	-	D HUMAN SERVICES					FORM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES					MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRU		(.	X3) DATE SURVEY COMPLETED
		345177	B. WING				C 01/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE		
				205 RATTLE	ESNAKE TRAIL		
	ARE HEALTH SVCS PIN	ERUKSI		PINEHURS	ST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	RECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AL DEFICIENCY)		E COMPLETION DATE
F 000	INITIAL COMMENTS		FO	00			
F 656 SS=D	to conduct a recertific survey and was unab 01/19/18 due to adve unsafe travel conditio returned to the facility the survey on 01/22/1 Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identifi assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.20, include	r on 01/19/18 and completed 8. Event ID #B4BR11. comprehensive Care Plan ensive Care Plans cility must develop and tensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ted in the comprehensive aprehensive care plan must 1- there to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse	F6	56			2/19/18
	provide as a result of recommendations. If findings of the PASAF rationale in the reside	ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Electronically Signed

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

01/30/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED . 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING		01/2	C 22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
MANOR C	ARE HEALTH SVCS PIN	FHURST	:	205 RATTLESNAKE TRAIL			
				PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	future discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, in requirements set forth section. This REQUIREMENT by: Based on observation record review, the fact comprehensive care p contractures (Residen reviewed for comprehe findings included Resident #27 was ad cumulative diagnoses and contractures. A review of a physicia Therapy dated 10/19/ bilateral hands at all thy giene." The order w A review of a physicia Therapy dated 10/26/ bilateral hand for four tolerated by Resident by the physician.	tive(s)- als for admission and afference and potential for ilities must document a desire to return to the seed and any referrals to s and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced ins, staff interviews and cility failed to develop a plan for bilateral hand int # 27) for 1 of 22 residents inensive care planning. The	F 650	The statement made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies herein. To remain compliance with all Federal and State regulations, the center has taken or wi take the actions set forth in the following plan of correction. The following plan correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been o will be corrected by the date indicated. It is the practice of the facility to develor comprehensive care plans that address contractures. 1. Resident #27 comprehensive care related to contractures was developed the Director of Nursing and the Minimu Data Set Nurse on January 22, 2018. 2. An audit was conducted on January	n in II ng of r pp s plan by im		
	bilateral hands at all thygiene." The order w A review of a physicia Therapy dated 10/26/ bilateral hand for four tolerated by Resident by the physician. The most recent quar	imes. Remove for hand vas signed by the physician. In order from Occupational 17 read -blue carrots in or more hours daily or as #27. The order was signed		 comprehensive care plans that address contractures. 1. Resident #27 comprehensive care related to contractures was developed the Director of Nursing and the Minimu Data Set Nurse on January 22, 2018. 	s plan by im		

Facility ID: 923320

			0.00			<u>8-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y	
			A. BUILDING		с		
		345177	B. WING		01/22/201	18	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		·	
MANOR C	ARE HEALTH SVCS PIN	EHURST		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	X5) PLETIO ATE	
F 656	Continued From page	e 2	F 65	56			
	10	with no behaviors and		like residents by the Direct	or of Nursing		
		nce with all his activities of		and the Unit Managers. A			
	daily living (ADLs).			care plan was developed f			
				identified in the audit who			
	-	an addressing Resident #27		contracture care plans/loss			
	's bilateral hand cont	ractures.		(9) residents were reviewe			
	In an interview and o	bservation on 1/16/18 at		care plans were either dev	. ,		
		27 was noted to have		revised. These were comp			
		ctures. Resident #27 was		29-30, 2018.	,, ,		
		capable of participating in					
		. Resident #27 confirmed he		3. Director of Nursing and			
		hand carrots as much as he		Managers will educate Lice			
		nfirmed no staff offered to nd carrots in place and he		to include full time, part tim diem nurses, Minimum Da	-		
	did not refuse to wear	-		and Interdisciplinary Team			
				Director, Director of Thera	-		
	In an observation on	01/16/18 at 3:18 PM,		Service Director, Food Ser	vice Director,		
		the activity room in his		and Dietician on comprehe			
		not wearing the bilateral hand		planning and updating resi			
	carrots for his hand c	ontractures.		contractures. Education to	-		
	In an observation on	01/17/18 1:10 PM, an aide		January 30, 2018. Nurses received education will be			
	was assisting Reside	nt #27 with his lunch. There d carrots in use. NA #1		until education is complete			
		e he should have them on		4. Director of Nursing or L			
		re of how often or duration.		will conduct audits on com	-		
		nt #27 was never known to		care plans for contractures			
		ots and when he wore them, know when he wanted them		monthly x2. These audits visual observations that the			
	removed.			complete and accurate reg	-		
				contractures and contractu	-		
	In an interview on 01/	/17/18 at 3:30 PM, Unit		The results of these audits			
	-	esident #27 was to wear		reviewed by the facility's Q			
		as much as he could		monthly x3 months. Reco			
		he was not aware of any		for further action will be rev			
	#27 was very cooperation	nand carrots and Resident		implemented as indicated.			
				5. Date of compliance will			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		-	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ARE HEALTH SVCS PIN	EHIIDST					
MANOR	ARE HEALTH SVCS FIR	LIIOKOT		P	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	11:30 AM, Resident # bilateral hand carrots. not offer to put them of he never refuses ther discomfort or impede quadriplegia. In an interview on 01/ stated she was assign did not get him up for called in to assist on f was familiar with Resi cooperative with his of Resident #27 was sup hand carrots but not s she referred to the Kar Resident #27. In an interview on 01/ stated she got Reside he wasn ' t feeling ver thought she offered to #27 ' s hands and if th have refused them. N was very cooperative not aware of him refus other aspect of his ca In an observation and 9:20 AM, Resident #27 bilateral hand carrots. not yet offered to place In an interview on 01/ stated Resident #27 r hand carrots when sh him. She stated he sh	A interview on 1/19/18 at 227 was not wearing the . He confirmed the staff did on. Resident #27 confirmed in and they do not cause any him in any way due to his (19/18 at 11:50 AM, NA #2 ned Resident #27 but she the day because she was first shift. She stated she ident #27 and he was very care. She stated she knew oposed to wear his bilateral sure how often. NA #2 stated ardex to know what to do for (19/18 at 12:00 PM, NA #3 ent #27 up this morning but ry well. She stated she o put the carrots on Resident hey were not there, he may IA #3 stated Resident #27 with his care and she was sing the hand carrots or any re. A interview on 1/22/18 at 27 was not wearing his . He indicated the staff had ce them. (22/18 at 9:55 AM, NA #4 hever refuses to wear his he was assigned to care for nould wear the hand carrots	F	656	19, 2018.		
	him. She stated he sh						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MANOR C	ARE HEALTH SVCS PIN	EHURST			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	stated she followed w Kardex in the comput In an interview on 01/ Nurse stated Residen contractures and he w carrots as tolerated do the contractures and he w carrots as tolerated of been care planned or dated 11/17/17 but wa The MDS Nurse state a care plan for any re aware he ever refused In an interview on 01/ Administrator stated in Resident #27 bilatera hand carrots would be Care Plan Timing and CFR(s): 483.21(b)(2)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inti includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac-	build let the staff know. NA #4 that was indicated on the er. 22/18 at 10:05 AM, the MDS at #27 had bilateral hand vas ordered bilateral hand aily. The MDS nurse stated hand carrots should have in his last MDS assessment as obviously overlooked. A Resident #27 did not have fusals because she was d any care or intervention. 22/18 at 10:30 AM, the t was her expectation that I hand contractures with be been care planned. I Revision (i)-(iii) ensive Care Plans orehensive care plan must I days after completion of ssessment. terdisciplinary team, that ited to rsician. the with responsibility for the		656			2/19/18

