PRINTED: 04/04/2018 FORM APPROVED OMB NO. 0938-0391

, , , , , , , , , , , , , , , , , , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345144	B. WING _				01/2018
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	<u> </u>
PINE RIDG	SE HEALTH AND REHAB	ILITATION CENTER			6 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 SS=G	§483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not limic corporal punishment, any physical or chemit treat the resident's method with the facility failed to provide the facility failed to provide for 1 of 3 resident #1 was admitted the diagnosis per Alzheimer's disease at 12/27/17), pressure ut 12/27/17), state of nu requirements (update A physician) as definition and the facility failed to provide for 1 of 3 resident #1 was admitted to the facility failed to provide for 1 of 3 resident #1 was admitted for the facility failed to provide for 1 of 3 resident #1 was admitted for the facility failed to provide for 1 of 3 resident #1 was admitted for 1 of 3 resident #1 was admitted for 1 of 3 resident for 1 of 3	in Abuse, Neglect, and right to be free from abuse, tion of resident property, offined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. If y must- e verbal, mental, sexual, or or oral punishment, or is not met as evidenced ewed and staff interviews, event neglect as evidenced not being completed as dent reviewed for wound eitted the facility on 10/12/17 ripheral vascular disease, and hypertension. If plan in place for of dementia (updated licers dated (updated trition is less then body	F	600	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible implementing the acceptable plan of correction. F600	e ne re nd	3/19/18
ADODATOS	wound to the left foot				TITLE		(X6) DATE

03/19/2018 **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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING				C 01/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010
	10115211 011 001 1 21211				706 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			FHOMASVILLE, NC 27360		
							I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 1	F	600			
	specifically where), w (cm) x 2 cm x 0.5 cm	hich measured 3 centimeter and this was the initial ion of the wound was 8 days			The plan of correcting the specific deficiency		
	and it had 80% necro				The position of Pine Ridge Nursing an	t	
	surgical debridement	esent. The wound underwent			Rehabilitation center regarding the process that lead to this deficiency-fail	uro	
		ated 2/2/18 revealed that the			to provide requested incontinence care		
		to be packed with sterile			was failure to follow established facility		
		wrapped with Kerlix every			policy for wound care.		
					Resident #1 was discharged on 2/5/20	18.	
		istration Record (TAR) for					
		d to pack with sterile gauze			The procedure for implementing the		
		p with Kerlix everyday			acceptable plan of correction for the		
	_	e TAR revealed that it was			specific deficiency cited		
		The TAR was blank for the			Dy 2/10/19 the director of pureing (DO	NI)	
	lollowing dates of 2/3	/18, 2/4/18 and 2/5/18.			By 3/19/18 the director of nursing (DO assistant director of nursing (ADON)	N),	
	There was no nursing	or progress noted for			and/or the quality assurance (QI) nurse	ے	
	_	that indicated wound care			will complete a skin inspection of all	•	
	was completed for thi				residents currently in the facility. Any		
		t shift with the resident on			negative findings were immediately		
	,	r of facility on 2/3/18, 2/4/18			addressed by the auditor. This audit w	ill	
		ft) was interviewed on			ensure all wounds are identified and		
	2/28/18 at 2:02 PM. S	She stated that the resident			treatments are being provided as orde	red.	
	was not alert and orie	ented and was very			No neglect noted related to treatments		
		nt had an amputation to one			On 3/13/18 the facility hired a treatmer	ıt	
		ind to her other leg. The			nurse. This treatment nurse started		
		seeing the wound. She			employment in the facility on 3/13/18.		
		know of any new recent			On 3/16/18 the facility formulated a pla	n to	
		ent had. The resident had			ensure treatments are completed if a		
		. She stated that nurses and			treatment nurse is not available. This p	nan	
		he hall were supposed to do but medication aides could			is for the hall nurses to complete treatments and assessments in the		
		to stage 1 and 2 wounds.			absence of the treatment nurse and th	Δ	
	as areasing changes	to stage i and 2 wounds.			scheduled assessments will be broken	-	
	 Medication Aide #1 w	as interviewed on 2/28/18 at			down by hall so that every resident is		
		the resident would swat at			assessed every 7 days.		
		he resident had a wound on			On 3/9/18 the facility consultant		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7. BOILDII	_		، ا	С
		345144	B. WING _				01/2018
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010
					06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			HOMASVILLE, NC 27360		
	OUR MARK OT	ATTIMENT OF REFIGIENCIES			· T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 2	F	300			
	· -	tated leg and a splint in			in-serviced the DON on wound		
		at the dressing sometimes.			assessment, including documentation	and	
		another wound on her			completion of treatments.	aa	
		I that she went one time to			On 3/9/18 the staff facilitator (SF) was		
		nurse with dressing change			in-serviced by the DON on wound		
	•	er refused care. After the			assessment, including documentation,		
	wound care nurse sto	pped working at the facility,			and completion of treatments.		
		e to change the dressings			By 3/19/18 all licensed nurses, includir	•	
		ted that she never changed			the newly hired treatment nurse, will be	;	
	the dressing to the resident feet, legs or knees				in-serviced by the SF on wound		
	•	ssisted the wound care			assessment, including documentation,		
		stated that the Nursing			and completion of treatments. This		
		d tell the supervising nurse if			in-service will be part of the orientation		
	_	be changed after they gave			process for all newly hired licensed nurses.		
		n between giving medication. nd was a stage 1 or 2, it			The monitoring procedure to ensure the	at	
		d in the treatment book.			the plan of correction is effective and the		
	would be decamented	a in the treatment book.			specific deficiency cited remains correct		
	Nurse #8 (The super	visor on 2/3/17 and 2/4/17			and/or in compliance with the regulator		
		interviewed on 2/28/18 at			requirements	,	
		e did not think he directly			'		
		ent in February, 2018. The			By 4/1/18 the treatment nurse QI, ADC	N,	
	resident needed exte	nsive assistance with care.			and DON will have follow-up observation	on	
		ent had a wound on her knee			and in-servicing as appropriate by the		
	and sacrum. He did n	ot remember any wounds to			corporate wound consultant, or facility		
		about any dressing changes.			consultant to ensure wound policies are	е	
		s interviewed on 2/28/18 at			being followed, including assessment,		
		doctor was doing the wound			documentation, and treatment complet	ion.	
	_	veek. The nurses should			The DON ADON and/or Olympia will		
	_	und assessments. The			The DON, ADON, and/or QI nurse will	do	
	about a month ago.	opped working at the facility			audit all treatment administration record (TARs) 5 times weekly x 12 weeks, to	uS	
	about a month ago.				include weekends, to ensure no holes	are	
	Nurse #7 (rounds with	n wound care doctor weekly			present on the TAR. This audit will be	ui C	
	,	interviewed on 2/28/18 at			documented on the TAR audit tool.		
