	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
	CONTRECTION	IDENTIFICATION NOWIDER.	A. BUILDING		C	
		345144	B. WING			8/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	E HEALTH AND REHA			706 PINEYWOOD ROAD		
				THOMASVILLE, NC 27360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF		(X5) COMPLETION
PREFIX TAG		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 000	INITIAL COMMENT	S	F 000			
	survey was conduct	t investigation and a revisit ted on 4/13/18. New and ted during the survey. Event				
F 580 SS=G		Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 580		5	/14/18
	 (i) A facility must im consult with the resist consistent with his correpresentative(s) with (A) An accident invorresults in injury and physician intervention (B) A significant charmental, or psychosod deterioration in heal status in either life-to clinical complication (C) A need to alter to a need to discontinue treatment due to ad commence a new for (D) A decision to traresident from the fas §483.15(c)(1)(ii). (ii) When making nor (14)(i) of this section all pertinent informatics available and prophysician. (iii) The facility must for the facility must facility must for the facility must for the facility must for the facility must for the facility must facility facility	olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial hreatening conditions or as); reatment significantly (that is, ue an existing form of verse consequences, or to orm of treatment); or unsfer or discharge the				
		m or roommate assignment 8.10(e)(6); or				

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.

05/07/2018

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE CO	ONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPI	
						C	2
		345144	B. WING			04/*	13/2018
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAI	BILITATION CENTER			DMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag	e 1	F 5	80			
		ent rights under Federal or					
		ons as specified in paragraph					
	(e)(10) of this section	i					
		record and periodically					
		mailing and email) and					
	phone number of the representative(s).	resident					
	§483.10(g)(15)						
		osite distinct part. A facility					
	· ·	istinct part (as defined in e in its admission agreement					
	- /	tion, including the various					
		se the composite distinct					
		y the policies that apply to					
		en its different locations					
	under §483.15(c)(9).	Γ is not met as evidenced					
	by:	i is not met as evidenced					
		ons, resident and staff			An acceptable plan of correction must		
	interviews, interview	with the pharmacist,		0	contain the following elements:		
		rse practitioner and record		'	" The plan of correcting the specific		
		ed to notify the attending			deficiency. The plan should address the	9	
		actitioner when Oxycodone n to refill. The facility failed			processes that lead to the deficiency cited;		
	to notify the attending	-				e	
		resident continued to		á	acceptable plan of correction for the		
		d pain for 2 days. This was		5	specific deficiency cited;		
		dents reviewed for pain			The monitoring procedure to ensur		
	management. (Resid Findings included	Jent #110)			that the plan of correction is effective ar that specific deficiency cited remains	iù	
	-	dmitted to the facility on			corrected and/or in compliance with the		
		ive diagnoses which included			regulatory requirements;		
		disorder, cerebrovascular			The title of the person responsible	for	
		ed hemiparesis, pain in joints			implementing the acceptable plan of		
	of left hand and oster Review of the quarter	oarthritis. rly Minimum Data Set (MDS)			correction.		
		2/29/17 revealed Resident		F	F580		
	#118 was assessed a						

Facility ID: 923017

If continuation sheet Page 2 of 55

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING	·			С
		345144	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	10/2010
				706	PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		тн	OMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIC DATE
F 580	Continued From page	e 2	F 58	30			
	-	short-term memory loss.			The plan of correcting the specific		
		and PRN (when every			deficiency		
	" Vocal complaints				The position of Pine Ridge Nursing and		
		n or possible pain observed			Rehabilitation center regarding the		
	daily.				process that lead to this deficiency-failu	ire	
	Review of the pain as	ssessment dated 3/1/18 and			to notify the attending physician or nurs	e	
		ealed resident's daily pain			practitioner when the resident continued		
		nd the pain site was front left			to experience unrelieved pain for 2 day	S 🗆	
	-	ized pain. Described the			was knowledge deficit.		
	pain as dull, worst at				T I II IC I CU I		
	repositioning and tran				The provider was notified of the need o		
		an targeted date of 3/29/18			hard prescription on 4/9/18 hall nurse for	Dr	
		us of potential for actual in. The goal included the			resident #118⊡s oxycodone.		
	-	a minimal level of pain daily			Oxycodone was ordered from the		
		ew date. The interventions			pharmacy on 4/10/18 and received by		
	included to notify the				facility on 4/11/18 for Resident #118 to		
	management was no				manage resident s breakthrough pain.		
		April 2018 monthly physician					
	orders included:				The procedure for implementing the		
	" Acetaminophen	325 mg po daily (QD) and			acceptable plan of correction for the		
	-	mg (2 tablets) by mouth			specific deficiency cited		
		n for pain or temperature					
	-	ahrenheit. A drug used for			On 4/11/18 through 4/13/18, the Directo		
	-	nild to moderate pain and			of Nursing (DON), the Assistant Directo	or	
	fever reducer.				of Nursing (ADON), and Staff		
		CR 1 tablet twice a day po.			Development Coordinator (SDC)		
	Oxycontin is a contro analgesic.	lied-release opioid			assessed all residents for pain using a questionnaire or the Wong-Baker faces		
		ng every 6 hours PRN.			pain rating scale. Any negative findings		
		synthetic opioid used to treat			were immediately addressed by the		
	moderate to severe p				auditor, including notification of the		
		at 2:50 PM with Resident			physician as appropriate. This audit		
		the facility ran out of her			ensures there is no unrelieved pain.		
		al days (unable to state the			On 4/11/18 through 4/13/18 the facility		
		(referring to the nurse) gave			consultants, director of nursing, assista	nt	
		nophen) and it did not help.			director of nursing, and staff developme	ent	
	An inquiry was made	about the level of pain the			coordinator completed and audit of all		

