345144 B. WING 08/07/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD PINE RIDGE HEALTH AND REHABILITATION CENTER THOMASVILLE, NC 27360 THOMASVILLE, NC 27360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		ATE SURVEY
PINE RIDGE HEALTH AND REHABILITATION CENTER Depresent to the process of the proces the proces of the process of the proces of the process of the p			345144	B. WING _			C 08/07/2017
PIPE RIDGE HEALTH AND REHABLITATION CENTER THOMASVILLE, NC 27360 (M) D MEEX TAG SUMMARY STATEMENT OF DEFICIENCIES (CALL DEFICIENCIES IN FOLLAND OF DEFICIENCIES (CALL DEFICIENCIES IN FOLLAND OF DEFICIENCIES (CALL DEFICIENCY AND RESPECT OF INDIVIDUALITY ID PREVEX (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 promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promotes maintenance or enhancened by: Discover and the resident. This REQUIREMENT is not met as evidenced by: Discover and the resident. 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 subunited as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the discase, impulse disorder and major depression disorder. 1. Resident # 6 was admitted June 13, 2000 with disgaposes of Alzheimer's disease, chronic kidney disease, impulse disorder and major depression disorder. F241 Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies for toge Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. Ridge Health and Rehabilitation Center reserves the right to refute any of the deficienci	NAME OF PR	OVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE,	, ZIP CODE	
Prefix Txs IEACH CORRECTURE ACTION SHOLLO BE CROSS REFERENCE TO F INTERPRETIVE ACTION SHOLLO BE CROSS REFERENCE TO FILL ACTION SHOLLO BE CROSS REFERENCE TO FILL ACTION SHOLLO BE CROSS REFERENCE TO FILL ACTION SHOLLO BE INTERPRETIVE ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO BE CROSS REFERENCE TO THE ACTION SHOLLO BE INTERPRETIVE ACTION SHOLLO BE TRUEHER ACTION SHOLLO BE SHOLLO ACTION SHOLLO BE INTERPRETIVE ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO ACTION SHOLLO BE TRUEHER AND ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO ACTION SHOLLO AC	PINE RIDGI	E HEALTH AND REHAB	BILITATION CENTER				
SS=D 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 (Gees odor) during a meal observation. The facility failed to provide a glassware to residents who received milk in an 8 ounce (oz.) paper carton during 2 of 2 meal observations. 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 is response to this Statement of Deficiencies or does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refue any of the deficiencies on thes sittement of Deficiencies on thes its 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 refue applicable rules and provisions of quality of any other admission that any deficiencies on thes sittement of Deficiencies on thes its Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the righto refue any of the defic	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIATE	COMPLETIO
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. Pine Ridge Health and Rehabilitation This REQUIREMENT is not met as evidenced by: Pine Ridge Health and Rehabilitation 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. Pine Ridge Health and Rehabilitation 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. Pine Ridge Health and Rehabilitation 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 no des 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 through Informal Dispute Resolution, formal appeal procedure and/or any other admisistrative or legal proceedings. 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 F241 On August 24, 2017, Nurse #24 and Nurses Assistant #21 received i				F 2	241		9/4/17
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		resident in a manner a promotes maintenance her quality of life reco- individuality. The facil promote the rights of This REQUIREMENT by: Based on observation interview the facility fa- dining experience for #6) who was served a with an offensive odor observation. The facil glassware to resident ounce (oz.) paper car observations. Findings included: 1. Resident # 6 was a diagnoses of Alzheim disease, impulse diso disorder. Review of Resident # (MDS) dated 7/11/201 was cognitively impain transfers were scored with two staff member required extensive as eating. An observation of Res at 7:00 PM revealed t supper meal in her ro- very offensive feces of	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and the resident. Is not met as evidenced ans, record review and staff ailed to provide a dignified 1 of 1 resident (Resident a meal in an environment r (feces odor) during a meal lity failed to provide s who received milk in an 8 ton during 2 of 2 meal admitted June 13, 2000 with er's disease, chronic kidney order and major depression 6 6's Minimum Data Set 17 revealed that resident red. Bed mobility and d as extensive assistance rs. Resident #6 also isistance of one person with sident #6 on August 5, 2017 that she was served her om while the room had a boor.		Center acknowledges Statement of Deficience this Plan of Correction the summary of finding correct and in order to compliance with applic provisions of quality of The Plan of Correction written allegation of cor Ridge Health and Reh response to this Stated does not denote agree Statement of Deficience constitute an admissio deficiency is accurate. Ridge Health and Reh reserves the right to re deficiencies on this State Deficiencies through In Resolution, formal app and/or any other admi proceedings. F241 On August 24, 2017, N Nurses Assistant #211 from the Director of Nu maintaining dignity and	receipt of the cies and proposes to the extent that gs is factually maintain cable rules and f care of residents. In is submitted as a ompliance. Pine abilitation Center⊡s ment of Deficiencies ement with the cies nor does it on that any Further, Pine abilitation Center efute any of the atement of nformal Dispute oeal procedure nistrative or legal	

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.

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/12/20 M APPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		345144	B. WING			C / 07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				706 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 241	Continued From page	e 1	F 24	41		
				residents residing in the fa	cility to include	
	An interview with Nur	rse # 24 at 7:00 PM revealed		activities of daily living dur	-	
		ommate had behaviors and		offensive odors, and prope	er tableware.	
		er colostomy bag resulting in		On August 28, 2017,the D		
		room. She stated that the		Nursing (DON), Minimum		
		A# 21) had set up Resident #		(MDS), and Quality Improv	. ,	
		room for the resident to eat		nurse initiated a 100% lice		
	even with the offensiv	ve odor in the room.		certified nursing assistant,		
	During on interview	with Director of Number		staff in-service titled Dignit	· ·	
	-	vith Director of Nursing August 5, 2017 she stated		The in-service instructs sta		
t		ant to eat a meal in the room		importance of maintaining respect of residents to incl		
		there". The DON also		daily living during meal tim		
	indicated that Resident #6's roommate had		odors, and proper tablewa			
		frequently "mess" with her		in-service is to be complet		
	colostomy bag.	· ·		September 1, 2017. All ne licensed nurses, certified r	ewly hired	
	During an interview w	vith the Administrator on		assistants, and dietary sta	ff will receive	
		M she revealed she was		this in-service upon hire by		
		6's roommate's behavior		Nursing and /or Registered	d Nurse during	
		ed staff to take Resident #6		the orientation process.		
		the odor was gone and that				
		ave her dinner in the dining		On August 28, 2017 the D		
	room.			MDS, Activities director, an		
	2 During a moal can	vice observation in the		Worker began resident can and interviewing alert and		
		room on August 5, 2017 at		residents along with reside		
	6:20 PM nine resider	U		representatives for cognitiv		
		tly from the 8 oz. paper		residents to ensure that th		
		ere served other beverages,		treated with dignity and res		
	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	U		observation for cleanliness	-	
		-		of proper tableware. This i		
				being documented on a Di	gnity Audit Tool.	
	observed on the trays	S.				
		,		The DON and/or QI nurse		
		e facility's main dining room		Dignity/Respect Audits on		
	-	ust 6, 2017 at 8:20 AM		residents weekly times 4 v		
		ne residents were observed		once weekly times 8 week	s, then once	
	being served and cor	nsuming milk from the 8 oz.		monthly times one month.		