	3:59 PM. She stated				The DON, ADON, and/or QI nurse will		
		und care doctor on Fridays.			audit all pressure and non-pressure		
	_	ent had a wound on her			wounds weekly x 4 weeks then 50% of		
		saw the wound, it was a			pressure and non-pressure wounds		

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		345144	B. WING			03/	01/2018
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI	70 TI X	TREET ADDRESS, CITY, STATE, ZIP CODE OF PINEYWOOD ROAD HOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)	TAG		DEFICIENCY)	.16	
F 600	resident's family on 1 do debridement of the ankle was wrapped in resident was getting of 2/2/17, the resident's and the family wanter family agreed to have the wound on 2/2/18 bedside. She stated the with blackish tissue as was preventing it from the dressing changes the first shift for this regetting anacept to the Nurse #5 (worked wit 2/4/17 on 2nd shift) which was a special to the followed simple commounds and she wounds and she wounds and she wounds and she wounds acral area and vulvation knew of a wound on the stated that her did one at any time durit treatment book and the documented wound of Medication aides could ressing changes the 1st shift doesn't do do 2nd shift would try to they don't have a woot they really need one keep up.	ated that had called the /26/18 to get permission to e wound. The resident's a Kerlix so she thinks the dressing changes. On family was at the bedside d to see the wound. The e it debrided. They dressed and the family was at the the ankle wound was white round it and the black area in healing. She thinks that is were usually completed on esident. The resident was e ankle wound. The resident on 2/3/17 and was interviewed on 2/28/18 at it was very confused but mands. The resident had lid do wound care for a no treatment nurse. The on her toes, knee and a She stated she never the resident's ankle and had ressing change to her ankle. The sing changes could be ng the day. They have a	F	600	weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool. The monthly QI committee will review to results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administration and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive Quantities for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible firmplementing the acceptable plan of correction.	he of or od	

Facility ID: 923017

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING			1	C / 01/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	101/2016
					706 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			THOMASVILLE, NC 27360		
0/0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	<u> </u>	(45)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 4	F	600	0		
	and 2/3/18) was inter	viewed on 2/28/18 at 4:37					
		she help the wound care					
		sing a while ago but had					
		changes this month for this					
	_	that the supervising nurse					
		care on 1st shift most of the					
	time. The resident wa	as getting dressing change					
	completed in the mor	ning unless something					
	happens. She never l	knew of a wound to the					
	resident's ankle.						
	,	2/3/18 and 2/4/18 on third					
		ervisor for the facility those					
		d on 3/1/18 at 9:14 AM. She					
		nt was asleep most of the					
		s at times. The resident					
		mes. The resident had a					
	_	l area, left knee and sacral					
		as combative sometimes dent had many contractions					
	_	n her as much as possible.					
	-	loes not remember about a					
		t's foot/ankle area and had					
		mpted a dressing change to					
	-	eg. She only had completed					
		dent's knee occasionally					
	_	und pull off the dressing.					
	Since the treatment n	urse left, the even					
	numbered rooms, the	1st shift nurse would					
	complete the dressing	g changes and the odd					
	numbered rooms, 2nd	d shift would complete the					
	dressing changes for						
	anything about a wou	inds on the resident's ankle.					
		not even remember if the					
		ng on her foot or not before					
	_	the stated she usually					
	worked 300 and 400	halls and would have to					
		ng Assistant called out. She					
	stated they tried their	best to do things for this					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 3/01/2018	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		3/01/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	she wouldn't necess change a dressings should do it. Wound her shift so she can being done for resid was not done then so the shift for this resident at 9:27 AM. She sta work 200 hall and we there was a medicat that if they dressing wound do the even shift would do the or hall. For major wour dressing changes. Tallowed to do skin per major dressing's changes and nurses are respenow. She stated that through the TAR and changes that neederesidents. She stated dressing changes or remember the resident's wound can completed on 1st she even numbered room. Nurse #4 (worked 1: 2/4/18) was interview stated the resident work	we to prioritize their work and ary wake up this resident to and typically another shift care usually does not fall on not say if the wound care was ents but if she was told that it he would typically do it. In g nurse on 2/2/18 on second (a) was interviewed on 3/1/18 ted that usually she would could supervise the 400 hall if ion aide working. She stated changes to do, that 1st shift numbered rooms and 2nd did numbered rooms for that tods, the nurses had to do the the medication aides were reps and creams but not anges. The medication aides onsible for dressing changes at she would typically go did to the major dressing did to be completed for did that she had never done in this resident and doesn't ent's wounds in particular but resident. She stated the re should have been iff because she was in an	F 6				

l l		
345144 B. WING		C 03/01/2018
PINE RIDGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	00.0.1.20.10
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 600 Continued From page 6 and coccyx area. He stated he does not recall any wounds to her other leg (non-amputated leg). He stated that he has only completed the dressing changed to the resident's knee and the resident would let him do the dressing change. If a dressing change is completed, it is documented on the TAR or in the nursing notes. Since there was no treatment nurse, the dressing change are not done as regularly. Nurse #3 (worked on 2/2/18 on 3rd shift) was interviewed on 3/1/18 at 10:04 AM. She stated that she worked night shift from 11:00 PM to 7:00 AM. She stated she had never cared for any of the resident's wounds and did not know about them specifically because she had never changed the dressings. The resident would be resistive with care but she usually could provide her with care. At night, if there was a new wound then she wound do the wound care if needed. A nursing note dated 2/5/18 revealed that at 1:30 PM, the resident's family and relative stated there was something wrong with the resident. Vitals were taken and revealed the following: Temperature was 99.7, heart rate was 114 and irregular, respirations were 20 and blood pressure was 110/70. The writer was unable to hear breath sounds and the physician was notified. The resident's family insisted that the resident needed to go to the hospital and Emergency Medical Services (EMS) were called and the resident was transported at 1:45 PM to the hospital. The resident was admitted to the hospital on 2/5/18. Hospital records dated 2/5/18 revealed that the resident was admitted to the hospital. Hospital		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	1	PLETED
		345144	B. WING _				C 01/2018
	ROVIDER OR SUPPLIER BE HEALTH AND REHAL	BILITATION CENTER		706	EET ADDRESS, CITY, STATE, ZIP CODE PINEYWOOD ROAD DMASVILLE, NC 27360	1 03/	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	hospital with a wound measured 7 cm x 3 cunderlying tendon, but infected per the Emethospital records also was diagnosed with a source related to infewas the worst. Antibit recommended that the knee amputation. Ho spoken with to the faplaced on hospice cata skilled nursing facil. Resident's #1 dischated 2/5/18 revealed that cognitively impaired had short term memoral behaviors of rejeweek and physical beforeured 1 to 3 days extensive assistance locomotion and eating assistance with personal dressing and transferincontinent of bowel had a stage 3 pressure ulcer. The promise of the wound Care Do 3/1/18 at 10:38 AM. The foot near the ank facility (when asked a new left foot wound with the residual stage of the wound stage. The wound stage of the wound stage of the wound stage.	resident presented to the d to her left ankle that and had exposed lack eschar and smelled regency department note. To revealed that the resident sepsis with the suspected exted wound to her ankle as it otics were started and it was ne resident had an above the wever, the risks were mily and the resident was are instead and transferred to ity. Transferred to a days per estated to a days per e	F	600			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	, ,	ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		03/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	debrided. He stated in dressing changes we been told otherwise. his previous assessment wound. He stated that concerns with wound a great wound care in here anymore, he that still being completed. wound was avoidable the knee amputation contractures. The resident they wound care in thought it may have bettimes. The Administrator was 12:51 PM. She stated worse and the reside and had an above the vascular issues. The facility after the resident hey were possibly an other leg. She stated notes and the hospitationing that bad. The changed were being and the wound care or resident. There were changes that she kneed had a pressent the only ones that constated that the wound was on 1/14/18. She	d in necrotic tissue and it was	F 6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER GE HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	P CODE	33.0 1123.13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIA	DATE