Facility ID: 923017

If continuation sheet Page 3 of 55

						OMB NC	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	
							С
		345144	B. WING			04/	13/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	SE HEALTH AND REHAB	BILITATION CENTER			6 PINEYWOOD ROAD		
				TH	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 580	Continued From page	23	F 58	30			
		when the Oxycodone was	1.00		residents on pain medications to ensur	۵	
		Tylenol (Acetaminophen)			medication was available as ordered by		
	was administered. R			the physician. Any negative findings we	•		
	intensity of pain level			addressed immediately by the auditor,	-		
	10 (worst pain imagin			including notification of the physician a	s		
	and after the administ				appropriate. This audit ensured pain		
	(Acetaminophen). "I	was still in pain." Continued			medications were available as ordered.	-	
	interview with Reside	nt #118 revealed "I get the			By 5/14/18 all licensed nurses, includin	g	
	-	ic pain in my left arm and			the newly hired licensed nurses and		
		I ask them (referring to the			agency licensed nurses, will be		
	, ,	me the Oxycodone has not			in-serviced by the Staff Development		
	come yet "from the pharmacy. Resident #118 revealed Oxycodone "relieved my pain."				Coordinator (SDC) on pain assessmen		
	revealed Oxycodone	"relieved my pain."			including documentation, completion of	ſ	
	Deview of the Medice	tion Administration Decard			pain interventions, and notification of		
		tion Administration Record			provider in the case that a medication		
		aminophen 650 mg po was red at 12 AM, 6 AM and			needs to be reordered or the pain intervention is not effective. This		
		4/10/18 at 12 PM. The			in-service will be part of the orientation		
		aminophen was coded as #3			process for all newly hired licensed		
	which indicated slight			nurses, and agency staff.			
	was not available to b				The monitoring procedure to ensure the	at	
	Review of the progres				the plan of correction is effective and the		
		tempted to relieve the			specific deficiency cited remains correct		
		Acetaminophen was not			and/or in compliance with the regulator		
	effective.				requirements	5	
	Nurse #5 (who admin	istered the Acetaminophen					
	at 12 AM, 6 AM on 4/	9/18 and 4/10/18 at 12 PM)			The DON, SDC, QI nurse and/or		
	and documented the	Acetaminophen was slightly			Administrator will audit all progress not	es	
	effective was not avai				3 times weekly x 12 weeks, to include		
	Review of the progres				weekends, to identify if a resident has		
		ending physician or nurse			pain and that the appropriate intervention		
		e notified about the need for			were taken and documented either on i		
	the Oxycodone refill u				the progress notes or on the MAR. This	5	
		nced pain without relief.			audit will documented on the Progress		
		at 2:55 PM with Nurse #1			Note Review Audit Tool.	ha	
	revealed she was una				The monthly QI committee will review t		
		n or NP notification or the			results of the progress note review aud		
	reordening because s	he just returned to work.			tool monthly for 3 months for identificat	1011	

Facility ID: 923017

If continuation sheet Page 4 of 55

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				IPLETED
						С
		345144	B. WING		0	4/13/2018
AME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	GE HEALTH AND REHA			706 PINEYWOOD ROAD		
	DE NEALTH AND REHAL	BEHATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 580	Continued From pag	e 4	F 580			
	with the pharmacist f		1 000	the need for and/or frequency	/ of	
	-	icted. The pharmacist		continued monitoring, and ma		
		py prescription was required		recommendations for monitor		
		the attending physician could		continued compliance. The A	•	
	have called the phari	macy for a 3-day supply		and/or DON will present the f	indings and	
	pending obtaining the			recommendations of the mon		
		18 at 5:30 PM revealed		committee to the quarterly ex		
		cial grimacing and moaning		committee for further recomm	endations	
		An inquiry was made about		and oversight.		
		t and pain. The resident		The title of the nerven response	cible for	
	stated she was in pa	d been given earlier but "I still		The title of the person respon implementing the acceptable		
		t of 10 level." Review of the		correction.	plan of	
	•	0/18 at 12 noon Tylenol		The Director of Nursing is res	ponsible for	
	(Acetaminophen) had	•		implementing the acceptable		
	Interview on 4/12/18	at 9:15 AM with the		correction.	-	
	Administrator and Di	rector of Nurses was				
		ninistrator indicated that she				
		fy the physician as soon as				
		available and the resident's				
	pain was not relieved					
		at 7::30 am with Nurse #3 substance was needed for				
		call the pharmacy to have				
	•	an for a script (prescription),				
	-	macy or call the physician				
	for another method o					
	Interview on 4/13/18	at 9:18 AM with the NP who				
	-	s a communication book for				
	-	ated at the nurses' station.				
		as told about needing a hard				
		8 and was available at the week. Further interview				
		ed the facility should have				
		hard prescription was				
		could not be managed.				
F 636	-	-	F 636	3		5/14/18
	CFR(s): 483.20(b)(1)			• I		0, 1, 1, 10