Facility ID: 923017

		MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE	
	F CORRECTION	IDENTIFICATION NUMBER:	, ,	3	COMPLETED	T
					С	
		345144	B. WING		08/07/201	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
PINE RID	GE HEALTH AND REHA	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMP IE APPROPRIATE D/	X5) PLETION ATE
F 241	Continued From page	e 2	F 24	11		
	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,			The DON and/or QA nurse we the monthly Quality Improve committee the results of the three months for identification	ement (QI) audits for	
	2017 at 8:35 AM of th residents were serve directly from the 8 oz	ne 400 hall ten of fourteen d and consumed milk carton. No glass or cup for their milk. Straws were		actions taken, and to detern for an/or frequency of contin monitoring for continued cor QI nurse or DON will presen tool findings and QI committed recommendations to the quart	nine the need nued, npliance. The nt the Audit ree	
	2017 at 8:40 AM of th residents were serve directly from the 8 oz	e observation on August 6, ne 300 hall ten of fifteen d and consumed milk paper carton. No glass or em for their milk. Straws e trays.		assessment and assurance Committee for further recom and oversight.	(QAA)	
	2017 at 8:47 AM of th residents were serve directly from the 8 oz	e observation on August 6, ne 200 hall twelve of twenty d and consumed milk paper carton. No glass or em for their milk. Straw were s.				
	2017 at 8:50 AM on t residents were serve directly from the 8 oz	e observation on August 6, he 100 hall ten of thirteen d and consumed milk . paper carton. No glass or em for their milk. Straw e trays.				
	2017 at 8:55 AM of the dining room sixteen of served and consume paper carton. Reside served other beverage	e observation on August 6, ne 500 hall and the main of twenty-two residents were d milk directly from the 8 oz. nts were observed being ges, such as juices, water, coffee in a glass or a cup,				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
Contraction		A. BUILDING		C
	345144	B. WING		08/07/2017
ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
GE HEALTH AND REHAE	BILITATION CENTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		DATE
but were not offered to their milk. Straws were An interview on Augu Dietary Manager (DM informed to only use serving thickened liqu she was never inform provide a glass or a co stated that as soon a would provide a glass Straws were observe An interview on Augu Administrator revealed a cup be available for container that was see 483.24(a)(2) ADL CA DEPENDENT RESID (a)(2) A resident who activities of daily livin services to maintain of personal and oral hyo This REQUIREMENT by: Based on observation review and family inter provide incontinent ca residents (resident #8 for activities of daily II completely dependent care. The Facility failed	the use of a glass or cup for re observed on the trays. ast 6, 2017 at 11:30 AM, the 1) revealed that she was a glass or a cup when uids. The DM indicated that hed that she needed to cup when serving milk. She s the washer was fixed she is for the resident's milk. d on the trays. ast 6, 2017 at 3:30 PM, the ed it was her expectation that r every disposable beverage erved on a resident's tray. RE PROVIDED FOR DENTS is unable to carry out g receives the necessary good nutrition, grooming, and giene. T is not met as evidenced on, staff interview, record erview the facility failed to are to 2 of the 3 sampled 5 and Resident #8) reviewed iving (ADL) who were at on staff for incontinent ed to provide assisted with		F312 On August 24 & 28, 2017, The Director Nursing (DON), Minimum Data Set (MDS), and Quality Assurance/Improvement (QA/QI) nurse initiated a 100% licensed nurse and	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page but were not offered to their milk. Straws were An interview on Augu Dietary Manager (DM informed to only use serving thickened liqu she was never inform provide a glass or a co stated that as soon a would provide a glass Straws were observe An interview on Augu Administrator reveale a cup be available for container that was se 483.24(a)(2) ADL CA DEPENDENT RESID (a)(2) A resident who activities of daily livin services to maintain g personal and oral hyg This REQUIREMENT by: Based on observation review and family inter provide incontinent co residents (resident #8 for activities of daily I completely depender care. The Facility fail feeding for 1 of 3 sam	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345144 ROVIDER OR SUPPLIER SE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carrry 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	CORRECTION IDENTIFICATION NUMBER: A. BUILDING. 345144 B. WING	CORRECTION IDENTIFICATION NUMBER A BUILDING A BUILDING