F 641 SS=D	§483.20(g) Accuracy The assessment mu resident's status. This REQUIREMEN by: Based on record rev facility failed to code was not a physician Data Set assessmer reviewed for nutrition The findings included Resident #1 was add with the diagnosis of and Alzheimer's dise A physician's order of the resident was on diet. Resident #1 had a co (dated 12/13/17) and the body's requirement intake (dated 12/28/) A note from the Reg 1/16/18 revealed Re assistance with mea lunch and dinner and at lunch and dinner. ground diet and was supplements. The re loss in the last 3 mor pounds. Weights were review	of Assessments. It is not met as evidenced riew and staff interviews, the significant weight loss that prescribed on a Minimum of for 1 of 3 residents in (Resident #1). It is not met as evidenced riew and staff interviews, the significant weight loss that prescribed on a Minimum of for 1 of 3 residents in (Resident #1). It is not met as evidenced riew and staff interviews, the significant weight loss that prescribed on a Minimum of the staff of the staff interviews, the significant weight loss that a regular, ground textured are plan in place for eating if for nutrition was less than ents related to inadequate	F 6	An acceptable plan of cocontain the following eler The plan of correctind deficiency. The plan shorp processes that lead to the cited; The procedure for in acceptable plan of correcting the monitoring processes that the plan of correction that specific deficiency cited; The monitoring processes that lead to the plan of correction that specific deficiency cited; The title of the person implementing the acceptation of the person implementing the acceptation. F641 Accuracy of Assess The plan of correcting the deficiency The position of Pine Ridg Rehabilitation center region process that lead to this of the staff failure to follow of the procedure in accurately of with significant weight lose physician prescribed related deficit. On 3/1/18 resident # 1 as	ments: ng the specific uld address the ne deficiency mplementing th ction for the redure to ensur n is effective ar ited remains pliance with the responsible rable plan of sments e specific ge Nursing and arding the deficiency was established coding resident as that was not ated to knowled	e re nd for t

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					06 PINEYWOOD ROAD		
PINE RIDO	BE HEALTH AND REH	ABILITATION CENTER			HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pa	ge 10	F	641			
	the resident weight that the resident ha 6.60% in the last m	ed 99 pounds. This revealed d a significant weight loss of onth.			2/5/18 was modified by the minimum d set nurse (MDS). The modified assessment was submitted and accept by the national repository on 3/1/18.		
	(MDS) dated 2/5/18 severely impaired of making and had sh The resident require eating. The dischar weighed 99 pounds	arge Minimum Data Set B revealed the Resident #1 had cognition for daily decision ort term memory problems. ed extensive assistance with ge MDS noted the resident b, was 86 inches in height and prescribed weight loss			The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 3/8/18 the facility consultant completed an audit of minimum data s (MDS) assessment completed and transmitted in the past 90 days to ensusection K coding for weight loss was correct. Five MDS assessments were		
	2/28/18 at 2:12 PM had 14.5 % weight to her note in Janua ordered 2 different supplements for we supplements. The figround diet and wa potatoes with gravy She stated the Resplanned weight loss	titian (RD) was interviewed on . The RD stated Resident #1 loss in the 3 months according ary. The Resident had been types of nutritional eight loss and was taking her Resident was on a regular, s getting ice cream, mashed and supplements with meals. ident #1 was never on a diet and the MDS Nurse had of the discharge MDS.			noted to be coded incorrectly for physic prescribed weight loss in section K. On 3/9/18 the dietary manager modifies the 5 incorrectly coded MDS section K. On 3/8/18 the facility consultant in-serviced the MDS coordinator on MI accuracy to reflect the residents currer status including coding of section K based on the RAI manual. On 3/9/18 the facility consultant in-serviced the dietary manger on MDS accuracy to reflect the residents currer status including coding of section K based on the RAI manual in-serviced the dietary manger on MDS accuracy to reflect the residents currer status including coding of section K based on the RAI manual including coding of section K based on the RAI manu	d □s. OS oft sed	
	2:50 PM. She state section of the MDS did have significant discharge MDS dat Resident #1 was or regimen and this was not on a physic regimen. She adde code this section be because she coded	as interviewed on 2/28/18 at d she coded the nutrition dated 2/5/18 and Resident #1 weight loss. She stated the ed 2/5/18 revealed that a prescribed weight loss as an error as the resident cian prescribed weight loss d that normally dietary would at the RD must have been out at this section of the MDS. The led that she normally reviewed			on the RAI manual. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, MDS coordination or administrator will audit 100% of submitted MDS assessments weekly x weeks then 50% of submitted MDS assessments x 8 weeks to ensure sect K is accurately coded to reflect the	at nat cted ry tor,	

Facility ID: 923017

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	B. WING _			l	01/ 2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	BILITATION CENTER		70	REET ADDRESS, CITY, STATE, ZIP CODE 16 PINEYWOOD ROAD HOMASVILLE, NC 27360	1 00.	0172010
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	e 11	F6	641			
	the dietary notes, phy supplements and the order to code this sec	resident's actual weights in			residents current status based on the F manual. This audit will be documented the MDS Audit Tool		
	12:51 PM. She stated reflect the resident's of	s interviewed on 3/1/18 at at the MDS should accurately current health status.			The monthly QI committee will review to results of the MDS Audit Tool monthly of 3 months for identification of trends, actions taken, and to determine the new for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	or ed es e. ent ne	
F 684 SS=G	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profestice, the compreheare plan, and the residents.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure it treatment and care in essional standards of nensive person-centered	F6	884			3/19/18
		iew and staff interviews, the			An acceptable plan of correction must		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345144	B. WING _				03/01/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				70	6 PINEYWOOD ROAD			
PINE RID	GE HEALIH AND RE	HABILITATION CENTER		TH	HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From p	page 12	Fé	684				
	'	omplete dressing changes for a			contain the following elements:			
		esident reviewed for wound			The plan of correcting the specific	:		
	care (Resident #1				deficiency. The plan should address th			
	,	•			processes that lead to the deficiency			
	Findings included	:			cited;			
					" The procedure for implementing the state of the procedure for implementing the state of the	ne		
		admitted the facility on 10/12/17			acceptable plan of correction for the			
		s peripheral vascular disease,			specific deficiency cited;			
	Alzheimer's disea	se and hypertension.			The monitoring procedure to ensu			
	The resident had	a care plan in place for			that the plan of correction is effective a that specific deficiency cited remains	iriu		
		ue to dementia (updated			corrected and/or in compliance with the	_		
		re ulcers dated (updated			regulatory requirements;	•		
		f nutrition is less then body			" The title of the person responsible	for		
	requirements (up	dated 12/28/17).			implementing the acceptable plan of correction.			