If continuation sheet Page 5 of 55

RED.	IPLE CONSTRUCTION IG STREET ADDRESS, CITY, STAT	(X3) DATE COM	D. 0938-0391 E SURVEY PLETED
B. WING	STREET ADDRESS, CITY, STA		
	STREET ADDRESS, CITY, STAT	04	C / 13/2018
	706 PINEYWOOD ROAD THOMASVILLE, NC 2736	60	
ULL PRE	((EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	(X5) COMPLETION DATE
F	36		
s ment. s, e cified least on blems. s.			
	TION) TAG	Tob PINEYWOOD ROAD THOMASVILLE, NC 2738 S FULL TION) PREFIX PREFIX TAG PROVIDERS I (EACH CORREC CROSS-REFEREND DI DI S dically F 636 dically S ument. Is, ne cified least join bblems. s.	STREET ADDRESS, CITY, STATE, ZIP CODE 766 PINEYWOOD ROAD THOMASVILLE, NC 27360 S UD PROVIDER'S PLAN OF CORRECTION FROM CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 636 dically s ument. Is, ne cified least ion on med ion of ist

Facility ID: 923017

If continuation sheet Page 6 of 55

	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU		CONSTRUCTION	OMB NO	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMP	
		345144	B. WING				_ 13/2018
NAME OF P	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHA	BILITATION CENTER		7	06 PINEYWOOD ROAD		
				Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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)	BE	(X5) COMPLETIO DATE
F 636	Continued From page	e 6	F	636			
	with the resident, as licensed and nonlicen members on all shifts						
		required. Subject to the d in §413.343(b) of this					
		st conduct a comprehensive					
		dent in accordance with the					
		in paragraphs (b)(2)(i)					
p		ction. The timeframes 43(b) of this chapter do not					
	apply to CAHs.						
		r days after admission,					
		ons in which there is no					
		the resident's physical or					
		or purposes of this section,					
		a return to the facility absence for hospitalization					
	or therapeutic leave.	-					
	(iii)Not less than once						
	This REQUIREMEN	Γ is not met as evidenced					
	by:						
		iew and staff interviews the			An acceptable plan of correction must	t	
	facility failed to comp	ssment for Resident #118.			contain the following elements: The plan of correcting the specific	、	
	This was evident in 1				deficiency. The plan should address th		
	assessments reviewe	-			processes that lead to the deficiency		
	Findings included:				cited;		
		dmitted to the facility on			" The procedure for implementing t	he	
		ive diagnoses which included			acceptable plan of correction for the		
		disorder, cerebrovascular			specific deficiency cited;	Iro	
	of left hand and osted	ed hemiparesis, pain in joints			The monitoring procedure to ensu that the plan of correction is effective a		
		I Minimum Data Set (MDS)			that specific deficiency cited remains	UIU	
		26/18 revealed the following			corrected and/or in compliance with th	e	
		h meant the sections were			regulatory requirements;		
	incomplete:				" The title of the person responsible	e for	
		ification Information			implementing the acceptable plan of		
	" Section B - Hear	ring, Speech and Vision			correction.		