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/23/201 RM APPROVE IO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		TE SURVEY MPLETED
		345177	B. WING		C 01/22/2018		
NAME OF PF	OVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MANOR C	ARE HEALTH SVCS PIN	EHURST			95 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on record rev facility failed to review related to diuretic the therapy for 1 of 5 resi reviewed for unneces findings included: Resident #29 was mo facility on 2/6/17 with persistent vegetative The quarterly Minimu assessment dated 11 #29 was in a persiste not received anticoag medication during the	participation of the resident resentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review - is not met as evidenced iew and staff interview, the v and revise plans of care rapy and anticoagulant idents (Resident #29) isary medications. The post recently readmitted to the diagnoses that included state.	F	657	The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies herein. To rema compliance with all federal and state regulations, the center has taken or take the actions set forth in the follow plan of correction. The following pla correction constitutes the center's alleged deficiencies cited have been will be corrected by the date indicate It is the practice of the facility to revia and revise plans of care related to d therapy and anticoagulants after ead assessment, including comprehensia and quarterly review assessments.	nd do e ain in e will wing n of ll or ed. ew iuretic ch	
	1/18/18. The plan of areas of diuretic thera anticoagulant therapy A review of Resident	care included the focus apy (initiated on 1/30/17) and ((initiated on 2/2/17). #29 ' s physician ' s orders //19/18 indicated he had not			 Resident #29 comprehensive car related to diuretic therapy and anticoagulants were reviewed on Ja 22, 2018 and updated by the Minimu Date Set Nurse. 	nuary	
	therapy.				2. An audit was conducted on Janua	ary	