	A physician's wou	and note from the wound care						
		18 revealed the resident had a			F684			
		foot (the note did not say						
		e), which measured 3 centimeter			The plan of correcting the specific			
	evaluation. The d	cm and this was the initial uration of the wound was 8 days			deficiency			
		ecrotic tissue and 20%			The position of Pine Ridge Nursing an	d		
	-	e present. The wound underwent			Rehabilitation center regarding the	1		
	surgical debridem	nent.			process that lead to this deficiency-fail	ea		
	A physician's orde	er dated 2/2/18 revealed that the			to complete dressing changes for a wound was staff failure to follow			
	1	was to be packed with sterile			established policy related to knowledg	6		
		and wrapped with Kerlix every			deficit.	C		
	day.	,,						
					Resident #1 was discharged to the			
		dministration Record (TAR) for			emergency room on 2/5/18.			
		ealed to pack with sterile gauze						
		wrap with Kerlix everyday			The procedure for implementing the			
	_	. The TAR revealed that it was			acceptable plan of correction for the			
		/17. The TAR was blank for the 5/2/3/18, 2/4/18 and 2/5/18.			specific deficiency cited			
	Tollowing dates of	2.0/10, 2/7/10 and 2/0/10.			By 3/19/18 the director of nursing (DO	N)		
	There was no nur	rsing or progress noted for			assistant director of nursing (ADON)	٠٠,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI			Ι,	c l
		345144	B. WING				01/2018
NAME OF P	ROVIDER OR SUPPLIER	L	ı	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	. 03/	01/2010
					06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			HOMASVILLE, NC 27360		
24.0.1=	CLIMMADY CT	TATEMENT OF DEFICIENCIES	- 15	-			0/5)
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 13	F	684			
		3 that indicated wound care			and/or the quality assurance (QI) nurse	į	
	was completed for th				will complete a skin inspection of all		
	' 				residents currently in the facility. Any		
	Nurse #1 (Worked 1s	st shift with the resident on			negative findings were immediately		
	2/2/18 and superviso	r of facility on 2/3/18, 2/4/18			addressed by the auditor. This audit wi	II	
	and 2/5/18 for 1st shi	ft) was interviewed on			ensure all wounds are identified and		
		She stated that the resident			treatments are being provided as order		
	was not alert and orie	-			On 3/13/18 the facility hired a treatmen	t	
		nt had an amputation to one			nurse. This treatment nurse started		
	_	und to her other leg. The			employment in the facility on 3/13/18.		
		s seeing the wound. She			On 3/16/18 the facility formulated a pla	n to	
		know of any new recent dent had. The resident had			ensure treatments are completed if a treatment nurse is not available. This p	lan	
		e. She stated that nurses and			is for the hall nurses to complete	lall	
		the hall were supposed to do			treatments and assessments in the		
		s but medication aides could			absence of the treatment nurse and the	3	
		to stage 1 and 2 wounds.			scheduled assessments will be broken		
		•			down by hall so that every resident is		
	Medication Aide #1 w	as interviewed on 2/28/18 at			assessed every 7 days.		
	2:11 PM. She stated	the resident would swat at			On 3/9/18 the facility consultant		
		the resident had a wound on			in-serviced the DON on wound		
		itated leg and a splint in			assessment, including documentation a	and	
		at the dressing sometimes.			completion of treatments.		
		d another wound on her			On 3/9/18 the staff facilitator (SF) was		
		that she went one time to			in-serviced by the DON on wound		
		nurse with dressing change er refused care. After the			assessment, including documentation, and completion of treatments.		
		opped working at the facility,			By 3/19/18 all licensed nurses, including	α.	
		re to change the dressings			the newly hired treatment nurse, will be	•	
		ated that she never changed			in-serviced by the SF on wound		
		sident feet, legs or knees			assessment, including documentation,		
	_	assisted the wound care			and completion of treatments. This		
	_	stated that the Nursing			in-service will be part of the orientation		
	Assistants (NA) would	d tell the supervising nurse if			process for all newly hired licensed		
	_	be changed after they gave			nurses.		
		n between giving medication.					
		nd was a stage 1 or 2, it			The monitoring procedure to ensure the		
	would be documente	d in the treatment book.			the plan of correction is effective and the		
					specific deficiency cited remains correct	:ted	1

		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 03/01/2018		
NAME OF D	ROVIDER OR SUPPLIER	0.0.4.1			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	01/2016	
NAME OF T	TOVIDER OR SOLT LIER				06 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER			HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 14	F	684				
F 084	Nurse #8 (The super on second shift) was 2:42 PM. He stated h took care of the reside resident needed extered the thought the reside and sacrum. He did in her feet or ankles or a state of the thought the reside and sacrum. He did in her feet or ankles or a state of the thought the word assessments every was be doing the word wound care nurse state about a month ago. Nurse #7 (rounds with and SDC nurse) was 3:59 PM. She stated rounding with the word She stated this reside ankle. When she first stage 3 or so. She state of the the the word debridement of the ankle was wrapped in the tresident was wrapped w	visor on 2/3/17 and 2/4/17 interviewed on 2/28/18 at e did not think he directly ent in February, 2018. The nsive assistance with care. ent had a wound on her knee not remember any wounds to about any dressing changes. Is interviewed on 2/28/18 at doctor was doing the wound week. The nurses should and assessments. The apped working at the facility interviewed on 2/28/18 at that her job included and care doctor on Fridays. Ent had a wound on her saw the wound, it was a fated that had called the 1/26/18 to get permission to be wound. The resident's in Kerlix so she thinks the		684	and/or in compliance with the regulator requirements By 4/1/18 the treatment nurse QI, ADO and DON will have follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, and treatment completed. The DON, ADON, and/or QI nurse will audit all treatment administration record (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes appresent on the TAR. This audit will be documented on the TAR audit tool. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool.	N, on e ion. ds are		
	2/2/17, the resident's and the family wante family agreed to have the wound on 2/2/18 bedside. She stated with blackish tissue a was preventing it from the dressing changes the first shift for this rigetting anacept to the	dressing changes. On family was at the bedside d to see the wound. The e it debrided. They dressed and the family was at the the ankle wound was white round it and the black area in healing. She thinks that is were usually completed on esident. The resident was e ankle wound.			The monthly QI committee will review to results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrat and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive Q committee for further recommendations and oversight.	or nd		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345144	B. WING			C			
NAME OF B	20/4050 00 01 1001 150	040144	5		TREET ADDRESS SITY STATE 7/D SORE	03/	01/2018		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER		7	06 PINEYWOOD ROAD				
				Т	HOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 684	Continued From pag	ge 15	F	684					
		was interviewed on 2/28/18 at							
		ent was very confused but			The title of the person responsible for				
		mands. The resident had			implementing the acceptable plan of				
	•	uld do wound care for			correction.				
		s no treatment nurse. The			The Director of nursing is responsible f	ior			
		s on her toes, knee and			implementing the acceptable plan of	Oi			
		a. She stated she never			correction.				
		the resident's ankle and had			correction.				
		Iressing change to her ankle.							
	-	dressing changes could be							
		ring the day. They have a							
	treatment book and								
		care. She stated that the							
		uld only do wound care							
		at were simple. She stated							
		dressing changes often and							
		do them. She stated that							
	they don't have a wo	ound care nurse anymore and							
	they really need one keep up.	as she was trying to just							
		(worked 2nd shift on 2/2/18							
		rviewed on 2/28/18 at 4:37							
	PM. She stated that	she help the wound care							
	doctor change a dre	ssing a while ago but had							
	never done dressing	changes this month for this							
	resident. She stated	that the supervising nurse							
	would do the wound	care on 1st shift most of the							
	time. The resident w	as getting dressing change							
	completed in the mo	rning unless something							
	happens. She never	knew of a wound to the							
	resident's ankle.								
		n 2/3/18 and 2/4/18 on third							
	-	pervisor for the facility those							
		ed on 3/1/18 at 9:14 AM. She							
		ent was asleep most of the							
		us at times. The resident							
		times. The resident had a							
	wound to her inguina	al area, left knee and sacral							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 50125	_		(· .