Facility ID: 923017

TATEMENT (S FOR MEDICARE & of deficiencies correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345144	B. WING			04	C I/13/2018	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				70	06 PINEYWOOD ROAD			
	GE HEALTH AND REHAE	SELIATION CENTER		T	HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 636	Continued From page	e 7	E F	636				
	" Section E - Beha	avior						
	" Section G- Funct				F636			
	" Section H -Bladd							
	" Section J - Healt				The plan of correcting the specific			
	" Section L - Oral/				deficiency			
	 Section M - Skin Section N - Medi 				The position of Pine Ridge Nursing and	4		
		cial Treatments, Procedures			Rehabilitation center regarding the	1		
	and Programs				process that lead to this deficiency-fail	ure		
	0	raints and Alarms			to complete the annual comprehensive			
	On 4/10/18 at 3:28 Pl	M with the MDS coordinator			assessment for resident #118 □ was			
	stated she was aware				failure to follow established procedure.			
		he was the only MDS						
		ete the assessment. The cated the color red on the			Annual comprehensive assessment for			
		the section had not been			resident #118 was completed on 4/11/1 corporate MDS consultant and accepte			
		d interview with the MDS			on 4/11/18 by the national repository.	,u		
		the Care Area Assessment						
	(CAA) Summary and	care plan could not have						
	been completed beca	ause the annual MDS was			The procedure for implementing the			
	incomplete.				acceptable plan of correction for the			
		at 9:15 AM with the Director			specific deficiency cited			
		administrator was held. ted 2 (two) MDS corporate			From 4/11/18 until 4/12/18 and 4/17/18	!		
		n yesterday (4/11/18) to			until 4/19/18, two corporate MDS	,		
		ree assessment nurses were			consultants assisted the facility to achie	eve		
		tch up on assessments and			timely submission of comprehensive			
		IDS coordinator while on			Minimum Data Set (MDS) assessment	S.		
		Representative notified us						
	. ,	at MDS assessments were			On 4/13/18 and 4/20/18, one corporate	9		
	not updated. Continu	led interview with the difference of the differe			MDS consultant assisted the facility to achieve timely submission of			
		be updated and completed			comprehensive MDS assessments.			
	as required.							
	1				On 4/20/18, the facility consultant			
					in-serviced the MDS Nurse on complet			
					assessments timely. This in-service wil	I		
					be provided to any newly hired MDS			

Event ID: 3S4811

Facility ID: 923017

If continuation sheet Page 8 of 55

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345144	B. WING		04/13/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	E HEALTH AND REH	ABILITATION CENTER		706 PINEYWOOD ROAD	
				THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 636	Continued From pa	ge 8	F 636	 By 5/14/18, all comprehensive assessments will be submitted timely will accurately reflect each individual resident. The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains correct and/or in compliance with the regulator requirements The Administrator and/or DON will aurell completed MDS 100% weekly x 4 weeks then 50% of completed MDS weekly x 8 weeks to ensure all MDS assessments are completed timely an accurately reflect the resident. This a will be documented on the MDS audit The monthly QI committee will review results of the MDS audit tool monthly months for identification of trends, act taken, and to determine the need for and/or frequency of continued monitor and make recommendations for monitoring for continued compliance. administrator and/or DON will present 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. 	hat that ected ory dit dit dit dit tool. the for 3 ions ring, The the
F 638	Ortly Assessment a	t Least Every 3 Months	F 638	correction.	5/14/18

		ND HUMAN SERVICES MEDICAID SERVICES				FC	FED: 05/22/2018 ORM APPROVED NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING				C 04/13/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 638	Continued From page	e 9	F	638			
SS=D	CFR(s): 483.20(c)			000			
00-D	CFR(5). 403.20(C)						
	and approved by CM once every 3 months	s a resident using the ument specified by the State S not less frequently than					
	by:	is not met as evidenced					
		iew and staff interviews, the			An acceptable plan of correction mus	st	
		lete a quarterly Minimum			contain the following elements:	51	
	Data Set (MDS) withi				The plan of correcting the specif	ic	
		ce Date (ARD) for 1 of 3			deficiency. The plan should address		
	sampled residents re				processes that lead to the deficiency		
	assessments (Reside	ent #6).			cited;		
					" The procedure for implementing	the	
	The findings included	l:			acceptable plan of correction for the		
	D				specific deficiency cited;		
		nitted to the facility on			" The monitoring procedure to ens		
		ative diagnoses which			that the plan of correction is effective	and	
	disorder, and anxiety	ner ' s dementia, psychotic			that specific deficiency cited remains corrected and/or in compliance with t	ho	
					regulatory requirements;	ne	
	A review of Resident	#6 ' s last quarterly Minimum			" The title of the person responsib	le for	
	Data Set (MDS) asse				implementing the acceptable plan of		
		ce Date (ARD) was 3/27/18.			correction.		
		erly MDS assessment on					
		following sections were not			F638		
	· ·	e of the review: Sections A,					
	B, E, G, H, J, L, M, N	, O, and P.			The plan of correcting the specific deficiency		
	The facility 's MDS C	Coordinator was not available					
	-	vever, an interview was			The position of Pine Ridge Nursing a	nd	
		8 at 10:57 PM with the			Rehabilitation center regarding the		
		Assessment Instrument			process that lead to this deficiency-fa	ilure	
	(RAI)/Reimbursemen	t Consultant #1. During the			to complete a quarterly Minimum Dat	e Set	
		ant stated, "We knew there			(MDS) within 14 days after the		
		he late assessments so they			Assessment Reference Date (ARD)		
	called us in to get the	em (the facility) caught up."			was failure to follow established polic	зy.	