Event ID: U92B11

Facility ID: 923017

If continuation sheet Page 4 of 25

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u> </u>	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>'</i>		CONSTRUCTION	1 Y	E SURVEY IPLETED
							С
		345144	B. WING			08	8/07/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER			6 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
F 312	Continued From page	e 4	F 3'	12			
1 012		dmitted to the facility on	ГЭ	12	living. This is convice instructs the staff		
		ed on 3-24-17. The resident			living. This in-service instructs the staff proper application of adult briefs and	UII	
		ultiple diagnoses including			perineum care. The in-service is to be		
		alopathy and CVA with			completed by September 1, 2017. All		
	Aphasia.				newly hired licensed nurses and certifie	ed	
					nursing assistants will receive this		
	A review of the Minim	num Data Set (MDS) dated			in-service upon hire by the Director of		
	6-6-17 revealed resid	lent #5 was cognitively			Nursing during the orientation process.		
		also revealed resident #5					
		sist with 2+ persons in the			On August 29, 2017 the DON, QI nurse	э,	
	area of bed mobility,	transfers and toileting.			MDS, Activities Director, and Social		
t					Worker began resident care observation	ons	
		Plan dated 6-20-17 revealed			and interviewing alert and oriented		
	-	ident will be neat, clean and nt received showers on			residents along with resident representatives for cognitively impaired	4	
		The staff will provide a male			residents to ensure that they have bee		
		shower the resident. The			treated with dignity and respect,		
r		are. Staff will allow flexibility			observation for cleanliness, and to ens	ure	
		ily Living) routine. Pericare			that they are appropriately dressed. Th		
		ncontinent episode and staff			information is being documented on a		
	will prompt and remir	-			Dignity Audit Tool.		
	An observation of res	sident #5 occurred on 8-5-17			The DON and/or QA nurse will complet	te	
	at 3:35pm. The reside	ent was in the dining room.			Dignity/Respect Audits on 20% of		
		n communicative other than			residents weekly times 4 weeks, then		
		quid were noted on the front			once weekly times 8 weeks, then once		
		and the resident's pants			monthly times three months.		
	were noted to be wet	in the crotch area.				:41	
	An obcomination of the	continent are for resident			The DON and/or QA nurse will review	with	
		e continent care for resident om revealed that resident #5			the monthly Quality Improvement (QI) committee, the results of Dignity Audit	tool	
		that were both wet. The			for three months for identification of	1001	
		resent during the care and			trends, actions taken, and to determine	9	
		and is to only have "one pull			the need for and/or frequency of	-	
		d she did not know and that			continues monitoring for continued		
		shift was the last to change			compliance. The QA nurse or DON wi	11	
		e also asked why the			present the Dignity Audit Tool findings		
	resident was wearing	-			the quarterly quality assessment and		
	-				assurance (QAA) Committee for furthe	r	

Event ID: U92B11

Facility ID: 923017

If continuation sheet Page 5 of 25

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		<u> </u>	COMPLETED
					С
		345144	B. WING		08/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 706 PINEYWOOD ROAD	DE
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 312	Continued From page	- 5	F 31	2	
1 312	An interview with resi 8-5-17 at 5:45pm. Th was only changed on stated she usually ca her husband's pants The wife stated she fi husband so staff doe husband as often.	ident #5's wife occurred on e wife stated the resident ice on the day shift. The wife me near shift change and would be wet from urine. elt staff double briefs her s not need to change her	F 31	recommendations and overs	ight.
	8-6-17 at 2:45pm. The changed since 10:00 resident was noted to which had dry yellow wetness. The wife was and asked the NA whe was changed. The NA the resident around 1 why her husband had that morning. The NA	continent care occurred on e resident had not been am that morning. The b have only one brief on markings mixed with current as present again for the care then the last time her husband A stated she last changed 0:00am. The wife asked d not been changed since A replied she had been pulled while" and did not have time			
	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.				
	5-25-17 revealed the impaired. The MDS a	num Data Set (MDS) dated resident was cognitively also revealed the resident sist with one person for d hygiene.			
		Plan dated 6-9-17 revealed re after each incontinent			

Facility ID: 923017

If continuation sheet Page 6 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345144	B. WING				C / 07/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE RID	GE HEALTH AND REHAB	ILITATION CENTER			706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	An observation of the #8 occurred on 8-6-17 was noted to have on wet. Pericare was per was noted to place 2 An interview with the occurred on 8-6-17 at she normally does no not familiar with the re NA also stated she do protect the resident at possible leakage. An interview with resident at 1:00pm. The resided bath every morning bi- care 1-2 times a shift, shift was normal. The asked to be changed episode but that there help him. Resident #8 unaware that he had An interview with the occurred on 8-7-17 at expected staff to prov for the residents who or needed assistance "timely" as "whenever or within 5 minutes of 3. Resident #12 was a 10-27-08, with diagno disorder, major depre degenerative disease A review of a quarter	incontinent care of resident 7 at 9:40am. The resident 2 briefs which were both formed correctly. The NA new briefs on the resident. nursing assistant (NA#14) 10:00am. The NA stated t work first shift so she was esidents morning care. The buble briefs the resident to nd their clothing from dent #8 occurred on 8-7-17 ent stated he received a bed ut only received incontinent The resident stated once a resident stated he has when he had an incontinent e were no staff available to 8 also revealed he was on 2 briefs. Director of Nursing (DON) 12:45. The DON stated she ide "timely" incontinent care could not toilet on their own . The DON described a call light".	F	312			

Facility ID: 923017

If continuation sheet Page 7 of 25

		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 09/12/201 ORM APPROVE NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		CATE SURVEY
		345144	B. WING			C 08/07/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER					
				T	HOMASVILLE, NC 27360		
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	Continued From page		F	312			
I a T F F F F F F F F F F F F F F F F F F	 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. 						
		n Resident # 12's tray was t 1:15 PM for staff to assist r meal.					
		ervation, Resident #12 holler m hungry will somebody feed me".					
	walking down the hal 1:55 PM, NA # 41 inc Resident #12 with he	rvation NA # 41 observed I on August 6, 2017 about licated that she would assist r lunch. NA # 41 washed her sident #14 to help with					
	asked if her food was	nor was the Resident #12 s ok or cold. Resident # 12 in her for 50 minutes or					
	2:30 PM revealed that weekend there was of it took time to pass of residents. NA # 41 re short of staff. NA #41	# 41 on August 6, 2017 at at most of the time during the only one NA for each hall and ut the trays and feed the evealed that they were always 1 revealed that dinner trays					
	took time to pass out	when she was by herself it the trays but today we have taken time to get to the					