		345144	B. WING				01/2018
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	0112010
				7	06 PINEYWOOD ROAD		
PINE RID	GE HEALTH AND REHA	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	during care. The resi and they tried to clea She stated that she o wound to the resider never completed/atte a wound on her foot/ a dressing to the res when the resident wo Since the treatment in numbered rooms, the complete the dressin numbered rooms, 2n dressing changes for anything about a wor She stated she could resident had a dress she was discharge. S worked 300 and 400 cover when the Nurs stated they tried their resident but they hav she wouldn't necess change a dressings a should do it. Wound her shift so she cann being done for reside was not done then sl Nurse #2 (supervisin shift for this resident) at 9:27 AM. She stat work 200 hall and wo there was a medicati that if they dressing o wound do the even r shift would do the od	as combative sometimes dent had many contractions in her as much as possible. does not remember about a it's foot/ankle area and had empted a dressing change to leg. She only had completed ident's knee occasionally bund pull off the dressing.	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTE	RUCTION	(X3) DATE SURVEY COMPLETED C		
		345144	B. WING				01/2018	
	ROVIDER OR SUPPLIER GE HEALTH AND REH	ABILITATION CENTER		706 PINE	DDRESS, CITY, STATE, ZIP CODE YWOOD ROAD SVILLE, NC 27360	1 001	0172010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 684	major dressing's chand nurses are response. She stated that through the TAR are changes that neederesidents. She stated dressing changes of remember the resident's wound care completed on 1st seven numbered room to the resident was interviewed to the resident that be combativeness. However, any wounds to her the stated that he had coccyx area. Hany wounds to her the stated that he had resident would let had re	preps and creams but not langes. The medication aides ponsible for dressing changes at she would typically go and do the major dressing ed to be completed for ed that she had never done on this resident and doesn't dent's wounds in particular but a resident. She stated the are should have been with the because she was in an orm. Its shift on 2/3/18 and on ewed on 3/1/18 at 9:51 AM. He was only oriented to person, ehaviors and had intermittent wever, he never personally lent being combative. He had a wound on her left knee the stated he does not recall other leg (non-amputated leg), as only completed the othe resident's knee and the pair of the dressing change. If its completed, it is documented the nursing notes. Since there the urse, the dressing change are	F	584				
	the resident's wounthem specifically be	e had never cared for any of ds and did not know about ecause she had never ngs. The resident would be						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345144	B. WING _			C 03/01/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		0/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	her with care. At nighthen she wound do A nursing note date PM, the resident's was something wrowere taken and reverse taken and reverse taken and reverse taken and the phyresident's family instead to go to the hospital Services (EMS) we transported at 1:45. The resident was a 2/5/18. Hospital records daresident was admit records revealed the hospital with a wounderlying tendon, infected per the Em Hospital records als was diagnosed with source related to in was the worst. Antirecommended that knee amputation. It spoken with to the placed on hospice a skilled nursing faction of the placed on hospice a skilled nursing factions. Resident's #1 discharge to the cognitively impaired the cognitive the	out she usually could provide ght, if there was a new wound the wound care if needed. Ed 2/5/18 revealed that at 1:30 family and relative stated there ong with the resident. Vitals realed the following: 19.7, heart rate was 114 and ons were 20 and blood pressure riter was unable to hear breath sysician was notified. The sisted that the resident needed all and Emergency Medical one called and the resident was PM to the hospital. In dmitted to the hospital on the detect of the hospital. Hospital one resident presented to the not to her left ankle that is cm and had exposed black eschar and smelled hergency department note. The sor revealed that the resident many separations with the suspected of fected wound to her ankle as it biotics were started and it was the resident had an above the dowever, the risks were family and the resident was care instead and transferred to	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345144	B. WING _			03/	01/ 2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
DINE DID	NE LIEALTH AND DELLAD	NU ITATION OFNITED		706 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHAB	BILITATION CENTER		THOMASVILLE, NC 27360			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 684	week and physical be occurred 1 to 3 days. extensive assistance locomotion and eating assistance with persodressing and transfer incontinent of bowel a had a stage 3 pressur pressure ulcer. The pcm x 2.1 cm x 00.2 cm. The Wound Care Doc 3/1/18 at 10:38 AM. Ther foot near the anklifacility (when asked snew left foot wound withat nursing discovere sure. The wound star point had deteriorated.	ction of care 1 to 3 days per chavioral symptoms that The resident required with bed mobility, g. The resident required total and hygiene, toilet use, s. The resident was always and of bladder. The resident re ulcer and 1 stage 4 ressure ulcer measured 2.8 m. ctor was interviewed on the resident had a wound to be that had occurred at the expecifically about where the vas in his note). He thought ted the wound but wasn't ted as a scab and at some d. The last time he saw the	F6	584			
	debrided. He stated he dressing changes we been told otherwise. Ihis previous assessme wound. He stated that concerns with wound a great wound care in here anymore, he thoustill being completed. wound was avoidable the knee amputation accontractures. The resido they wound care be thought it may have be times. The Administrator was	In necrotic tissue and it was the assumed that the re being done and had not it was just a scab earlier on the then had formed into a the didn't know of any care and they used to have urse. Since she was not the the wound care was the did not think that the earlier and had multiple ident would always let him but had dementia and he the the the that the the the that the that the wounds had gotten in the wounds had					

l ' '		IDENTIFICATION NUMBER		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 5/01/2018	
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		70172010	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	and had an above the vascular issues. The facility after the reside they were possibly ar other leg. She stated notes and the hospite doing that bad. The changed were being and the wound care cresident. There were changes that she kne changes were comple on the TAR. The med a stage 1 and 2 press the only ones that constated that the wound was on 1/14/18. She there to be adequate care to residents. Treatment/Svcs to Pr CFR(s): 483.25(b)(1) Pressues and on the compreresident, the facility in (i) A resident receives professional standard pressure ulcers and of ulcers unless the indidemonstrates that the (ii) A resident with prenecessary treatment with professional start promote healing, prenew ulcers from developments and developments.	Int was combative with staff be knee amputation with family had come back to the ent was discharged and said imputating the resident's that she read the hospital all said the resident was not creatments for dressing completed by the hall nurses doctor was seeing the no concern of dressing ew of. Usually the dressing eted daily and documented dication aide could complete sure ulcer but a nurse were uld stage a wound. She dicare nurse's last work day stated she would expect for staffing to provide wound event/Heal Pressure Ulcer (i)(ii) grity are ulcers. The ensive assessment of a nust ensure that- as care, consistent with dis of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and assure ulcers receives and services, consistent indards of practice, to vent infection and prevent	F 68			3/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345144	B. WING _			0:	C 3/01/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/01/2010	
					706 PINEYWOOD ROAD			
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER			THOMASVILLE, NC 27360			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECT			(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI; TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 686	Continued From page	e 21	F	686				
	by:							
	Based on record rev	iew and staff interviews, the			An acceptable plan of correction must			
		s a pressure ulcer for 1 of 3			contain the following elements:			
		r pressure ulcers (Resident			" The plan of correcting the specific			
	#2).				deficiency. The plan should address the	.e		
					processes that lead to the deficiency			
	Findings included:				cited;			
	1 Decident #2 was a	dmitted to the facility on			" The procedure for implementing the	ıe		
		dmitted to the facility on ent diagnosis of dementia,			acceptable plan of correction for the specific deficiency cited;			
		peripheral vascular disease			" The monitoring procedure to ensu	re		
	and multiple contract				that the plan of correction is effective a			
					that specific deficiency cited remains			
	Resident #2 quarterly	Minimum Data Set (MDS)			corrected and/or in compliance with the	Э		
	dated 12/22/17 revea	led that the resident was not			regulatory requirements;			
		e resident required extensive			" The title of the person responsible	for		
	assistance with bed r				implementing the acceptable plan of			
		and total assistance with			correction.			