Facility ID: 923017

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STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION		<u>3 NO. 0938-039</u> DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · · ·	COMPLETED
						С	
		345144	B. WING				04/13/2018
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE PINEYWOOD ROAD		
PINE RIDO	E HEALTH AND REHAE	BILITATION CENTER			MASVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 638	Continued From page	e 10	F	538			
	When asked about th						
	assessment for Resid	dent #6, the consultant			Quarterly Minimum Data Set (MDS)		
		nent was completed on		-	assessment for resident #6 was sub	mitted	
	4/12/18 (16 days afte should have been do	r the ARD date) and that it $A/10/18$ The			on 4/12/18 by a corporate MDS consultant, and accepted on 4/12/18	۱. ۱	
	consultant stated this	-			he notational repository.	ы	
		id added, "We are aware of					
	the problem." She re	•					
		o the facility on 4/11/18 to			The procedure for implementing the		
		sessments, two consultants on 4/12/18, and she was the			acceptable plan of correction for the specific deficiency cited		
		y on 4/13/18 to help get the			Until		
	-	up. She stated when the					
		the facility on 4/11/18, there		F	From 4/11/18 until 4/12/18 and 4/17	/18	
		ments that were overdue.			Intil 4/19/18, two corporate MDS		
	She reported the facilities assessments being o	lity was now down to 4			consultants assisted the facility to ac imely submission of quarterly Minim		
		ducted on 4/13/18 at 2:00			Data Set (MDS) assessments.	IUIII	
		Director of Nursing (DON)			On 4/13/18 and 4/20/18, one corpor	ate	
		prporate Consultant #1.			MDS consultant assisted the facility		
		N stated her expectation			achieve timely submission of quarte	rly	
		essments to be completed in		1	MDS assessments.		
	a timely manner and	on time.			On 4/20/18, the facility consultant		
					n-serviced the MDS Nurse on comp	letina	
					assessments timely. This in-service	0	
					e provided to any newly hired MDS		
					Nurses during orientation.		
					By 5/14/18, all quarterly assessmen		
					be submitted timely and will accurate eflect each individual resident.	eiy	
					The monitoring procedure to ensure		
					he plan of correction is effective and		
					specific deficiency cited remains cor and/or in compliance with the regula		
				6	analor in compliance with the regula	itor y	

Event ID: 3S4811

Facility ID: 923017

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/22/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345144	B. WING				C / 13/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2010
	GE HEALTH AND REHAB	BILITATION CENTER			96 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 638 F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio interviews and record	or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and		638	The Administrator and/or DON will aud all completed MDS 100% weekly x 4 weeks then 50% of completed MDS assessments are completed timely and accurately reflect the resident. This au will be documented on the MDS audit to The monthly QI committee will review to results of the MDS audit tool monthly for months for identification of trends, action taken, and to determine the need for and/or frequency of continued monitori and make recommendations for monitoring for continued compliance. The administrator and/or DON will present to 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.	dit ool. he or 3 ons ng, The the	5/14/18

Event ID: 3S4811

Facility ID: 923017

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		MEDICAID SERVICES			OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		с	
		345144	B. WING		04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/10/2010	
				706 PINEYWOOD ROAD		
PINE RID	GE HEALTH AND REHAI	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETI	
E 077						
F 677	Continued From pag		F 67			
		ne resident's skin after an		deficiency. The plan should address		
		e (Resident #18) 2. The		processes that lead to the deficienc	y I	
	facility failed to follow			cited;	- 46 -	
		e skin after use. (Resident		" The procedure for implementin		
	#2). This was evider reviewed for incontin			acceptable plan of correction for the specific deficiency cited;	÷	
	The findings included			" The monitoring procedure to er	nsure	
	•	admitted to the facility on		that the plan of correction is effectiv		
		ive diagnoses which included		that specific deficiency cited remain		
		cident, diabetes, anemia and		corrected and/or in compliance with		
	admitted with a stage			regulatory requirements;		
	Review of the signific	ant change Minimum Data		" The title of the person responsi	ible for	
		2/18 revealed resident had		implementing the acceptable plan o	of	
	-	term memory problems. He		correction.		
		recall of staff names and		F077		
		sided in a nursing home. The		F677		
		3/2 for personal hygiene sive assistance of one staff		The plan of correcting the specific		
		thing which required total		deficiency		
		aff, always incontinent of		denoicitely		
		equired extensive assistance		The position of Pine Ridge Nursing	and	
		bility (turning side to side in		Rehabilitation center regarding the		
		s noted to be highly impaired.		process that lead to this deficiency		
		d care plan dated 2/16/18		facility staff delayed incontinence ca		
		esident at risk for further		failed to thoroughly cleanse the		
		opment. The interventions in		resident s skin after an incontinent	ce 🛛	
		nse perineal area well with		episode, and failed to follow		
	-	bisode and to apply barrier		manufacturer s instruction to rinse		
	cream per physician			skin after use - was knowledge defi	Cit.	
		18 at 9:35 AM was made		Desident #19 was provided income		
	-	Resident #18's room as he		Resident #18 was provided incontin care on 4/11/18 the CNA on the hal		
		the covers over him and to the room. The resident			1.	
		and had been waiting for 2		Resident #2 was thoroughly cleanse	ed	
	hours to get changed			after an incontinence episode on 4/		
		en asked what time he first		the CNA on the hall.		
		, the resident reported				
	around 7:00 AM.	· · · · · · · · · · · · · · · · · · ·		The procedure for implementing the	e	