Facility ID: 923017

If continuation sheet Page 8 of 25

AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER PINE RIDGE HEALTH AND REHABILI (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M TAG REGULATORY OR LSC F 312 Continued From page 8 Resident # 12. NA #41 a can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 glad families comes out really do need more sta An interview with on Aug	also revealed that they bod; they are required to et a new plate of food and al indicated that Resident	A. BUILDING B. WING S 7	E CONSTRUCTION BTREET ADDRESS, CITY, STATE, ZIP CODE CO6 PINEYWOOD ROAD FHOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		E SURVEY PLETED C /07/2017 (X5) COMPLETION DATE
PINE RIDGE HEALTH AND REHABILITY (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M TAG Continued From page 8 Resident # 12. NA #41 at can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 # 12 loves to eat. NA #4 glad families comes out really do need more state staff assistance resident is taff assistance resident is taff assistance resident is taff assistance resident is taff assistance resident to be assistance expectation that food is 483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	ATATION CENTER EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) also revealed that they bod; they are required to bet a new plate of food and 11 indicated that Resident	ID PREFIX TAG	706 PINEYWOOD ROAD THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DN DBE	(X5) COMPLETION
PINE RIDGE HEALTH AND REHABILIT (X4) ID SUMMARY STATE (EACH DEFICIENCY M REGULATORY OR LSC) F 312 Continued From page 8 Resident # 12. NA #41 at can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 glad families comes out really do need more state An interview with on Aug Administrator revealed in staff assistance resident meals, that 30 minutes of resident to be assistance expectation that food is 483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	also revealed that they bod; they are required to et a new plate of food and al indicated that Resident	ID PREFIX TAG	706 PINEYWOOD ROAD THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DN D BE	(X5) COMPLETION
(X4) ID PREFIX TAGSUMMARY STATE (EACH DEFICIENCY M REGULATORY OR LSC)F 312Continued From page 8 Resident # 12. NA #41 a can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 # 12 loves to eat. NA #4 glad families comes out really do need more stated Administrator revealed i staff assistance resident meals, that 30 minutes or resident to be assistance expectation that food is SS=DF 323483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	also revealed that they bod; they are required to et a new plate of food and al indicated that Resident	ID PREFIX TAG	THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION
(X4) ID PREFIX TAGSUMMARY STATE (EACH DEFICIENCY M REGULATORY OR LSC)F 312Continued From page 8 Resident # 12. NA #41 a can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 # 12 loves to eat. NA #4 glad families comes out really do need more stated Administrator revealed i staff assistance resident meals, that 30 minutes or resident to be assistance expectation that food is SS=DF 323483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	also revealed that they bod; they are required to et a new plate of food and al indicated that Resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION
PREFIX TAG (EACH DEFICIENCY M REGULATORY OR LSC) F 312 Continued From page 8 Resident # 12. NA #41 a can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 # 12 loves to eat. NA #4 glad families comes out really do need more sta An interview with on Aug Administrator revealed i staff assistance residen meals, that 30 minutes or resident to be assistance expectation that food is F 323 483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	also revealed that they bod; they are required to et a new plate of food and at indicated that Resident	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION
Resident # 12. NA #41 a can't reheat resident's for go to the kitchen and ge that takes longer. NA #4 # 12 loves to eat. NA #4 glad families comes out really do need more sta An interview with on Aug Administrator revealed i staff assistance residen meals, that 30 minutes resident to be assistance expectation that food is 483.25(d)(1)(2)(n)(1)-(3) HAZARDS/SUPERVISION (d) Accidents. The facility must ensure (1) The resident environ	also revealed that they bod; they are required to et a new plate of food and 11 indicated that Resident	F 312			+
 (2) Each resident receiv and assistance devices (n) - Bed Rails. The fac appropriate alternatives bed rail. If a bed or side must ensure correct insi maintenance of bed rails to the following element (1) Assess the resident from bed rails prior to in 	to help but the facility ff". gust 6, 2017 at 3 PM, the t was her expectation that ts immediately with all was to long for any e with their meals, her served hot.) FREE OF ACCIDENT ON/DEVICES e that - ment remains as free as is possible; and res adequate supervision to prevent accidents. sility must attempt to use prior to installing a side or e rail is used, the facility tallation, use, and s, including but not limited s. for risk of entrapment stallation.	F 323			9/4/17

Facility ID: 923017

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		MEDICAID SERVICES	(X2) MUT		CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	、 <i>,</i>			1 Y Y	PLETED
				_			С
		345144	B. WING			08/07/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER			06 PINEYWOOD ROAD		
	1			Т	HOMASVILLE, NC 27360		1
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	a 0		323			
1 020	informed consent price			323			
	(3) Ensure that the be	ed's dimensions are					
		sident's size and weight.					
		Γ is not met as evidenced					
	by:	in report review, staff			F333		
		on, record review, staff It interview the facility failed			F323		
		n to prevent repeated falls			On August 7, 2017, The Director of		
f		10) sampled residents			Nursing (DON), placed a urinal in		
	reviewed for accident				Resident #10⊡s room.		
	Findings include:				Beginning August 28, 2017 and comple	ete	
	Desident #10 was ad	mitted to the facility on			by September 1, 2017, The DON and		
		mitted to the facility on ed on 11-8-16. The resident			Quality Improvement (QI) nurse will in-service all licensed nurses and certif	fied	
		ultiple diagnoses including			nursing assistants on providing	lica	
		of the left Kidney and Renal			supervision to prevent falls and care		
	Pelvis, Alzheimer's, C	Chronic Kidney Disease			guides to include appropriate		
	-	on information revealed the			interventions.		
	resident was admitted	d under hospice care.					
					On August 30, 2017, The DON, Minimu	um	
		num Data Set (MDS) dated			Data Set (MDS) nurse, and QI nurse		
		t the resident was cognitively of bed mobility and transfers			initiated a 100% room versus care plan/care guide audit to ensure that		
	•	ve with a two person assist.			appropriate interventions were in place	for	
		and hygiene were scored			each resident. The audit revealed less		
	extensive with one pe	erson assist while bathing			than 10% of interventions were needing	g to	
	was total dependence	e with one person assist.			be corrected. These items will be		
					corrected by September 4, 2017, by th		
		s note dated 6-13-17			DON, Maintenance Director, and/or QI		
		t #10 had a fall at 3:25am. NA found the resident face			nurse.		
	down on top of the fa				Beginning on September 1, 2017, the 0	SI	
	-	nd a bruise and a slight skin			nurse, DON, and/or MDS nurse will		
	elevation on the left s				monitor 20% of residents weekly x 4		
	forehead. The note re	evealed the resident said he			weeks, then once weekly times 8 week	KS,	
	was going to the bath documented.	nroom. No other injuries were			then once monthly times one month.		