Facility ID: 923320

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Production of Deficiencies AND PLANOF CORRECTION (N) PROVIDERSUPPLIERCUM INDERTIFICTION NUMBER: (P2) NULTIFIC CONSTRUCTION A DULDING (P2) NULTIFIC CONSTRUCTION B NUMCY STRUCTION A DULDING (P2) NULTIFIC CONSTRUCTION B NUMCY STRUCTION A DULDING (P2) NULTIFIC CONSTRUCTION B NUMCY STRUCTION A DULDING (P2) NULTIFIC CONSTRUCTION B NUMCY STRUCTION B NUMCY STRUCTION B NUMCY STRUCTION B NUMCY STRUCTION B NUMCY STRUCTION B NUMCY STRUCTION ADDITION B NUMCY STRUCTION ADDITION B NUMCY STRUCTION ADDITION B NUMCY STRUCTION ADDITION B NUMCY STRUCTION B NUMCY STRU		-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02 FORM API OMB NO. 09	PROVED		
346177 91/22/2018 STIME OF PROVIDER OR SUPPLIER Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued From page 6 F 657 Continued	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		(X3) DATE SURV COMPLETE	/EY		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY STALE 2IP CODE MANOR CARE HEALTH SVGS PINEHURST 28 RATTLESMACE TRAIL PREFIXER, NC 28374 (VAI) PREFIX TAG SUMMARY STREEMENT OF DEFICIENCIES (EACH DEPICIONY MUST BE PRECEDED BY FULL RECOULDENT OF LAPPROPHATICS) PROVIDERS FLAN OF CORRECTION (EACH DEPICIONY MUST BE PRECEDED BY FULL RECOULDENT OF LAPPROPHATICS) 00 (PREFIX (EACH DEPICIONY MUST BE PRECEDED BY FULL RECOULDENT OF LAPPROPHATICS) 00 (PREFIX (EACH DEPICIONY MUST BE PRECEDED BY FULL RECOULDENT OF LAPPROPHATICS) 00 (PREFIX (EACH DEPICIONY MUST BE PRECEDED BY FULL RECOULDENT ACTION FOR RECTION (EACH CORRECTIVE ACTION FOR RECORECTION (E			345177	B. WING		_	018		
MANDE CARE HEALT NUCS PINEHURST PINEHURST, NC 28374 (M) [0] PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIATION FOR MUST BE PRECIDE AY FILL RECOLUTION OF LISC IDENTIFYING INFORMATION) ID PREFIX RECOLUTION OF LISC IDENTIFYING INFORMATION) IP PREFIX RECOLUTION OF LISC IDENTIFYING INFORMATION) ID PREFIX RECOLUTION OF LISC IDENTIFYING INFORMATION RECOLUTION OF LISC IDENTIFYING INFORMATION OF LISC IDENTIFYING INFORMATION RECOLUTION OF LISC IDENTIFYING INFORMATION	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
ONLID Inscription Submerve structure of respective services Description Description <td>MANOR C</td> <td>ARE HEALTH SVCS PIN</td> <td>EHURST</td> <td></td> <td colspan="5"></td>	MANOR C	ARE HEALTH SVCS PIN	EHURST						
PREFIX TAG (EACH OFFICIENCY MUST BE PRECIDED BY FULL REGULTORY OR LSC DENTFYING INFORMATION) PREFIX TAG CACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION UNIT F 657 Continued From page 6 An interview was conducted with the MDS Nurse on 1/19/18 at 1:30 PM. The care plans related to diuretic therapy and anticoagulant therapy for Resident #29 were reliveed with the MDS Nurse. The physician 's orders for Resident #29 that indicated he had not received diuretic therapy or anticoagulant therapy. Show was conducted with the MDS Nurse stated she was unsure if Resident #29 had received diuretic therapy of a anticoagulant therapy for Resident #29 's record. F 657 3.2018 by the Director of Nursing to review the care plans which reflect current status for resident swho are oident therapy. A comprehensive care plans which reflect our anticoagulant therapy of and incoagulant therapy of Resident #29 had received diuretic therapy and all cated be needed to review Resident #29 's record. F 657 3. The Director of Nursing There were 17 patients not Accurate and comprehensive care plans. No revisions or updates needed. 5. The Director of Nursing, Administrator or Unit Managers will be developed of uny state therapy and all 17 patients had accurate and comprehensive care plans. No revisions or updates needed. 3. The Director of Nursing, Administrator or Unit Managers will ducate Licensed Nurses to include full time, part time and per diem, Ministrum Data Set Nurse and the Interview was conducted with the Administrator inforced and revised to reflect any changes in their status. 3. The Director of Nursing, Administrator or Unit Managers will conduct and Social Services Director) on the accuracy of comprehensive care plans to reflec						PECTION			
 An interview was conducted with the MDS Nurse on 1/19/18 at 1:30 PM. The care plans related to diuretic therapy and anticoagulant therapy. A resident #29 were reviewed with the MDS Nurse. The physician's orders for Resident #29 that indicated he had not received diuretic therapy or anticoagulant therapy. Since his readmission on 2/6/17 were reviewed with the MDS Nurse. The MDS Nurse stated she was unsure if Resident #29 had received diuretic medication and anticoagulant medication in the past. She indicated she needed to review Resident #29 's record. A follow up interview was conducted with the MDS Nurse revealed to review Resident #29 's record. A follow up interview was conducted with the MDS Nurse revealed to review Resident #29 's record. A follow up interview as conducted with the MDS Nurse revealed the care plans related to diuretic therapy and atticagulant therapy for Resident #29 's care plan as he had not received either type of medication since his most recent readmission on 2/6/17. She indicated she was going to revise the care plans for Resident #29 and discontinue the focus areas of diuretic therapy and atticagulant therapy. An interview was conducted with the Administrator in119/18 at 2:11 PM. The Administrator in119/18 at 2:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE CON	MPLETION		
An interview was conducted with the MDS Nurse on 1/19/18 at 1:30 PM. The care plans related to diuretic therapy and anticoagulant therapy for Resident #29 were reviewed with the MDS Nurse. The physician 's orders for Resident #29 that indicated he had not received diuretic therapy or anticoagulant therapy since his readmission on 2/6/17 were reviewed with the MDS Nurse. The MDS Nurse stated she was unsure if Resident #29 had received diuretic medication and anticoagulant medication in the past. She indicated she needed to review Resident #29 's record.review the care plans were editered eveloped for any patients who are identified. There were 16 patients on Diuretic therapy and 3 care plans were optated. These care plans were updated. These care plans were update. These care plans. No revisions or updates needed.A follow up interview was conducted with the MDS Nurse ervealed the care plan for Resident #29 and discontinue the focus areas of diuretic therapy and all tree plans. No revisions or updates needed The Director of Nursing. Administrator or Unit Managers will ducate Licensed Nurses to include full time, part time and per diem , Minimum Data Set Nurse will conduct audits on residents who are identified as not having an accurat	F 657	Continued From page	e 6	F 65	57				
care plans of any resident who is no		on 1/19/18 at 1:30 PM diuretic therapy and a Resident #29 were re The physician ' s orde indicated he had not anticoagulant therapy 2/6/17 were reviewed MDS Nurse stated sh #29 had received diu anticoagulant medica indicated she needed record. A follow up interview MDS Nurse on 1/19/1 Nurse revealed the ca therapy and anticoag #29 were inaccurate. sure why these focus #29 ' s care plan as h type of medication sir readmission on 2/6/1 going to revise the ca and discontinue the for therapy and anticoag An interview was con Administrator indicate to accurately reflect to to be reviewed and re	<i>A</i> . The care plans related to anticoagulant therapy for eviewed with the MDS Nurse. ers for Resident #29 that received diuretic therapy or <i>y</i> since his readmission on 1 with the MDS Nurse. The ne was unsure if Resident retic medication and tion in the past. She 1 to review Resident #29 ' s was conducted with the 18 at 1:48 PM. The MDS are plans related to diuretic ulant therapy for Resident She stated she was not areas were on Resident the had not received either noce his most recent 7. She indicated she was ire plan for Resident #29 bocus areas of diuretic ulant therapy. ducted with the //18 at 2:11 PM. The ed she expected care plans he status of the resident and		 review the care plans which refisitatus for residents who are on and/or anticoagulant therapy. Comprehensive care plan will be developed for any patients who identified. There were 16 patien Diuretic therapy and 5 care planeither developed or updated. The plans were update January 30-by the Director of Nursing. The patients on Anticoagulant thera 17 patients had accurate and comprehensive care plans. No or updates needed. 3. The Director of Nursing, Add or Unit Managers will educate INURSES to include full time, part per diem, Minimum Data Set No the Interdisciplinary team (Director Comprehensive care plans to recurrent status for residents who identified as not having an accur plan or no longer needing a care Education to begin on January and be completed by February Nurses who do not receive the will be unable to work until education to accur the will be unable to work until education to accur the status for residents who require care plans to recompleted. 4. The Director of Nursing or No Data Set Nurse will conduct au residents who require care plans 	flect current diuretic A e o are ents on ns were These care 31, 2018 re were 17 py and all o revisions ministrator Licensed t time and Aurse and ctor of Social racy of effect o are urate care re plan. 30, 2018 19, 2018. education cation is Minimum dits on ns for			
					care plans of any resident who	is no			