		and personal hygiene. The			5000			
	-	incontinent of bowel and			F686			
		had no unhealed pressure			The plan of correcting the aposition			
	for the bed.	a reducing pressure device			The plan of correcting the specific deficiency			
	ioi tile bed.				deficiency			
	The resident had a ca	are plan in place updated on			The position of Pine Ridge Nursing and	d		
	1/30/18 for pressure	ulcers.			Rehabilitation center regarding the			
					process that lead to this deficiency-fail	ure		
	A wound care assess	ment dated 1/2/18 revealed			to assess a pressure ulcer- was staff			
		a wound to his right heel			failure to follow established policy and			
		use that measured 0.5 cm x			procedure.			
	0.3 cm x 0 cm and wa	_			Desident # Oberd entire about accorde	L		
	notified on 1/2/18.	tive and physician was			Resident # 2 had a skin check complete	.eu		
	110111100 011 1/2/10.				on 3/2/18 by facility nurse. Resident #2□s right heel wound was			
	 Physician's orders da	ited 1/2/18 revealed that the			assessed and documented in the skin			
		order to cleanse the area			check on 3/2/18 by facility nurse.			
	with wound cleanser,				S. S. S. S. S. Z. To by Idolity Haros.			
		dressing and to change			The procedure for implementing the			
	every 2 days.				acceptable plan of correction for the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345144	B. WING			1	C (04/2048
NAME OF D	ROVIDER OR SUPPLIER	0.01.11			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	01/2018
TVAIVIL OF T	TOVIDER OR GOLT EIER				706 PINEYWOOD ROAD		
PINE RIDO	SE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	a 22		686			
1 000	Continued From page	5 22	-	000			
	Another wound core	accomment dated 1/0/19			specific deficiency cited		
		assessment dated 1/9/18 dent had a wound to his			Dy 2/10/19 the director of purping (DO	NI)	
		isured 0.5 cm x 0.2 cm x 0			By 3/19/18 the director of nursing (DO assistant director of nursing (ADON)	N),	
	cm.	isuled 0.5 cm x 0.2 cm x 0			and/or the quality assurance (QI) nursi	2	
	GIII.				will complete a skin inspection of all	-	
	A note from the woun	nd care doctor dated 2/1/18			residents currently in the facility. Any		
		had a pressure ulcer to his			negative findings were immediately		
		eable and this was a chronic			addressed by the auditor. This audit w	ill	
		also had a sacral wound,			ensure all wounds are identified,		
	which had now resolv				assessments completed, and treatmer	ıts	
	There was no wound	care assessment or skin			are being provided as ordered.		
	checks or documenta	ation of wound			On 3/13/18 the facility hired a treatmer	nt	
	measurements of the	wound from 2/2/18 through			nurse. This treatment nurse started		
	3/1/18 on the residen	t's paper or electronic chart.			employment in the facility on 3/13/18.		
					On 3/16/18 the facility formulated a pla	n to	
		wound assessments from			ensure treatments and wounds		
	the physician from 2/	1/18 to 3/1/18.			assessments are completed if a treatm		
					nurse is not available. This plan is for t		
		ed for 2/2018 and revealed			hall nurses to complete treatments and	i	
		s were being completed as			assessments in the absence of the		
	ordered.				treatment nurse and the scheduled		
	\/\a\\\\a\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	amind an 2/20/40 at 42:20			assessments will be broken down by h		
		erved on 2/28/18 at 12:26 If a wound approximately the			so that every resident is assessed eve	1 y 7	
		ar to his right outer heel. It			days. On 3/9/18 the facility consultant		
	•	nd approximately 80% was			in-serviced the DON on wound		
		tissue. The wound had a			assessment, including documentation	and	
		rainage on the old dressing.			completion of treatments.	und	
		was performed as ordered			On 3/9/18 the staff facilitator (SF) was		
	by nurse #8.				in-serviced by the DON on wound		
	_				assessment, including documentation,		
	The Administrator wa	s interviewed on 2/28/18 at			and completion of treatments.		
	3:19 PM. She stated	that the wound doctor was			By 3/19/18 all licensed nurses, includir	ıg	
		essment every week on			the newly hired treatment nurse, will be		
	wounds. The nurses	should also be doing the			in-serviced by the SF on wound		
		The wound care nurse			assessment, including documentation,		
		ne facility about a month ago.			and completion of treatments. This		
	The nurses were sup	posed to be documenting			in-service will be part of the orientation	I	

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345144	B. WING _		0:	C 3/01/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	•	5/01/2010	
			706 PINEYWOOD ROAD	,		
PINE RIDGE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 2736	0		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 686 Continued From pag	ge 23	F 6	886			
the skin assessment documentation system. (NA) do the full skin there is a new skin is and the nurse would system. She stated the checks and that they turnover lately. The do a full skin check of the stated that she care doctor on Frida responsible for doing would report any iss nurse's note, there we checks being comple check the resident's residents. She stated measured. She stated often the wound were or where it should be that she just rounds makes sure the orders. Nurse #8 nurse was 4:46 PM. He stated resident's skin then the skin if there was nurse was measurin here. He stated that everything. He stated were being measure would be documented communicated to him.	t in the electronic em. The Nursing Assistants checks and only document if ssue and would tell the nurse put it in the computer they are working on the skin y have had a lot of staff wound care doctor would not	F	process for all newly nurses. The monitoring proces the plan of correction specific deficiency of and/or in compliance requirements The DON, ADON, are audit all pressure and non-processure and non-processure and seekly x 8 weeks to assessments have be within the last 7 days documented on the version of the seekly and the seekly that the last 7 days documented on the seekly and the seekly that the last 7 days documented on the seekly and the seekly that the last 7 days documented on the seekly that the last 7 days documented on the seekly and the seekly that the last 7 days documented on the seekly that the seekly	edure to ensure that in is effective and that ted remains corrected with the regulatory. Ind/or QI nurse will donon-pressure weeks then 50% of essure wounds ensure wound en documented is. This audit will be wound audit tool. Indicate will review the indication of in, and to determine in the audit tools is for identification of in, and to determine in the audit tools is for identification of in, and to determine in the audit tools in the monitoring for the interest the findings and in the monthly QI earterly executive QA in recommendations. In responsible for ceptable plan of ing is responsible for the interest in the findings and in the monthly QI earterly executive QA in recommendations.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345144	B. WING				C 01/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHA	BILITATION CENTER		70	REET ADDRESS, CITY, STATE, ZIP CODE 6 PINEYWOOD ROAD HOMASVILLE, NC 27360	1 001	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 686	wasn't sure if it was that he would usually Nurse #5 was intervishe stated she wasn skin checks/assessm would usually report new skin breakdown who was doing the stresidents (when ask assessments). Nurse #2 was intervishe stated that she measuring/assessing now that there was not sure. Nurse #9 was intervishe stated that maybe the who supposed to do she was not sure. Nurse #9 was intervishe stated that the note of the wasness was intervished to treatments and it night shift unless the thinks that Nurse #1 stated that when she the facility about not changes because she stated that she dressing change unlithat she think nurse and measurement. Nurse #10 was atternattempts were unsuch Nursing Assistant #1	even documented but stated a try to put a note in about it. ewed on 2/28/18 at 4:19 PM. In the sure who was doing the ments for residents. The NA's it to them if the resident had a she stated she wasn't sure kin assessments for red about Resident #2 skin ewed on 3/1/18 at 9:27 AM. It was not sure who was goldocumenting the wounds no wound care nurse. She had a a season a stated that she had no time to its to be done early on the dressing comes off. She of measured the wounds. She having to do dressing he already had so much to do. It does not do this resident's less it is needed. She stated the method in the wound care in the wound care in the wound care in the wound care in the wound should be started the wounds. She is started here, she talked to having to do dressing the already had so much to do. It is needed. She stated the wound care in t	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345144	B. WING _			C 3/01/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	•	0/01/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	Continued From pag	ue 25	F 6	586		
	she knew of. The res	ds and had no behaviors that sident will let them reposition . She stated that the nurses nges to his wound.				