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	3	C
		345144	B. WING		08/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINE RID	GE HEALTH AND REHAB	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 323	A review of the nurse that resident #10 had revealed the resident his knees with his for note denied any injury the resident said he w A review of the care p revision on 7-31-17 re resident will not sustan next review. Staff will determine whether a addressed, chair eval determine best chair with urinal and offer/ frequently, educate st use a urinal, added of position, fall mat on fl protocol, articles with keep call lite within re for factors causing fall mobility transfers, che provide incontinence needed. An observation of res at 11:00am revealed to resident's bed or in the An interview with a nu occurred at 11:05am she usually does not that she "tries" to che hours. The NA stated resident #10 needed frequently or that he u	's note on 6-17-17 revealed a fall at 11:18pm. The note was found by a med aide on ehead on his scooter. The y. The incident log revealed vas using the bathroom. blan dated 6-13-17 with a evealed the following: The in serious injury through the analyze previous falls to pattern/trend can be luation by nursing to for resident, provide resident assist him to use it taff that resident can and will hair alarm, bed in lowest oor when in bed, fall risk in reach, urinal within reach, each, monitor and intervene lls i.e. bowel/bladder needs, eck for incontinence and care frequently and as ident #10's room on 8-6-17 there was no urinal by the bathroom. ursing assistant (NA13) on 8-6-17. The NA stated work resident #10's hall but ck the residents every 2 she was unaware that to be checked more	F 32	The DON and/or QA nurse will the monthly Quality Improveme committee the results of the aud three months for identification of actions taken, and to determine for an/or frequency of continued monitoring for continued compli QI nurse or DON will present th tool findings and QI committee recommendations to the quarte assessment and assurance (Q/ Committee for further recomme and oversight.	nt (QI) dits for of trends, the need d, ance. The e Audit rly quality AA)

					OMB NO. 09	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURV COMPLETE	
			A. BUILDING		с	
		345144	B. WING		08/07/2	017
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		517
				706 PINEYWOOD ROAD	002	
INE RIDO	SE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COM THE APPROPRIATE	MPLÉTIO DATE
F 323	Continued From pag	e 11	F 32	3		
	up and down on his	own but should have				
		se revealed that staff				
		ask for help but he does not.				
		sident #10 was getting up on				
		has to go to the bathroom. resident does not use the				
		does not remember how.				
		ent should have a urinal in his				
	room and the resider	nt is checked every 2 hours				
c ii	An observation of res	sident #10's room occurred				
	on 8-7-17 at 1:40pm	. The resident was in the bed				
		n. 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. Th	ne resident stated he got up				
		wheelchair and laid down.				
		nis falls happened in the				
		d to go to the bathroom. The bes know to ask for help but				
		ed for someone to help me l				
		full". The resident revealed				
		inal in his room but that he				
	would try to use it if h	ne had one.				
	An interview with the	Director of Nursing (DON)				
	occurred on 8-7-17 a	t 12:45. The DON revealed				
		ing meeting every morning to				
		rventions. The DON stated				
		s in the interventions, this mmunicated with the rest of				
	-	tated she expected staff to				
		ns put in place to prevent the				
	falls.					
F 353		FICIENT 24-HR NURSING	F 35	3	9/4/	17
SS=D	STAFF PER CARE F	PLANS				

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345144	B. WING				C /07/2017
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	GE HEALTH AND REHAB	ILITATION CENTER			706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	 483.35 Nursing Servia The facility must have the appropriate comp provide nursing and re- resident safety and at practicable physical, re- resident assessments and considering the n- diagnoses of the facili accordance with the f at §483.70(e). [As linked to Facility A- be implemented begin (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must sufficient numbers of of personnel on a 24- nursing care to all ress resident care plans: (i) Except when waive this section, licensed (ii) Other nursing perss limited to nurse aidess (a)(2) Except when w this section, the facility nurse to serve as a cl duty. (a)(3) The facility must nurses have the spect 	e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care umber, acuity and ity's resident population in acility assessment required assessment, §483.70(e), will mning November 28, 2017 at provide services by each of the following types hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not	F	353	3		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/1 FORM APPR OMB NO. 0938	ROVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	(
		345144	B. WING		08/07/201	7
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP		
	SE HEALTH AND REHAE			706 PINEYWOOD ROAD		
				THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DA	(5) LETION ATE
F 353	Continued From page	e 13	F 35	53		
		ident assessments, and				
	assessing, evaluating resident care plans a needs.	includes but is not limited to g, planning and implementing nd responding to resident's				
	by: Based on record rev resident and families failed to provide staffi quality to provide inco who required assistant affected 7 out of 12 re	esidents (Resident # 1, nt #6, Resident #8, Resident		F 353 On August 30, 2017 a 100 completed by the Administ back at the last 14 days of ensure sufficient staffing w provide adequate care. N staffing issues were identit	trator looking f staff records to vas in place to o sufficient	
	This tag is cross refer 312, and F 323. Findings included:	renced tags F241, F 364, F		On August 28, 2017, the D Nursing (DON) and Quality (QI) nurse initiated a 100% all licensed nurses and ce	y Improvement	
	F-241 Based on obse staff interview the fac dignified dining exper (Resident #6) who wa environment with an	ervations, record review and ility failed to provide a rience for 1 of 1 resident as served a meal in an offensive odor (feces odor) ation. The facility failed to		assistants regarding maint and respect, offensive odd times, proper tableware, a to the administrator and/or staffing challenges during On August 29, 2017, the I	taining dignity ors during meal nd notification • DON for a shift. DON, QI nurse,	
	in an 8 ounce (oz.) pa meal observations.	residents who received milk aper carton during 2 of 2		Minimum Data Set nurse (director, and Social Worker resident care observations interviewing alert and orien along with resident represent	er began s and nted residents	
	resident interviews an failed to serve food a			along with resident represe cognitively impaired reside that they have been treate and respect, observation f and utilization of proper ta information is being docum	ents to ensure d with dignity or cleanliness, bleware. This	