Facility ID: 923017

If continuation sheet Page 13 of 55

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLET	
			A. BOILDING		с	
		345144	B. WING		04/13/2018	
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				706 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHA	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DMPLETIC DATE
F 677	Continued From pag	e 13	F 67	7		
		as waiting for someone to had an incontinent episode		specific deficiency cited		
		d care since the night shift.		On 4/16/18, the facility consultant		
		knew the timing, he referred		in-serviced the Director of Nursing	on	
	to the large clock on	the wall.		providing ADL care for dependent		
		at 9:40 AM with Nurse # 4		residents and following manufactur	er⊡s	
	-	ad one Nursing Assistant (NA)		instructions.		
		the other scheduled NA was		On 4/16/18, the Staff Development		
		r interview with Nurse #4 who		Coordinator (SDC) was in-serviced DON on providing timely ADL care		
		n (referring to the Director of trator) was made aware that		dependent residents and following		
		aide and the response was		manufacturer s instructions.		
		as running late and no		By 5/14/18, all nursing staff, includi	ng the	
	additional staff was p	-		newly hired nursing staff and agend	-	
	-	at 9:54 AM with NA #1		will be in-serviced by the SDC on		
	revealed she just arr	ived at the facility (no time		providing timely ADL care for deper	ndent	
	provided) because s	-		residents and following manufactur		
		at 10:01 AM with NA #2		instructions. This in-service will be		
		ned the resident and fed him.		the orientation process for all newly	hired	
		not change him because I		nursing staff, and agency staff.		
		ce. Been the only aide since		The monitoring procedure to ensure		
	7 AM. Several resid			the plan of correction is effective ar specific deficiency cited remains co		
		care but was not able to get vation on 4/11/18 at 10:07		and/or in compliance with the regul		
	-	re performed by NA #1		requirements		
	revealed she remove					
	resident. One across			The Director of Nursing, SDC, Qua	lity	
		ent had experience an		assurance nurse and/or weekend	-	
		of urine and stool. There was		manager on duty will audit a minim		
		nell. NA #1 cleansed the		20 residents a week x 4 weeks and		
	•	ith rinse free foaming body		10 residents a week x 8 weeks to e		
		the resident and cleansed		timely ADL care is provided to resid		
	his buttocks. Then a			This audit will be documented on th	e	
		nt's penis was not cleansed. ted to have a bandage on the		Resident Care Audit Tool. The monthly QI committee will revie	w the	
		i colored substance like stool.		results of the resident care audit to		
		skin issues observed. The		monthly for 3 months for identificati		
		as notified and the bandage		trends, actions taken, and to deterr		

Facility ID: 923017

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, í		COMPLETED	
					С	
		345144	B. WING		04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	SE HEALTH AND REHAE			706 PINEYWOOD ROAD		
	E REALTH AND REHAD	SELITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETI	
F 677	Continued From page	e 14	F 677	7		
		lly stated that she cleansed	1 077	continued monitoring, and make		
		After continued interview NA		recommendations for monitoring for		
		lent had a hole at the top of		continued compliance. The Administ	rator	
	his penis and did not	•		and/or DON will present the findings		
	resident's penis for fe			recommendations of the monthly QI		
	Record review reveal	led no skin issues with the		committee to the quarterly executive	QA	
	resident's penis.			committee for further recommendation	ons	
	Interview on 4/12/18			and oversight.		
		ector of Nurses (DON) was				
		N and the Administrator		T		
		informed them that there		The title of the person responsible fo		
		ember on the unit for direct the the the the the the the the the th		implementing the acceptable plan of correction.		
		ation was residents to		The Director of Nursing is responsible	e for	
		mely incontinence care.		implementing the acceptable plan of correction.		
	2. Review of the ma	anufacturer's instruction				
	shampoo/body wash gel should be thoroughly rinsed off the body.					
		nitted to the facility on				
		ive diagnoses which included				
	Alzheimer's disease.					
		quarterly Minimum Data Set				
		coded the resident as totally aff for activities of daily living				
	except for eating.	an for activities of daily living				
		d care plan dated 2/22/18				
		activities of daily living which				
	required staff assista	, ,				
		ired mobility. The goal was				
		care with staff support. The				
		d total care of one person to				
	bath and provide pers					
	Observation on 4/11/					
		rformed by Nursing Assistant				
		nt had experienced an				
	resident was cleanse	of urine and stool. The				
	disposable washcloth					