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/23/2018 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE	
		345177	B. WING			C 22/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ARE HEALTH SVCS PIN	EHIIDST	2	05 RATTLESNAKE TRAIL		
	ARE HEREIT SVCS FIR		F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page		F 657	therapy weekly x4 weeks and then monthly x2. Results of these audits wi be reviewed by the Quality Assurance Committee monthly x3 months. Recommendations for further action wi be reviewed and implemented as indic 5. Date of compliance will be February 19, 2018	ill ted.	
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)-	crease in ROM/Mobility -(3)	F 688			2/19/18
	resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidal §483.25(c)(2) A reside motion receives appro-	ent with limited range of opriate treatment and				
		ange of motion and/or to ase in range of motion.				
	receives appropriate s assistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by:	ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable.				
	interviews and record utilize bilateral hand o devices (carrots) as o	ns, resident and staff review, the facility failed to contracture management ordered for 1 (Resident #27) ed for mobility. The findings		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies herein. To remain compliance with all federal and state regulations, the center has taken or wi	in	

Facility ID: 923320

If continuation sheet Page 8 of 23

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/23/20 M APPROVE D. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345177	B. WING _			C 01/22/2018		
NAME OF P	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
				205	5 RATTLESNAKE TRAIL			
MANOR	ARE HEALTH SVCS PI	NEHURST		PI	NEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE	
F 688	Continued From pag	e 8	F 6	888				
					take the actions set forth in the following	ng		
		dmitted 07/05/16 with			plan of correction. The following plan	of		
		s of quadriplegia, aphasia			correction constitutes the center's			
	and contractures.				allegation of compliance such that all			
	A purging note dates	1 10/17/17 read the Resident			alleged deficiencies cited have been of will be corrected by the date indicated			
		iented. He was non-verbal			will be corrected by the date indicated	•		
		cate. His body was stiff with			It is the practice of the facility that a			
	contractures.				resident with limited mobility receives			
					appropriate services, equipment, and			
		an order from Occupational			assistance to main or improve mobility	<i>'</i> .		
		0/17 read "carrot splint to times. Remove for hand			1. Resident #27 orders for contracture	_		
		was signed by the physician.			management devices were reviewed.	;		
					Orders were to apply splint/device to			
	A review of the Octo	ber 2017 medication			bilateral hands as tolerated Care plan	was		
		d (MAR) read beginning			created January 19 2018 by the Minim	num		
		27 was to wear carrot splints			Data Set Nurse. Direct observation wa	IS		
		at all time and to remove for			completed by Director of Nursing on			
		vas only listed as "For Your nd required no nurse initials.			January 29, 2018.			
		la requirea no nuise initiais.			2. An audit was conducted by the Dire	ector		
	A review of the unda	ted electronic Kardex for the			of Nursing on January 29, 2018 for	50101		
		IA) to follow read Resident			patients with contracture management	t		
	#27 was to wear car	rot splints to his bilateral			devices. Contracture management			
		I to remove for hand hygiene.			devices were reviewed for orders,			
	-	as FYI and required no NA			placement, and appropriateness for an			
	initials.				patients identified on the audit. Nine (residents were audited for splint/devic			
	A review of a physici	an order from Occupational			and/or for loss of range of motion. An			
		6/17 read -blue carrots in			those nine (9) residents, seven (7)	-		
	bilateral hand for four or more hours daily or as				residents had a care plan either			
	-	t #27. The order was signed			developed or updated as needed by th	ne		
	by the physician.				Director of Nursing on January 29-30, 2018.			
		mber 2017 MAR read "carrot						
	-	ids at all times-Remove for			3. Director of Nursing, Administrator			
		was evidence of the nurses '			and/or Unit Managers began educatio			
	miliais as completed	on 7:00 AM-7:00 PM and			January 23, 2018 with Licensed nurse	5		