Facility ID: 923017

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/12/201 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		345144	B. WING		08	C 6/07/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	
				706 PINEYWOOD ROAD		
PINE RIDO	E HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 353	Continued From page	e 14	F 353			
	e entina e a riem pag		1 000	Dignity Audit Tool.		
	F-312 Based on obse	ervation, staff interview,				
		mily interview the facility		On August 29, 2017, The Ad	ministrator	
	failed to provide inco	ntinent care to 2 of the 3		and DON continued discussi	ng the topic	
		esident #5 and Resident #8)		of sufficient staffing in the mo	-	
		s of daily living (ADL) who		department head meeting to		
	were completely dep			scheduler was providing the		
		Facility failed to provide		and/or DON the opportunity t		
		for 1 of 3 sampled residents wed for activities of daily		staffing schedule three days		
		e completely dependent on		On August 29, 2017, the sch reflected sufficient staff signe		
	staff for assistance w			for staff to carry out their ass		
	F-323 Based on obse	ervation, record review, staff		On August 29, 2017, the Adn	ninistrator	
		nt interview the facility failed		and DON initiated the Staffin		
		n to prevent repeated falls		Tool to ensure appropriate st		
	for 1 of 3 (resident #1	10) sampled residents		identify staffing needs, includ	ling staffing	
	reviewed for accident	ts.		on evenings, weekends, and		
				The goal of the Staffing Assig		
		our on August 5, 2017 from		is to ensure sufficient staff ar		
		e NA on the 100 Hall, one NA		the daily assignment sheet for		
		NA on the 300 Hall, one NA one NA who indicated that		of residents and ensure the s	-	
		and 300 halls from 3pm		are given appropriate assign meet the needs of the reside		
	until 7am on Sunday	•		include pericare and applicat		
	and run on ounday			briefs. The DON will utilize th		
	An interview with NA	# 23 on August 5, 2017 at		Assignment Tool 5 times wee	•	
		at most of the time during the		weeks, twice weekly for 4 we		
		only one NA for each hall and		weekly x 4 weeks. Any identi		
		ut the trays and feed the		concerns will be addressed in	mmediately	
		vealed that they were always		by the DON.		
		3 revealed that dinner trays				
		when she was by herself it		The DON and/or QI nurse wi		
	•	the trays. NA #23 also		the monthly Quality Improver		
	-	n't reheat resident's food;		committee, the results of the		
	new plate of food and	to the kitchen and get a		Tool for three months for ider trends, actions taken, and to		
	new plate of 1000 and	ה המנומתכים וטוושכו.		the need for and/or frequenc		
	An interview with NA			continues monitoring for continues		1

Facility ID: 923017

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	PLETED	
						С	
		345144	B. WING		0	8/07/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
	GE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 353	Continued From page	15	F 35	3			
F 333	8:15 PM revealed that weekend that was on 24 indicated that she residents and it hard the residents. NA # 2 wait a long time for ca- minutes and sometime that we have been as would listen to us". An interview with NA 5:45 AM revealed that with 23 to 30 resident hard to meet the need shift. NA # 32 indicate are asleep but she st during the night that r NA #32 stated she sti five showing during the five residents up befor #32 indicated she has assistance with the lift not use the lift any re- asked "Can you pleas Facility' NA #32 had An interview with fam 6, 2017 at 11 AM reve short staff on all shifts waited up two hours I was assisted with car	th most of the time during the ly one NA for each hall. NA # had about 15 total care to the meet the needs of all 4 indicated that residents do are and treatment up to 30 hes longer, NA # 24 indicated sking for staff and "No one # 32 on August 6, 2017 at it she had worked on the hall is by herself and it's very ds of the resident during this ed that most of the residents ill had several residents up need assisted with ADL care. Ill had to give about three to his shift and get about four to ore the first shift coming. NA is residents who needs it and she indicated she will sident by herself. NA # 32 is get us some help at the	F 35	compliance. The QI nurse or present the Dignity Audit Tool the quarterly quality assessmu assurance (QAA) Committee recommendations and oversig	findings to ent and for further		
	8-7-17 at 1:45pm. Th	resident #10 occurred on e resident stated he got up /heelchair and laid down.					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE C	CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
		345144	B. WING		0	8/07/2017
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DDE	
	GE HEALTH AND REHAE	BILITATION CENTER		S PINEYWOOD ROAD OMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 353 F 356 SS=D	evening when he had resident stated he do then stated "if I waite would have a bucket he had not seen a un would try to use it if h An interview with the August 7, 2017 at 3 F one NA that can give also indicated that the to hire more staff sind DON could not answe been hired since Jun- got nine new employe 8, 2017 An interview with the 2017 at 3:00 PM she about two months an place to hire more stat this was identified be 483.35(g)(1)-(4) POS INFORMATION 483.35 (g) Nurse Staffing Infi (1) Data requirement the following information (i) Facility name. (ii) The current date.	A to go to the bathroom. The es know to ask for help but d for someone to help me I full". The resident revealed nal in his room but that he e had one. Director of nursing on PM indicated that she "got 25 baths in one day." DON e facility had a plan in place be June 2017. However er to how many staff had e. DON revealed the facility ees for orientation on August Administrator on August 7, only been at the facility for d the facility had a plan in aff. Administrator indicated fore she got to the facility. STED NURSE STAFFING formation ths. The facility must post tion on a daily basis:	F 353	DEFICIENCY		9/4/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 1 APPROVED
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345144	B. WING				C 07/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	GE HEALTH AND REHAB	BILITATION CENTER			06 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 356	Continued From page	9 17	F	356			
	(A) Registered nurses	3.					
	(B) Licensed practica vocational nurses (as	l nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					
	(iv) Resident census.						
	(2) Posting requireme	ents.					
		ost the nurse staffing data h (g)(1) of this section on a inning of each shift.					
	(ii) Data must be post	ted as follows:					
	(A) Clear and readabl	le format.					
	(B) In a prominent pla residents and visitors	ace readily accessible to					
	The facility must, upo make nurse staffing d	posted nurse staffing data. n oral or written request, lata available to the public ot to exceed the community					
	facility must maintain staffing data for a min required by State law	tion requirements. The the posted daily nurse nimum of 18 months, or as , whichever is greater. is not met as evidenced					
	Based on observatio interviews the facility staffing information du	ns, record reviews and staff failed to post daily nurse uring one (1) of three (3) ailed to post correct number			F356 On August 6, 2017, the regional vice president(RVP) in-serviced the		