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	S	COMPLETED	
					С	
		345144	B. WING		04/13/2018	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE RIDO	E HEALTH AND REHA	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO	
F 677	Continued From page	e 15	F 67	77		
	retracted and cleanse	ed. Before a clean brief				
	-	ne resident another urinary				
	incontinence episode occurred. NA #3 obtained a					
	basin of water and used the shampoo/body wash					
	gel to cleanse the resident's buttocks and genitals. The gel was not rinsed off the resident's					
	skin.	not mised on the resident s				
	Interview on 4/11/18	at 11 AM with NA #3				
		luct was new and was not				
	-	ould be thoroughly rinsed off				
		e in serviced on the gel.				
	Interview on 4/12/18 Administrator and Div					
	Administrator and Director of Nurses (DON) was conducted. The DON indicated the skin should					
		oughly rinsed based on the				
	manufacturer's instru	ctions.				
F 697 SS=G	Pain Management CFR(s): 483.25(k)		F 69	17	5/14/18	
	§483.25(k) Pain Man					
	-	ure that pain management is who require such services.				
	1	ssional standards of practice,				
	-	erson-centered care plan,				
	and the residents' go	als and preferences.				
		r is not met as evidenced				
	by:	and resident and staff		An acceptable alon of correction and	-1	
	interviews, interview	ons, resident and staff		An acceptable plan of correction mu contain the following elements:	SL	
		rse practitioner and record		The plan of correcting the specif	fic	
		ed to provide pain relief to		deficiency. The plan should address		
		two) days. This was evident		processes that lead to the deficiency	,	
	in 1 of 3 residents rev	viewed for pain		cited;	44	
	management.			" The procedure for implementing	tne	
	Findings included: Resident #118 was a	dmitted to the facility on		acceptable plan of correction for the specific deficiency cited;		
		ive diagnoses which included		" The monitoring procedure to ens	sure	
	depression, anxiety of	-	1	that the plan of correction is effective		

Event ID: 3S4811

Facility ID: 923017

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/22/20 M APPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	COM	E SURVEY PLETED
		345144	B. WING		C 04/13/2018		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHA			70	6 PINEYWOOD ROAD		
		BEHANON GENTER		TH	HOMASVILLE, NC 27360		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 697	Continued From pag	e 16	F 6	97			
1 001		ed hemiparesis, pain in joints			that specific deficiency cited remains		
	of left hand and oste			corrected and/or in compliance with t	he		
		rly Minimum Data Set (MDS)			regulatory requirements;	1 - 6 - 1	
	#118 was assessed a	2/29/17 revealed Resident			" The title of the person responsib implementing the acceptable plan of	le for	
		short-term memory loss.			correction.		
		ndence with decision making					
	in new situations.				F697		
		nood or behaviors.					
	Extensive Activit	ties of Daily Living except for			The plan of correcting the specific		
	eating.	and PRN (when every			deficiency		
	necessary) pain man				The position of Pine Ridge Nursing a	ind	
	" No non-medicati	•			Rehabilitation center regarding the		
	" Vocal complaints	-			process that lead to this deficiency \square	the	
	-	n or possible pain observed			facility failed to provide pain relief to		
	-	pain assessment dated n 3/5/18 revealed resident's			resident #118 for two days- was		
		7 (seven)and the pain site			knowledge deficit.		
		er and generalized pain.			The provider was notified on of the n	eed	
	Described the pain a				of a hard prescription on 4/9/18 by ha		
		itioning and transfers. The			nurse for resident #118 s oxycodone	e.	
	assessment indicate						
	positioning devices a pain better. Continue	and medication makes the			Oxycodone was ordered from the pharmacy on 4/10/18 and received b	M	
	assessment revealed	-			facility on 4/11/18 for Resident #118	-	
		d was effective in relieving			manage resident⊡s breakthrough pa		
	•	lan targeted date of 3/29/18			The procedure for implementing the		
		cus of potential for actual			acceptable plan of correction for the		
		in. The goal included the			specific deficiency cited		
		a minimal level of pain daily ew date. The interventions			On 4/11/18 through 4/13/18, the Dire	ctor	
		jement of the presence of			of Nursing (DON), the Assistant Dire		
	-	administer pain medication			of Nursing (ADON), and Staff		
	as ordered and note	-			Development Coordinator (SDC)		
		nplaints and non-verbal signs			assessed all residents for pain using		
	of pain.	A 11.0040			questionnaire or the Wong-Baker fac		
	Record review of the	April 2018 monthly physician			pain rating scale. Any negative findin	gs	