Facility ID: 923320

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		ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				LETED
		345177	B. WING				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	05 RATTLESNAKE TRAIL		
	ARE HEALTH SVCS PIN	ERUKSI		Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 688	(MDS) dated 11/17/17 was cognitively intact required total assistant daily living (ADLs). There was no care plat 's bilateral hand cont A review of the Decer splint to bilateral hand hand hygiene. There initials as completed of again 7:00 PM-7:00 A A review of the Janua splint to bilateral hand hand hygiene. There initials as completed of again 7:00 PM-7:00 A In an interview and of 11:10 AM, Resident # bilateral hand contract cognitively intact and the interview process was to wear bilateral could tolerate. He cor place his bilateral hand did not refuse to wear In an observation on a Resident #27 was in to wheelchair. He was n carrots for his hand contract	M daily. terly Minimum Data Set 7 indicated Resident #27 with no behaviors and nce with all his activities of an addressing Resident #27 ractures. mber 2017 MAR read "carrot ds at all times-Remove for was evidence of the nurses ' on 7:00 AM-7:00 PM and M daily. rry 2018 MAR read "carrot ds at all times-Remove for was evidence of the nurses ' on 7:00 AM-7:00 PM and M daily. pservation on 1/16/18 at 27 was noted to have stures. Resident #27 was capable of participating in . Resident #27 confirmed he hand carrots as much as he offirmed no staff offered to nd carrots in place and he r them. 01/16/18 at 3:18 PM, the activity room in his ot wearing the bilateral hand ontractures.	F	688	 which include full time, part time, and p diem, Minimum Data Set Nurse, and in disciplinary team (Director of Rehab, Social Services Director, and Activities Director) on contracture management devices, orders, placement, and monitoring. Nurses who do not receive the education will be unable to work ur education is completed 4. The Director of Nursing and/or Unit Managers will conduct paper audits an visually audit to determine accuracy of contracture management devices and proper documentation weekly x4 week and then monthly x2 months. Results these audits will be reviewed by the facility's Quality Assurance Committee monthly x3 months. Recommendation for further action will be reviewed and implemented as indicated. 5. Date of compliance will be February 19, 2018 	ter e htil d s, of s	
	Resident #27 was in t wheelchair. He was n carrots for his hand c	the activity room in his ot wearing the bilateral hand					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C 22/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	ARE HEALTH SVCS PIN	EHIIDST		2	05 RATTLESNAKE TRAIL			
	ARE HEALTH SVCS FIN	LIIOKST		Р	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 688	were no bilateral hand stated she was not as did not get him up on was aware he should unaware of how often Resident #27 was new hand carrots and whe let the staff know whe let the staff know whe let the staff know whe let the staff know whe lateral hand carrots tolerate. She stated s refusals to wear the h #27 was very coopera In an observation and 11:30 AM, Resident # bilateral hand carrots not offer to put them of he never refuses ther discomfort or impede quadriplegia. In an interview on 01/ stated she was assign did not get him up for called in to assist on f was familiar with Resi cooperative with his of Resident #27 was sup hand carrots but not s she referred to the Ka Resident #27. In an interview on 01/	nt #27 with his lunch. There d carrots in use. NA #1 ssigned Resident #27 and 01/17/18. She stated she have them on his hands but or duration. NA #1 stated ver known to refuse the en he wore them, he would en he wanted them removed. 17/18 at 3:30 PM, Unit esident #27 was to wear as much as he could he was not aware of any and carrots and Resident ative. 1 interview on 1/19/18 at 27 was not wearing the . He confirmed the staff did on. Resident #27 confirmed in and they do not cause any him in any way due to his 19/18 at 11:50 AM, NA #2 hed Resident #27 but she the day because she was first shift. She stated she ident #27 and he was very care. She stated she knew oposed to wear his bilateral sure how often. NA #2 stated ardex to know what to do for	F	688				
		ent #27 up this morning but ry well. She stated she						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING _				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MANOR C	ARE HEALTH SVCS PIN	EHURST			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	thought she offered to #27 's hands and if th have refused them. N was very cooperative not aware of him refus other aspect of his ca In an interview on 1/1 Director of Nursing st order was put into the the Kardex was popul the bilateral hand carri- into the computer did rather as an FYI. She this way would not ha carrots as a task for th DON stated she was the facility a week or sunaware how the order MAR for the nurses to In an interview on 01/ Rehabilitation Directo therapy was involved management and ord Resident #27 to have as tolerated and to re In an interview on 01/ stated when she initia Resident #27 's hand either because she of aides reported they w Resident #27 did not care. In an observation and 9:20 AM, Resident #27	 b put the carrots on Resident b put the carrots on Resident h #3 stated Resident #27 with his care and she was sing the hand carrots or any 9/18 at 1:20 PM, The ated that when the original e electronic medical record, lated with the new order for rots but whoever entered it not mark it as a task but e stated entering the order in we triggered the hand he aides to document. The interim and had only been at so. She stated she was er was placed on the nursing o sign off on each shift. (19/18 at 1:52 PM, the or confirmed occupational for hand contracture 	F	688			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/23/2018 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C 01/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR C	MANOR CARE HEALTH SVCS PINEHURST				05 RATTLESNAKE TRAIL			
				F	PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From page not yet offered to place In an interview on 01/ stated Resident #27 r hand carrots when sh him. She stated he sh as much as he could them removed, he wo stated she followed w Kardex in the comput In an interview on 01/ Administrator stated if Resident #27 be appl as ordered. Free from Unnec Psy CFR(s): 483.45(c)(3)(§483.45(e) Psychotroo §483.45(c)(3) A psych affects brain activities	e 12 be them. 22/18 at 9:55 AM, NA #4 hever refuses to wear his e was assigned to care for hould wear the hand carrots tolerate and if he wanted build let the staff know. NA #4 that was indicated on the er. 22/18 at 10:30 AM, the t was her expectation ied his bilateral hand carrots chotropic Meds/PRN Use (e)(1)-(5) pic Drugs. hotropic drug is any drug that associated with mental ior. These drugs include,	F	758			2/19/18	
	(iv) Hypnotic Based on a comprehe	ensive assessment of a						
	psychotropic drugs ar unless the medication	nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented						