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		MEDICAID SERVICES				3 NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>			
		345144	B. WING			C	
	ROVIDER OR SUPPLIER	343144		STREET ADDRESS, CITY, STATE, ZI		08/07/2017	
NAME OF FI	CONDER OR SUFFLIER			706 PINEYWOOD ROAD	FCODE		
PINE RIDO	GE HEALTH AND REHAD	BILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLETIO	
F 356	Continued From pag	e 18	F 35	56			
	of resident census du	uring one (2) of three (3)		administrator, director of	nursing (DON),		
	days during the surve			and scheduler regarding	posting the Daily		
				Nursing Staffing Sheet i			
	Findings Included:			non-licensed and non-ce			
	An observation on A.			(non-resident care staff)			
		ugust 5, 2017 at 3:30 PM lipboard in the hall that		Daily Nursing Staffing sh the regulatory guidelines			
		ly Nursing Staffing posted for					
		nd Rehabilitation Center.		On August 8, 2017, the c	director of nursing		
				(DON) in-serviced the re			
	An interview with the	e Admission staff on August		third shift nurses regardi	ng: 1) the Daily		
	· ·	vealed that the resident		Nursing Staffing sheets a			
	census was 139.			completed in pencil, 2) w			
		Adminution shoff at 2.50DM		change, corrections are	-		
		Admission staff at 3:50PM		Nursing Staffing sheet to			
		d to contact the staffing did not know where to		hours, and 3) Non-licens			
	locate this informatio			are not included on the r	,		
				sheet, according to the r			
	An observation on Au	ugust 5, 2017 at 5:00 PM		guidelines.			
	revealed an empty cl	lipboard on the hall that					
		ly Nursing Staff posted for		The administrator, DON,			
	Pine Ridge Health ar	nd Rehabilitation.		improvement (QI) nurse			
	An observation on A.	revet 5, 204 at 7:45 DM		consultant will audit and			
		ugust 5, 201 at 7:15 PM 4, 2017 "Daily Nursing		Nursing Staffing sheets t accurate completion of s			
		Ridge HRC 7am-3pm 132		and to ensure non-nursir			
		om-11pm Resident Census		non-certified staff (non-re	-		
		t Census nothing for 11pm-		are not included in the ca	,		
	7am. Under August 4	1, 2017 was August 5, 2017		according to the regulate	ory guidelines.		
		017 "Daily Nursing Staffing,					
		IRC 7am-3pm had 125		The audit will be complete			
		d for 3pm-11pm no census		weekly for 4 weeks (to in			
		time that the survey begin		and Sunday), then 3 time			
	listed.	t Census in was nothing		weeks, then 1 time week The receptionist or sche	•		
	แอเอน.			immediately re-educated			
	An interview with the	Director of Nursing on		administrator, DON, QI N	-		
		30 PM revealed that the		corporate consultant for			

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		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVI NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
		345144	B. WING			C)8/07/2017
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	E HEALTH AND REHAE			706 PINEYWOOD ROAD		
				THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 356	Continued From page	e 19	F 35	6		
	Resident Census was	s 131.		incorrect Daily Nursing Staffin	g sheets.	
	revealed "Daily Nursi Ridge HRC from 3pm residents listed. An interview with The 2017 at 3:30 PM reve trained to complete th That this information on Friday she complet An interview with the 2017 at 3:40 PM reve census for today was her expectation that the correct with the census	Igust 6, 2017 at 3:30 PM ng Staffing, Facility Pine h-11pm revealed no census e Scheduler on August 7, ealed that was how she was he Daily Staffing information. was to be posted daily and etes it for the weekend. Administrator on August 7, ealed that the resident 132. She stated that it was he posted nurse staffing be us residents listed and that posted daily by the correct		The QI nurse or DON will revi monthly Quality Improvement the results of the Daily Nursin audit reviews monthly for 3 m trending, root cause analysis recommendations. The QI nurse or DON will revi quarterly Quality Assessment Assurance (QAA) Committee of the Daily Nursing Staffing a QI Committee recommendation facility progress with the QI C recommendations for 1 quarte additional root cause analysis commendations, and addition monitoring requirements as m administrator is responsible for QAA Committee.	Committee g Staffing onths for and ew with the and the results udit reviews, ons, and ommittee er for al eeded. The or ensuring ations are	
F 364 SS=E	PALATABLE/PREFE	RITIVE VALUE/APPEAR, R TEMP	F 36	4		9/4/17
	(d) Food and drink					
		es and the facility provides-				
	(d)(1) Food prepared nutritive value, flavor,	by methods that conserve and appearance;				
	and at a safe and app	that is palatable, attractive, betizing temperature; is not met as evidenced				
	Based on observatio	ns, record reviews, resident		F364		

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		MEDICAID SERVICES				0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLI	
					С	
		345144	B. WING		08/0	7/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	SE HEALTH AND REHAE			706 PINEYWOOD ROAD		
		SENATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 364	Continued From page	e 20	F 36	4		
		nterviews the facility failed to	1 00			
		eptable temperature and		On August 30, 2017, 100% of die	etary	
	provide palatable foo			staff/cooks will be in-serviced on	-	
	(Resident #1 and Res	sident # 9) that were		preparation, following recipes, ta	king	
	reviewed for food pal	atability.		temperatures and tray delivery b	у	
				corporate consultant and/or dieta		
	Findings included:			manager. The in-service will inc	lude all	
				cooks will follow recipes to have		
		admitted to the facility on diagnoses of cerebral		consistency in appearance and p of food and meals will not be pla		
	-	struction and hypertension.		steam table more than 30 minute		
		struction and hypertension.		the beginning of service.		
	Resident #1's minim	um data set and care plan				
	had not been comple			Beginning on September 1, 2017	7.	
				temperature of menu items will b		
	An interview on Augu	ıst 5, 2017, at 6:00 PM with		and recorded prior to beginning		
	Resident #1 revealed	that his meals were cold		cook and/or dietary manager. Di	etary staff	
		ed to him. He stated he		will record time when tray cart le	aves the	
		to a nurse and she told him		kitchen.		
	it was because the fa	acility was short staffed.				
	• • • • •			Dietary staff will announce the de	-	
		Ist 5, 2017 at 6:05 PM with		location of tray cart leaving the k		
		member (FM) #1 indicated ed to go to the main dining		alert nursing staff that trays are r service on a specific hall for all the	-	
		s on time and maybe the		meals.	liee	
	food would not be co	-		incuis.		
				The dietary manager and/or lead	l cook will	
	An observation was r	made of the steam table in		audit trays to ensure that food is		
		t 6, 2017 at 11:15 AM. The		temperatures, food palatability, a		
		ady on the steam table and		cooked by the recipe. This audit		
		at she had placed the food		performed five times a week for		
		t 10:30 AM and that she		then two times a week times 4 w		
		temperatures around 11:30		then twice monthly times 1 mont	n.	
		eratures were taken by the				
		ugust 6, 2017, using a ter and were: roast turkey		The DON and/or QA nurse will re the monthly Quality Improvement		
		y gravy 172 degrees F,		committee the results of the aud		
	cornbread dressing 1			three months for identification of		
		ees F, hamburger meat 168		actions taken, and to determine		