	at 12:46 PM. She sta wound on his right h She stated that she unless there was so stated that when she measure the wounds made aware of any of	ated that the resident had a eel that was unstageable. sees the patient monthly mething acute going on. She comes in, she would so She stated she was not concerns related to the expect that the wound were kly.				
	1:24 PM. She stated wound to his heel ar brought to her attent responsible for measurements/asse	as interviewed on 3/1/18 at that the resident had a and no concerns have been ion. The nurses were suring wounds every 7 days. would expect ssments of wounds would be und ulcer flowsheet in the				
	at 1:24 PM stated th assessment sheets. Nursing Assistants wissue with the reside she went to check for However, she stated of these sheets for minterviewed some Nunot use those sheets that these sheets that	for skin checks that the yould draw on if there was an ent's skin. She stated that or these sheet for resident #2. I that she could not find any esident #2 and had As and they stated they do anymore. She also added at the NA's would draw a part of the resident's				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345144	B. WING _		C 03/01/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 725 SS=D	CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each re- resident assessmen and considering the diagnoses of the fact accordance with the at §483.70(e). §483.35(a)(1) The fact by sufficient number types of personnel of nursing care to all re- resident care plans: (i) Except when wais this section, licensed (ii) Other nursing pe limited to nurse aide §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMEN by: Based on record re- staff interviews, the sufficient nursing sta- changes for one res- one resident's press	t Staff. Ye sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by its and individual plans of care number, acuity and ility's resident population in facility assessment required acility must provide services so feach of the following in a 24-hour basis to provide esidents in accordance with eved under paragraph (e) of its nurses; and resonnel, including but not is.	F 7	An acceptable plan of correction recontain the following elements: The plan of correcting the specificiency. The plan should addresprocesses that lead to the deficiencited; The procedure for implementiacceptable plan of correction for the specific corr	ecific ss the acy ng the

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345144	B. WING _				C 01/2018
NAME OF PR	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010
					06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHA	BILITATION CENTER			THOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 725	Continued From page	e 27	F7	725			
	Findings included:				specific deficiency cited;		
					" The monitoring procedure to ensu	re	
	This tag was crossed	I referenced to:			that the plan of correction is effective a	nd	
					that specific deficiency cited remains		
	F684: Based on reco				corrected and/or in compliance with the	Э	
		/ failed to complete dressing			regulatory requirements;	_	
	•	for 1 of 3 resident reviewed			" The title of the person responsible	tor	
	for wound care (resid	ient #1).			implementing the acceptable plan of correction.		
	F686: Based on reco	ard review and staff			Correction.		
		/ failed to assess a pressure			F725		
		ents reviewed for pressure			1720		
	ulcers (Resident #2).	·			The plan of correcting the specific		
	,				deficiency		
	Nurse #2 was interview	ewed on 3/1/18 at 9:27 AM.					
	She stated that the a	cuity of the residents isn't as			The position of Pine Ridge center		
	bad as it was before,	if she was the supervising			regarding the process that lead to this		
		then she would have 55 to			deficiency-failed to provide nursing sta	ff of	
	60 resident and woul				sufficient quantity to provide dressing		
		stated that amount of			changes for one resident and properly		
		helming and the staff had			assess one resident □s pressure ulcers		
		erns to administration. She			was failure to communicate staffing ne	ed.	
		me when they were able to			Desident #1 was discharged to the		
	<u>-</u>	edication passes and hey couldn't like they used			Resident #1 was discharged to the emergency room on 2/5/18.		
		nany times she has to stay			Resident # 2 had a skin check complete	had	
		get things done. The turnover			on 3/2/18 by facility nurse.	,cu	
		stated that she wasn't			Resident #2 s right heel wound was		
		e staffing issue started. She			assessed and documented in the skin		
		was quite overwhelming but			check on 3/2/18 by facility nurse.		
	they just try to keep of	on working the best they can.			Facility is actively recruiting and hiring		
					nursing staff utilizing online resources,		
		ewed on 3/1/18 at 9:51 AM.			and onsite interviews when an applicat	ion	
		not enough staff to get the			is submitted.		
		arly for all residents. Since			Facility is utilizing incentive pay for fac	lity	
		ent nurse, the dressing			staff to cover as needed.		
	~	ne as regularly. He stated			The procedure for implementing the		
		pervising the medication			acceptable plan of correction for the		
	aide, he would have	60 patients. If he was not			specific deficiency cited		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY IPLETED
							С
		345144	B. WING _			03	3/01/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REH	IABILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 725	Continued From pa	age 28	F7	725			
	supervising the me	edication aide then he would			By 3/19/18 the director of nursing (DO	N).	
	have 30 patients o				assistant director of nursing (ADON)	/,	
	'				and/or the quality assurance (QI) nurs	е	
	Nurse #5 (worked	with resident #1 on 2/3/17 and			will complete a skin inspection of all		
	2/4/17 on 2nd shift) was interviewed on 2/28/18 at			residents currently in the facility. Any		
	4:19 PM. She state	ed that the staffing was			negative findings were immediately		
	horrible. She state	d 1st shift doesn't do dressing			addressed by the auditor. This audit w	ill	
	_	2nd shift would try to do them.			ensure all wounds are identified,		
		ey don't have a wound care			assessments completed, and treatmer	nts	
	-	d they really need one as she			are being provided as ordered.		
		eep up. She stated she wasn't			On 3/13/18 the facility hired a treatmen	nt	
		g the skin assessments for			nurse. This treatment nurse started		
		sked about Resident #2 skin			employment in the facility on 3/13/18.	n to	
	·	e NA's would usually report it to ident had any new skin			On 3/16/18 the facility formulated a platensure treatments, and wound	111 10	
		se was the one responsible for			assessments are completed if a treatn	nent	
		ing resident's wounds but there			nurse is not available. This plan is for		
	_	2 nurses for halls 300 and 400			hall nurses to complete treatments and		
		on hall (which has 8 residents			assessments in the absence of the		
		don't have anyone to help			treatment nurse and the scheduled		
	them (nurses).	•			assessments will be broken down by h	all	
					so that every resident is assessed eve	ry 7	
	Nurse #6 was inter	viewed on 3/1/18 at 9:14 AM.			days.		