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/23/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 01/22/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE,	ZIP CODE
MANOR C	ARE HEALTH SVCS PIN	EHURST		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 758	§483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs p unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he o rationale in the reside indicate the duration §483.45(e)(5) PRN o drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev physician interview, a interview, the facility for orders for as needed medications were tim 5 residents (Resident reviewed for unneces The findings included	ants who use psychotropic I dose reductions, and ons, unless clinically a effort to discontinue these ants do not receive ursuant to a PRN order n is necessary to treat a ondition that is documented and rders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. ' is not met as evidenced iew, staff interview, and Pharmacy Consultant failed to ensure physician ' s (PRN) psychotropic e limited in duration for 3 of as #13, #66, and #77) asary medications.	F	The statements made correction are not an a not constitute an agree alleged deficiencies he compliance with all fed regulations, the center take the actions set for plan of correction. The correction constitutes a allegation of compliance alleged deficiencies cit	admission to and do ement with the erein. To remain in leral and state has taken or will rth in the following e following plan of at the center's ce such that all

Event ID: B4BR11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2018 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
				20	05 RATTLESNAKE TRAIL		
	ARE HEALTH SVCS PIN	EHURST		Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG			ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	× 1.4		750			
F 750	Continued From page			758			
	on 5/4/17 with diagno	I most recently readmitted ses that included dementia,			will be corrected by the date indicated.		
	delusional disorder, a	nd personality and			It is the practice of the facility that PRN		
	behavioral disorders.				antipsychotic medications are limited to 14 days. Except as provided in 483.48		
		or Resident #13 dated					
		an (antianxiety medication)			1. Residents #13, #66, and #77 still		
	U	eeded (PRN) every 6 hours.			reside in the facility. PRN psychotropi		
	There was no stop da	te for this PRN Ativan order.			orders were reviewed by the Director of		
	A Pharmacy Consulta	tion Report dated 12/19/17			Nursing on January 22,2018 and adjust by Medical Director according to current		
		armacy Consultant indicated			regulations which is to include time	ii.	
		PRN order for Ativan which			limiting of 14 days unless Doctor believ	/es	
		ater than 14 days and had			it is appropriate and then he will docun		
	no stop date. The Ph	armacy Consultant 's			the rationale and indicate the duration	of	
		to discontinue the PRN			the PRN order. No adverse reactions		
		t the indication for use, the			noted.		
	intended duration, and				2 An eviditures completed on lenver		
		The physician signed the dicated he declined the			 An audit was completed on January 30, 2018 by the Director of Nursing for 		
	recommendation.	dicated he declined the			patients who have orders for psychotro		
					prn medications. PRN orders will be	200	
	The annual Minimum	Data Set (MDS)			reviewed for any patients identified in t	he	
		11/18 indicated Resident			audit. There were 13 residents who w		
	#13 's cognition was				on psychotropic as needed (prn)		
		sessed with no behaviors			medication. All 13 residents were		
	and no rejection of ca				reviewed by Medical Director and orde		
		ion on 7 of 7 days and			to be obtained to make them time limit	ea	
	antianxiety medication	i oli i oli i udys.			and if longer than 14 days, Medical Director to document rationale. Doctor	r	
		t physician ' s orders for			orders will be reviewed by Director of		
		nducted on 1/17/18. The			Nursing and/or Unit Managers.		
		orders included the order					
	dated 9/20/17 for PRI	N Ativan with no stop date.			3. Administrator, Director of Nursing a Unit Managers began educated on		
	A phone interview wa				January 22, 2018 for the Licensed nur		
		on 1/19/18 at 12:04 PM.			which include full time, part time, and p	ber	
		are of the new regulations			diem, Minimum Data Nurse and the		
	regarding PRN psych	otropic medications. He			Interdisciplinary Team (Director of Reh	ab,	

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	F DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	T T	O. 0938-039			
	CORRECTION	IDENTIFICATION NUMBER:	· ,			1 Y /	IPLETED			
						С				
		345177	B. WING			01	/22/2018			
NAME OF PR	ROVIDER OR SUPPLIER	•	-	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•				
				20	95 RATTLESNAKE TRAIL					
WANURC	ARE HEALTH SVCS PIN	ENORSI		PI	INEHURST, NC 28374					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE			
F 758	Continued From page	e 15	F 75	58						
		n making recommendations			Activities Director, Dietician, and Socia	al				
		psychotropic medications to			Service Director) on psychotropic drug					
	be time limited in dur	ation as per the regulations.			requiring end date and re-evaluation.	Any				
	-	ultant indicated for any PRN			nurse who did not attend the education					
		tion (excluding antipsychotic			will be unable to work until the educati	on				
	<i>,</i> .	scriber was required to and indicate a time limited			has been completed. Administrator					
		vas to extend past 14 days.			reviewed with the Medical Director, the regulations on January 22, 2018 and	5				
					again during Quality Assurance					
	An interview was con	ducted with the physician on			Committee Meeting on January 31, 20	18.				
	1/19/18 at 12:48 PM.	The physician 's order for			Medical Director voiced understanding	of	of end			
		9/20/17 for PRN Ativan was			regulations. Any nurse who did not at					
		vsician. The Pharmacy			the education will be unable to work up	ntil				
		dated 12/19/17 for Resident			the educations has been completed.					
		ed a discontinuation of the neutration of the			4 Director of Nursing and/or Unit					
		ation, and the rationale for			 Director of Nursing and/or Unit Managers will conduct audits on PRN 					
		riod was reviewed with the			psychotropic orders weekly x4 weeks	and				
		cian reported he declined			then monthly x2. Results of the audits					
		as he believed the PRN			be reviewed by the facility's Quality					
	Ativan was necessary	y to treat Resident #13 ' s			Assurance Committee monthly x3					
		of extreme agitation and			months. Recommendations for furthe					
		e had not implemented a			action will be reviewed and implement	ed				
		Ativan for Resident #13.			as indicated.					
		ed he thought that an is an acceptable time frame			5. Date of Compliance will be Februar	-v				
		nore specific stop date was			19, 2018.	3				
		he was going to adjust the			,					
	-	Resident #13 with the								
	inclusion of a stop da	te.								
	An interview was con	ducted with the								
		9/18 at 2:11 PM. She								
	indicated she expected									
		tions to have a time limited								
		gulations. She additionally								
	indicated she expected	-								
	document a rationale duration if the PRN p	and indicate the time limited								

