DON) in-serviced the receptionist and third shift nurses regarding: 1) the Daily Nursing Staffing sheets are to be completed in pencil, 2) when staff hours change, corrections are made to the Daily Nursing Staffing sheet to reflect actual hours, and 3) Non-licensed and non-certified staff (non-resident care staff) are not included on the nursing staffing sheet, according to the regulatory guidelines. The administrator, DON, quality improvement (QI) nurse and/or corporate consultant will audit and initial the Daily Nursing Staffing sheets to ensure accurate completion of staffing sheets and to ensure non-nursing and non-certified staff (non-resident care staff) are not included in the calculations according to the regulatory guidelines. The audit will be completed, 5 times weekly for 4 weeks (to include Saturday and Sunday), then 3 times a week for 4 weeks, then 1 time weekly for 4weeks. The receptionist or scheduler will be immediately re-educated by the administrator, DON, QI Nurse and/or corporate consultant for any noted	

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F 356	Continued From page 19 Resident Census was 131. An observation on August 6, 2017 at 3:30 PM revealed "Daily Nursing Staffing, Facility Pine Ridge HRC from 3pm-11pm revealed no census residents listed. An interview with The Scheduler on August 7, 2017 at 3:30 PM revealed that was how she was trained to complete the Daily Staffing information. That this information was to be posted daily and on Friday she completes it for the weekend. An interview with the Administrator on August 7, 2017 at 3:40 PM revealed that the resident census for today was 132. She stated that it was her expectation that the posted nurse staffing be correct with the census residents listed and that this information be posted daily by the correct times.	F 356	incorrect Daily Nursing Staffing sheets. The QI nurse or DON will review with the monthly Quality Improvement Committee the results of the Daily Nursing Staffing audit reviews monthly for 3 months for trending, root cause analysis and recommendations. The QI nurse or DON will review with the quarterly Quality Assessment and Assurance (QAA) Committee the results of the Daily Nursing Staffing audit reviews, QI Committee recommendations, and facility progress with the QI Committee recommendations for 1 quarter for additional root cause analysis, commendations, and additional monitoring requirements as needed. The administrator is responsible for ensuring QAA Committee recommendations are implemented and for reporting back to the QAA Committee.	
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident	F 364	F364	9/4/17

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F 364	Continued From page 20 interviews and staff interviews the facility failed to serve food at an acceptable temperature and provide palatable food for 2 of 2 residents (Resident #1 and Resident # 9) that were reviewed for food palatability. Findings included: a) Resident #1 was admitted to the facility on August 4, 2017 with diagnoses of cerebral infarction, chronic obstruction and hypertension. Resident #1's minimum data set and care plan had not been completed. An interview on August 5, 2017, at 6:00 PM with Resident #1 revealed that his meals were cold when they were served to him. He stated he reported his concern to a nurse and she told him it was because the facility was short staffed. An interview on August 5, 2017 at 6:05 PM with Resident #1's family member (FM) #1 indicated that "maybe he needed to go to the main dining room to get his meals on time and maybe the food would not be cold in there". An observation was made of the steam table in the kitchen on August 6, 2017 at 11:15 AM. The lunch meal was already on the steam table and the cook revealed that she had placed the food on the steam table at 10:30 AM and that she usually took the food temperatures around 11:30 AM. The food temperatures were taken by the cook on 11:30 AM August 6, 2017, using a calibrated thermometer and were: roast turkey 159 degrees F, turkey gravy 172 degrees F, cornbread dressing 193 degrees F, mixed vegetables 198 degrees F, hamburger meat 168	F 364	On August 30, 2017, 100% of dietary staff/cooks will be in-serviced on meal preparation, following recipes, taking temperatures and tray delivery by corporate consultant and/or dietary manager. The in-service will include all cooks will follow recipes to have consistency in appearance and palatability of food and meals will not be placed on steam table more than 30 minutes prior to the beginning of service. Beginning on September 1, 2017, temperature of menu items will be taken and recorded prior to beginning service by cook and/or dietary manager. Dietary staff will record time when tray cart leaves the kitchen. Dietary staff will announce the designated location of tray cart leaving the kitchen to alert nursing staff that trays are ready for service on a specific hall for all three meals. The dietary manager and/or lead cook will audit trays to ensure that food is at correct temperatures, food palatability, and cooked by the recipe. This audit will be performed five times a week for 4 weeks, then two times a week times 4 weeks, and then twice monthly times 1 month. The DON and/or QA nurse will review with the monthly Quality Improvement (QI) committee the results of the audits for three months for identification of trends, actions taken, and to determine the need	