	She stated that the	e facility was trying to hire staff.			On 3/9/18 the facility consultant		
		ses tried their best to do things			in-serviced the DON on wound		
		t they have to prioritize their			assessment, including documentation	and	
		dn't necessary wake up			completion of treatments.		
	-	change a dressing and typically			On 3/9/18 the staff facilitator (SF) was		
		d do it. She stated she was so			in-serviced by the DON on wound		
	•	t get a break sometimes. She			assessment, including documentation,		
		ically has 52 resident and at			and completion of treatments.	~	
		ve any medications aides. It's			By 3/19/18 all licensed nurse, including the newly hired treatment nurse, will be		
		to act fast and hope there was that she runs into. She stated			in-serviced by the SF on wound	-	
		cute happens then she would			assessment, including documentation,		
	_	nedication pass. Wound care			and completion of treatments. This		
		Ill on her shift so she cannot			in-service will be part of the orientation	1	
	-	are was being done for			process for all newly hired licensed	-	
		was told that it was not done			nurses.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING _			1	C 01/2018
NAME OF P	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010
				70	06 PINEYWOOD ROAD		
PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER		TI	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	12:51 PM. The treatm were being completed wound care doctor was There were no conce changes that she kned dressing changes we documented on the TRecord. The medicati treatments for a stage nurses were the only wound. She stated the last work day was on would expect for there provide wound care to are interviewing staff. She stated they did justice.	s interviewed on 3/1/18 at nents for dressing changed d by the hall nurse and the as seeing Resident #1.	F7	725	The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements By 4/1/18 the treatment nurse QI, ADC and DON will have follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, and treatment completed The DON, ADON, and/or QI nurse will audit all treatment administration record (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes appresent on the TAR. This audit will be documented on the TAR audit tool. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool. The administrator or director if nursing review staffing 5 times weekly x 12 week to include weekend staffing to ensure staffing is adequate to provide treatments as ordered, and wounds are assessed. This audit will be documented on the sufficient staff audit tool. The monthly QI committee will review to results of the resident care audit tool, for audit tool, and sufficient staff audit tool. The monthly QI committee will review to results of the resident care audit tool, for audit tool, and sufficient staff audit tool.	nat cted cy NN, on e ion. ds are e will eks nts .	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345144	B. WING _			C 03/01/2018	
	ROVIDER OR SUPPLIER BE HEALTH AND REHAE	SILITATION CENTER		70	REET ADDRESS, CITY, STATE, ZIP CODE 16 PINEYWOOD ROAD HOMASVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725 F 835 SS=G	enables it to use its re	on. ninistered in a manner that esources effectively and		725	actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will press the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	ns e. sent	3/19/18
	well-being of each rest This REQUIREMENT by: Based on record revi interviews, the facility provide leadership ar the needs of the resid wound care and treat Resident #2). The failu address these concer	mental, and psychosocial sident. is not met as evidenced ew, observations and staff 's administration failed to admanagement to ensure lent were met in the areas of ments (Resident #1, ure of administration to as resulted in one resident's pass related to an infected			An acceptable plan of correction must contain the following elements: "The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; "The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited.	e ne re	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Υ
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	ROVIDER OR SUPPLIER	IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		E, ZIP CODE	10
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F 835	interviews, the fact changes for a would care (refor wound care (reformation) interviews, the fact ulcer for 1 of 3 resulcers (Resident # The Administrator Director of Nursing were present) was PM. She stated shadequate staffing residents. She stated trying to recruhire an administration Nursing and Associated they have a every two months quality assurance address any quality.	eferenced to ecord review and staff ility failed to complete dressing and for 1 of 3 resident reviewed sident #1). ecord review and staff ility failed to assess a pressure idents reviewed for pressure 2). (Director of Nursing, Associate g, and corporate consultant interviewed on 3/1/18 at 12:51 e would expect for there to be to provide wound care to ted they were interviewing staff it staff. She stated they did just tion nursing team (Director of ciate Director of Nursing). She quality assurance meeting and she would expect for the committee to recognize and y issues/concerns. She stated cerns about wound dressing	F	that specific deficience corrected and/or in corregulatory requirement. The title of the perimplementing the accorrection. F835 The plan of correcting deficiency The position of Pine Rehabilitation center process that lead to the administration failed the and management to be residents were met in care and treatments with knowledge. Resident #1 was discusted emergency room on 2 Resident #2 had a skin on 3/2/18 by facility in Resident #2 sright hassessed and docum check on 3/2/18 by facility in Resident #2 had a skin on 3/2/18 by facility in Resident #2 had a skin in the procedure for implication and/or the quality assignation will complete a skin in residents currently in negative findings were	ompliance with the ints; erson responsible for septable plan of geptable p	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	03/	01/2010	
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PINE RID	GE HEALTH AND REHA	BILITATION CENTER			HOMASVILLE, NC 27360			
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F 835	Continued From pag	e 32	F	835	addressed by the auditor. This audit wi ensure all wounds are identified, assessments completed, and treatmen are being provided as ordered. On 3/13/18 the facility hired a treatmen nurse. This treatment nurse started employment in the facility on 3/13/18. On 3/16/18 the facility formulated a pla ensure treatments, and wound assessments are completed if a treatm nurse is not available. This plan is for thall nurses to complete treatments and assessments in the absence of the treatment nurse and the scheduled assessments will be broken down by his of that every resident is assessed ever days. On 3/9/18 the facility consultant in-serviced the DON on wound assessment, including documentation a completion of treatments. On 3/9/18 the staff facilitator (SF) was in-serviced by the DON on wound assessment, including documentation, and completion of treatments. On 3/12/18 the administrator was in-serviced by the facility consultant on facility must be administered in a mann that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physic mental, and psychosocial well-being of each resident, including wound care and treatments. By 3/19/18 all licensed nurse, including the newly hired treatment nurse, will be in-serviced by the SF on wound assessment, including documentation, and completion of treatments. This	ts t n to ent ne all y 7 and a er al,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010	
PINE RID	GE HEALTH AND REHA	BILITATION CENTER			6 PINEYWOOD ROAD HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 835	Continued From pag	e 33	F	835	in-service will be part of the orientation process for all newly hired licensed nurses. On 3/16/18 the administrator reviewed above audits and in-services. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The DON, ADON, and/or QI nurse will audit all treatment administration record (TARs) 5 times weekly x 12 weeks, to include weekends, to ensure no holes a present on the TAR. This audit will be documented on the TAR audit tool. The administrator will review this completed audit tool weekly x 12 weeks to ensure treatments were completed. The DON, ADON, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the wound audit tool. Tadministrator will review this completed audit tool weekly x 12 weeks to ensure wound care (assessments) have been completed. The monthly QI committee will review the results of the resident care audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of	at eat eat eat eat eat eat eat eat eat e		

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PINE RIDO	SE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD		
				THOMASVILLE, NC 27360		
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F 835	Continued From page	e 34	F 83	continued monitoring, and make recommendations for monitoring for continued compliance. The administra and/or DON will present the findings a recommendations of the monthly QI committee to the quarterly executive (committee for further recommendation and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	nd QA	