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2018 // APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C 22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR C	ARE HEALTH SVCS PIN	EHURST			205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE		
F 758	extend past 14 days. 2. Resident #66 was a The quarterly Minimul 12/19/17 revealed Re hearing and vision and diagnoses were, non- anxiety, depression. The care plan dated 1 #66 was at risk for be and depression, can be insulin administration, effects of psychotropi The physician medicat dated 1/1/18 revealed hours as needed for a have a stop date for re A review of Resident and medication administration resident received Loratimes a week. 3. Resident #77 vas a Resident #77 's phys revealed nursing repo- increased behaviors, was negative. Resident #77 's annu- revealed the resident vision and was able to and understood other impaired cognitive ski and short and long-te	admitted on 10/10/15. m Data Set (MDS) dated sident #66 had adequate d an intact cognition. The Alzheimer's dementia, 12/14/17 revealed Resident haviors due to dementia be non-compliant with , and at risk for adverse c medication. ation order for Resident #66 1 Lorazepam 1 mg every 12 anxiety. The order did not eevaluation. #66 ' s January 2018 ation record revealed the azepam as needed several admitted on 1/6/16. ician's note dated 11/28/17 orted the resident had The physical assessment mal MDS dated 12/26/17 had adequate hearing and o make himself understood	F	758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE			
		345177	B. WING				C 22/2018		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
MANOR C	MANOR CARE HEALTH SVCS PINEHURST			205 RATTLESNAKE TRAIL PINEHURST, NC 28374					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
F 758	diagnoses were, non- depression, and anxie Resident #77 ' s care revealed an interventi dementia, inappropria non-compliance with wandering, difficulty of anti-psychotic medica A review of Resident medication administra resident received Lora times a week. Nurses' note dated 1/ was observed by staff carrying his brief acro assessment brief was brief and redressed re to wander around his furniture around room for agitation and effect signs and symptoms Resident #77 ' s phys 1/1/18 revealed Loraz as needed for agitatic an end date for reeva On 1/19/18 at 1:45 pr conducted with the pr stated that he provide Lorazepam, but had r review for Residents a On 1/19/17 at 4:00 pr conducted with the Ad	Alzheimer's dementia, ety. plan updated 1/8/18 ion for behaviors related to ate undressing, care, potential for communicating, and ation administration. #77 ' s January 2018 ation record revealed the azepam as needed several 4/18 revealed Resident #77 f in his room naked and oss the room. Upon a dry. Staff applied a new esident. Resident continued room and attempt to move h. Ativan was administered ctive on recheck. No further of agitation was noted. dician medication order dated zepam 1 mg every 6 hours on. The order did not have fluation. m an interview was hysician. The physician ed a rationale to continue the not provided an end date for #66 and #77. m an interview was	F	75					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/23/20 FORM APPROVE OMB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 01/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-
MANOR C	ARE HEALTH SVCS PIN	IEHURST		95 RATTLESNAKE TRAIL INEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIO
F 758	date. The Administration change	tion did not have an end ator stated she was aware of e that all psychotropic is needed required an end	F 758		
F 812 SS=E	CFR(s): 483.60(i)(1)(§483.60(i) Food safe The facility must - §483.60(i)(1) - Procu approved or consider state or local authorit	ty requirements. re food from sources red satisfactory by federal,	F 812		2/19/18
	from local producers, and local laws or regu- (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision doe	subject to applicable State ulations. es not prohibit or prevent produce grown in facility ompliance with applicable			
	serve food in accorda standards for food se	prepare, distribute and ance with professional ervice safety. Γ is not met as evidenced			
	to label and date ope discard expired food failed to label and dat nourishment rooms (f included:	interview, the facility failed ned/ thawed items and in the walk-in cooler and		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies herein. To rema compliance with all federal and state regulations, the center has taken or v take the actions set forth in the follow plan of correction. The following plar correction constitutes the center's	id do in in vill ving

Event ID: B4BR11

Facility ID: 923320

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		ND HUMAN SERVICES			FORI	D: 02/23/20 ⁻ MAPPROVE D. 0938-039
TATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345177	B. WING			C / 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		22/2010
				205 RATTLESNAKE TRAIL		
MANOR CARE HEALTH SVCS PINEHURST			PINEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	Continued From page	o 10	F 04			
F 012	10		F 81			
		the cook. Observation		allegation of compliance such t		
		g: a total of 65 cartons of akes thawed and undated, 25		alleged deficiencies citied have will be corrected by the date inc		
		at shakes thawed and				
	-	ons of orange juice thawed		It is the practice of the facility to	o store.	
		acturer's instructions on the		prepare, distribute, and serve f		
	carton for the health	shakes and the orange juice		accordance to professional sta		
		een (14) days after thawing. ler was 1/2 bucket of		food service safety.		
	macaroni salad dated	d to discard 1/14/18, a		1. No residents were identified	I. Outdated	
		m opened with a use by date		items were immediately thrown		
	of 1/7/18 and 1 pack	-		January 16, 2018. Items with n		
	unwrapped and unda	ated.		were also immediately thrown a	•	
	On 1/16/19 at 0:20 A	M on interview was		January 16, 2018 and again on	January	
	On 1/16/18 at 9:20 A	ook who stated dietary staff		19, 2018.		
		rozen great shakes and		2. All residents have the poten	itial to be	
	-	uld use them until the box		affected by this practice.		
	was empty. She said					
		k for outdated/ expired		3. Administrator educated on J	January 16,	
	items.			2018 and January 19, 2018 the	e Food	
				Service Director and on Januar	ry 31, 2018	
	A second observation			with the Interdisciplinary Team,		
		Dietary Manager on 1/19/18 at		included Director of Nursing, U		
		is ¹ / ₂ carton of individual sour		Managers, Director of Rehab, F		
	cream packets with a	an expiration date of 1/8/18.		Service Director, Activities Dire		
		ducted with the Distance		Social Service Director on labe storage and discard of food iter	-	
		nducted with the Dietary at 12 noon. She stated she		Service Director educated all d		
	•	e for checking for labeled,		on labeling and storage and dis	•	
	-	ods in the kitchen. She said		food items. This education beg		
	she checked for item			January 28, 2018.	-	
	morning and before s	-				
				4. Administrator and/or Food S		
		noon, an observation of the		Director will conduct audits on	-	
		ator on Carolina Hall was		storage, and discarding of food		
		ietary Manager. There was		weekly x4 weeks and then mor	-	
		¹ / ₂ of a rotisserie chicken. It		months. These audits will also		
	was not labeled or da	ated. The Dietary Manager		off shifts and on weekends. Re	SUIS OF	