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F 364	Continued From page 21 degrees F and rice 187 degrees F. A test tray was prepared at 1: 05 PM on August 6, 2017 from the kitchen steam table and contained the turkey with gravy, cornbread dressing, and mixed vegetables. The test tray was delivered to the 400 hall at 1:07 PM where Resident #1 resided and ate his meals. There were 20 trays that were delivered on the cart. The last tray was delivered at 2:00 PM and the temperatures of the test tray were taken by the DM using a calibrated thermometer. The internal food temperatures were turkey and gravy 124 degrees F, cornbread dressing 124 degrees F and the mixed vegetables 119 degrees F. The food items were tasted by the surveyor and the DM. The turkey and mixed vegetables tasted barely warm and the cornbread dressing tasted uncooked. An interview on August 6, 2017 at 2:30 PM with Resident #1, revealed that his "lunch was served cold and cornbread dressing was mushy." An interview on August 6, 2017 at 2:45 PM with the DM revealed that all foods should be held and served at the required temperatures. She stated that she was going to talk with the cook about baking the cornbread dressing and not putting all the food on the steam table at one time. She stated that she wanted all of the residents to be satisfied with their meals and she expected that their food to be served hot and cooked correctly. An interview with on August 6, 2017 at 3:30 PM, the Administrator revealed it was her expectation that food is cooked per the recipe, palatable and served hot. b) Resident #9 was admitted to the facility on	F 364	for and/or frequency of continued, monitoring for continued compliance. The QI nurse or DON will present the Audit tool findings and QI committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.	

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F 364	Continued From page 22	F 364		

July 27, 2017 and diagnoses included anemia, hypertension, renal insufficiency and arthritis.

Review of Resident #9 Minimum Data Set (MDS) dated August 1, 2017 revealed that Resident #9 was cognitively intact. He required extensive assistance with eating.

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An interview on August 5, 2017 at 6:30 PM with Resident #9 revealed that his meals were frequently cold when they were served to him. Resident # 9 revealed that he had reported his concerns to the nursing assistants (NA) on the hall and the nursing assistant reported back to him that she would be the only one on the hall and she was doing her best to pass the trays. Resident # 9 revealed he ate cold food every day.

An interview with NA # 23 on August 5, 2017 at 7:30 PM revealed that most of the time during the weekend there was only one NA for each hall and it took time to pass out the trays and feed the residents. NA #23 revealed that they were always short of staff. NA #23 revealed that dinner trays were always late and when she was by herself it took time to pass out the trays. NA #23 also revealed that they can't reheat resident's food; they are required to go to the kitchen and get a new plate of food and that takes longer.

An observation was made of the steam table in the kitchen on August 6, 2017 at 11:15 AM. The lunch meal was already on the steam table and the cook revealed that she had placed the food on the steam table at 10:30 AM and that she usually took the food temperatures around 11:30 AM. The food temperatures were taken by the cook on 11:30 AM August 6, 2017, using a calibrated thermometer and were: roast turkey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 08/07/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 23	F 364		

159 degrees F, turkey gravy 172 degrees F, cornbread dressing 193 degrees F, mixed vegetables 198 degrees F, hamburger meat 168 degrees F and rice 187 degrees F.

An interview with the Cook on August 6, 2017 at 11:35 AM revealed that she did not bake or cook the cornbread dressing. She stated she just put it in the steamer to heat and then placed it on the steam table. She stated that the residents had complained that the cornbread was too hard and that is why she just placed it in the steamer. In an observation at the time of the interview, the cornbread dressing appeared uncooked to this surveyor.

A test tray was prepared at 1: 05 PM on August 6, 2017 from the kitchen steam table and contained the turkey with gravy, cornbread dressing, and mixed vegetables. The test tray was delivered to the 400 hall at 1:07 PM where Resident #1 resided and ate his meals. There were 20 trays that were delivered on the cart. The last tray was delivered at 2:00 PM and the temperatures of the test tray were taken by the DM using a calibrated thermometer. The internal food temperatures were turkey and gravy 124 degrees F, cornbread dressing 124 degrees F and the mixed vegetables 119 degrees F. The food items were tasted by the surveyor and the DM. The turkey and mixed vegetables tasted barely warm and the cornbread dressing tasted uncooked.

An interview on August 6, 2017 at 2:20 PM with Resident #9, revealed that his "lunch was served cold and that it was early today."
An interview on August 6, 2017 at 2:45 PM with the DM revealed that all foods should be held and served at the required temperatures. She stated

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F 364	Continued From page 24 that she was going to talk with the cook about baking the cornbread dressing and not putting all the food on the steam table at one time. She stated that she wanted all of the residents to be satisfied with their meals and she expected that their food to be served hot and cooked correctly. An interview with on 8/6/17 at 3:30 PM, the Administrator revealed it was her expectation that food is cooked per the recipe, palatable and served hot.	F 364		