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345144	B. WING		C 08/07/2017
NAME OF PF	ROVIDER OR SUPPLIER	•••••		STREET ADDRESS, CITY, STATE, ZIF	
			706 PINEYWOOD ROAD		
PINE RIDG	E HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE COMPLE D THE APPROPRIATE DAT
F 364	Continued From page 21		F 36	64	
	degrees F and rice 18	87 degrees F.		for and/or frequency of co	
	A toot trov was propa	rod at 1:05 DM on August 6		QI nurse or DON will pres	
		red at 1: 05 PM on August 6, n steam table and contained		tool findings and QI comr	
		, cornbread dressing, and		recommendations to the	quarterly quality
	0	ne test tray was delivered to		assessment and assuran	
		PM where Resident #1 neals. There were 20 trays		Committee for further rec and oversight.	ommendations
		n the cart. The last tray was		and oversight.	
		and the temperatures of the			
	-	by the DM using a calibrated			
		ernal food temperatures			
	were turkey and gravy 124 degrees F, cornbread dressing 124 degrees F and the mixed				
	vegetables 119 degre	ees F. The food items were			
		or and the DM. The turkey			
	cornbread dressing ta	s tasted barely warm and the asted uncooked.			
	•	ist 6, 2017 at 2:30 PM with			
		esident #1, revealed that his "lunch was served Id and cornbread dressing was mushy."			
	-	ist 6, 2017 at 2:45 PM with			
		all foods should be held and demonstrated be also and temperatures. She stated			
	•	talk with the cook about			
	•••	I dressing and not putting all			
		n table at one time. She			
		ed all of the residents to be eals and she expected that			
		ed hot and cooked correctly.			
		August 6, 2017 at 3:30 PM,			
		ealed it was her expectation			
	that food is cooked po	er the recipe, palatable and			
	b) Resident #9 was a	admitted to the facility on			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345144	B. WING		_		C 07/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				706 PINEYWOOD ROAD			
PINE RIDO	E HEALTH AND REHAB	ILITATION CENTER		THOMASVILLE, NC 27	360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364	hypertension, renal in Review of Resident #4 dated August 1, 2017 was cognitively intact assistance with eating An interview on Augus Resident #9 revealed frequently cold when a Resident # 9 revealed concerns to the nursing hall and the nursing a him that she would be and she was doing he Resident # 9 revealed An interview with NA a 7:30 PM revealed that weekend there was ou it took time to pass ou residents. NA #23 rev short of staff. NA #23 were always late and took time to pass out revealed that they can they are required to g new plate of food and An observation was m the kitchen on August lunch meal was alread took the food AM. The food temper	gnoses included anemia, sufficiency and arthritis. 9 Minimum Data Set (MDS) revealed that Resident #9 He required extensive g. st 5, 2017 at 6:30 PM with that his meals were they were served to him. I that he had reported his ng assistants (NA) on the ssistant reported back to the only one on the hall er best to pass the trays. I he ate cold food every day. # 23 on August 5, 2017 at t most of the time during the nly one NA for each hall and it the trays and feed the ealed that they were always revealed that dinner trays when she was by herself it the trays. NA #23 also n't reheat resident's food; o to the kitchen and get a that takes longer. hade of the steam table in 6, 2017 at 11:15 AM. The dy on the steam table and t she had placed the food 10:30 AM and that she temperatures around 11:30 ratures were taken by the	F 36				
	on the steam table at usually took the food t AM. The food temper cook on 11:30 AM Au	10:30 AM and that she temperatures around 11:30 atures were taken by the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	0RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		345144	B. WING				08/07/2017
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE RIDO	GE HEALTH AND REHAB	ILITATION CENTER			706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 364	159 degrees F, turkey cornbread dressing 1 vegetables 198 degree degrees F and rice 18 An interview with the 11:35 AM revealed th the cornbread dressin in the steamer to hea steam table. She stat complained that the of that is why she just pl observation at the tim cornbread dressing a surveyor. A test tray was prepar 2017 from the kitcher the turkey with gravy, mixed vegetables. Th the 400 hall at 1:07 P resided and ate his m that were delivered of delivered at 2:00 PM test tray were taken b thermometer. The interview on delivered at 2:00 PM test tray were taken b thermometer. The interview dressing 124 degrees vegetables 119 degree tasted by the surveyo and mixed vegetables cornbread dressing ta An interview on Augu Resident #9, revealed cold and that it was e An interview on Augu the DM revealed that	y gravy 172 degrees F, 93 degrees F, mixed ees F, hamburger meat 168 87 degrees F. Cook on August 6, 2017 at at she did not bake or cook ng. She stated she just put it t and then placed it on the ed that the residents had combread was too hard and aced it in the steamer. In an e of the interview, the ppeared uncooked to this red at 1: 05 PM on August 6, a steam table and contained combread dressing, and e test tray was delivered to M where Resident #1 teals. There were 20 trays in the cart. The last tray was and the temperatures of the py the DM using a calibrated ernal food temperatures y 124 degrees F, combread a F and the mixed tess F. The food items were r and the DM. The turkey is tasted barely warm and the asted uncooked. st 6, 2017 at 2:20 PM with d that his "lunch was served	F	364			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 08/07/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PINE RIDGE HEALTH AND REHABILITATION CENTER				706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			COMPLETION DATE
F 364	Continued From none	04	F 00				
F 304	4 Continued From page 24 that she was going to talk with the cook about		F 364	+			
	baking the combread 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 serve	d 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 served hot.	e recipe, palatable and					

Facility ID: 923017

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