Facility ID: 923320

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				LE CONSTRUC		OMB NO. 0938-	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·		с	
		345177	B. WING		01/22/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE		
				205 RATTLES	NAKE TRAIL		
MANOR C	ARE HEALTH SVCS PI	NEHURST		PINEHURST	, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D 47	
F 812	Continued From pag	e 20	F 81	2			
	· · · · · · · · · · · · · · · · ·	ually checked the refrigerator	101		udits will be reviewed by the		
		poms and all items in the			Quality Assurance Committee		
		posed to be labeled and		-	x3 months. Recommendation	s	
	dated.				er action will be reviewed and ented as indicated.		
				5. Date	of Compliance will be Februar	y	
F 867 SS=E			F 86			2/19/18	
	§483.75(g) Quality a	ssessment and assurance.					
	§483.75(g)(2) The quassurance committee	uality assessment and e must:					
	action to correct ider	ement appropriate plans of itified quality deficiencies; T is not met as evidenced					
	by:						
		views and record review, the			tements made on this plan of		
		sessment and Assurance			on are not an admission to and	do	
		maintain implemented itor the interventions the			stitute an agreement with the deficiencies herein. To remain	in	
	committee put into p			-	nce with all federal and state		
		of 020/3/17. This was for			ons, the center has taken or wil	I	
		ch were recited during the		-	actions set forth in the followin		
		of 01/22/18 in the area of		plan of o	correction. The following plan of	of	
		nt at F656 and F657. The			on constitutes the center's		
		ed was in the area of			on of compliance such that all	.	
	-	at F758. The continued during two federal surveys of			deficiencies cited have been or orrected by the date indicated.		
		ern of the facility 's inability to			on colou by the date indicated.		
		Quality Assessment and		It is the	practice of the facility to develo	p	
		The findings included:		and imp	lement appropriate plans of act	tion	
	This citation is cross	referenced to:			dents #27 care plans were ed and implemented on Janua		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/23/2018 MAPPROVEE D. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	MULTIPLE CONSTRUCTION (SURVEY
		345177	B. WING				C /22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR CARE HEALTH SVCS PINEHURST			20	05 RATTLESNAKE TRAIL		
	ARE HEALTH SVCS PIN	ENURSI		Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Continued From page	e 21	F 8	867			
					22, 2018. Resident #29 care plans w	ere	
		ervations, staff interviews			removed relating to diuretic therapy a		
		ne facility failed to develop a			anticoagulant therapy on January 22,		
		plan for bilateral hand			2018. Residents #13, #66 and #77 w		
		nt # 27) for 1 of 22 residents hensive care planning.			reviewed by Medical Director. Reside #13 medication was discontinued on	ent	
		nensive care planning.			January 23, 2018. Resident #66		
					medication was discontinued on Janu	larv	
	F657-Based on recor	rd review and staff interview,			23, 2018. Resident #77 was changed	•	
	the facility failed to re	eview and revise plans of			read give for 14 days. This was done	on	
		ic therapy and anticoagulant			January 23, 2018.		
		idents (Resident #29)					
	reviewed for unneces	ssary medications.			2. All Residents have the potential to	be	
					affected by this practice who have contractures, diuretic therapy and/or		
		rd review, staff interview, and Pharmacy Consultant			anticoagulant therapy		
		ailed to ensure physician 's			3. Administrator educated		
	orders for as needed				Interdisciplinary (Director of Nursing,		
		ne limited in duration for 3 of			Director of Rehab, Minimum Data Set	t	
		ts #13, #66, and #77)			Nurse, Unit Managers, Food Service		
	reviewed for unneces	ssary medications.			Director, Social Service Director and Activities Director Team on January 2	3	
					2018 on Quality Assurance process a		
	In an interview on 01	/22/18 at 11:11 AM, the			follow up.		
		vledged understanding of the			-		
	reciting of F656, F65	7 and F758 during the			4. Administrator will review validation		
	recertification survey				audits that were completed by Direct		
		the facility recently included			Nursing and/or Unit Managers to ensu	ure	
		e planning process rather			that issues have been resolved or to	nd	
		up to the Minimum Data Set ator stated there had been			address concerns weekly x4 weeks a monthly x2 months. Quality Assurance		
		e administration of the			Committee will meet monthly x3 mo		
	•	with the hiring of a new			and quarterly thereafter to review find		
		nd Unit Managers. She			trends, and to review issues identified		
	added the facility also	o planned to expand the			appropriate action plans and resolution		
		ic medical records program					
		es in the care plan. The			5. Date of Compliance will be Februa	ary	
	Administrator stated	with the new regulations			19, 2018.		

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC). 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	ING _			С	
		345177	B. WING				22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR C	ARE HEALTH SVCS PIN	FHURST			05 RATTLESNAKE TRAIL			
				P	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE	
					DEFICIENCY)			
F 867	Continued From page	e 22	F	867				
	regarding the as need							
	the Medical Director.	d been working closely with						

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