Facility ID: 923017

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-03 E SURVEY	
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	. ,	G	CON	IPLETED	
						С	
		345144	B. WING		0	4/13/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
				706 PINEYWOOD ROAD			
	GE HEALTH AND REHAE	BEHATION CENTER		THOMASVILLE, NC 27360			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	EAPPROPRIATE	COMPLETIO DATE	
F 697	Continued From page	e 17	F 69	97			
	orders included:			were immediately addressed	by the		
	Acetaminophen 325	milligrams (mg) po daily		auditor, including notification	of the		
		ohen 325 mg (2 tablets) po		physician as appropriate. Th			
		pain or temperature above		ensures there is no unrelieve			
	-	neit. A drug used for the		By 5/14/18 all licensed nurse			
	-	to moderate pain and fever		the newly hired licensed nurs			
	reducer.			agency licensed nurses, will			
		QD. Drug used for the		in-serviced by the Staff Deve	•		
	treatment of mental h			Coordinator (SDC) on pain a			
		b every morning po and 0.25		including documentation, cor	-		
		Drug used to treat anxiety. CR 1 tablet twice a day po.		pain interventions, and notific provider in the case that a m			
	Oxycontin is a contro			needs to be reordered or the			
	analgesic.			intervention is not effective.	•		
		ng every 6 hours PRN.		in-service will be part of the o			
	-	synthetic opioid used to treat		process for all newly hired lic			
	moderate to severe p			nurses, and agency staff.			
	· ·	at 2:50 PM with Resident		The monitoring procedure to	ensure that		
	#118 who stated that	the facility ran out of her		the plan of correction is effect	tive and that		
	Oxycodone for sever	al days and they (referring to		specific deficiency cited rema	ains corrected		
	the nurse) gave me T	Tylenol (Acetaminophen and		and/or in compliance with the	e regulatory		
		quiry was made about the		requirements			
		lent experienced when the					
		available and the Tylenol		The DON, SDC, quality assu			
		s administered. Resident		and/or Administrator will aud			
		sity of pain level on a scale		notes 3 times weekly x 12 we			
		worst pain imaginable) was		include weekends, to identify			
		after the administration of hen."		has pain and that the approp interventions were taken and			
		with Resident #118 revealed		either on in the progress note			
		for chronic pain in my left		MAR. This audit will docume			
	arm and legs and "ev			Progress Note Review Audit			
	-	they tell me the Oxycodone		The monthly QI committee w			
	_ · · · · · · · · · · · · · · · · · · ·	om the pharmacy. Resident		results of the resident care a			
	-	one "relieved my pain."		monthly for 3 months for ider			
		ation Administration Record		trends, actions taken, and to			
	(MAR) revealed on th	ne back of the record		the need for and/or frequenc			
		10 mg po was administered		continued monitoring, and m			
	on 4/7/18 at 2:30 AM	or PM (illegible). On the		recommendations for monito	rina for		

Facility ID: 923017

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, ,	· · · · · · · · · · · · · · · · · · ·	COMPLETED	
					С	
		345144	B. WING		04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	
F 697	Continued From page	e 18	F 69	7		
	Nurse #5-who docum time-that Oxycodone administered. The bl was a superimposed Review of the progres documentation of the associated with Nurse Continued review of the Acetaminophen 650 r administered at 12 AI 4/9/18 and 4/10/18 at the Acetaminophen w indicated slightly effect Review of the progress indication that staff at resident's pain when effective. Nurse #5 (who admin at 12 AM, 6 AM on 4/ was not available for Interview on 4/10/18 a revealed she was una Oxycodone or the red returned to work. Observation of the na 3:05 PM revealed no Resident #118. Interview via the phor with the pharmacist fr pharmacy was condu-	ock under Nurse #5 initials marking with an x-mark. ss notes did not have administration times e #5. he MAR revealed mg po was initialed as M, 6 AM and 12PM on to 12 PM. The response to vas coded as #3 which ctive. ss notes revealed no tempted to relieve the Acetaminophen was not istered the Acetaminophen 9/18 and 4/10/18 at 12 PM) interview. at 2:55 PM with Nurse #1 aware of the lack of ordering because she just arcotic box on 4/10/18 at Oxycodone 10 mg po for the on 4/10/18 at 3:36 PM		continued compliance. The admir and/or DON will present the findir recommendations of the monthly committee to the quarterly execut committee for further recommend and oversight. The title of the person responsible implementing the acceptable plan correction. The Director of Nursing is respon implementing the acceptable plan correction.	ngs and QI tive QA lations e for n of sible for	
	copy prescription was interview the pharma reorder 3 days before a sticker was placed	s required. Continued cist stated the facility can e the drug was to run out and on the medication card to ycodone was getting low and				

Facility ID: 923017

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/22/20 DRM APPROVE NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING			C 04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP COD)E	
				706 P	PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		тно	MASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 697	was received on 4/9/ interview with the pha Oxycodone was proc and would leave the PM-7:30 PM and be facility (unsure of the facility). Additionally that the attending phy pharmacy for a 3-day the hard prescription. Interview on 4/10/18 Assistant #3 stated s Oxycodone not being Observation on 4/10/ Resident #118 had fa	py prescription dated 4/9/18 18 at the pharmacy. Further armacist who stated that the essed and filled on 4/10/18 oharmacy around 6:30 delivered on 4/10/18 to the exact time of delivery to the , the pharmacist indicated ysician could have called the r supply pending obtaining at 5:20 PM with Medication he was unaware of		597			
	the resident's comfor stated she was in pai (Acetaminophen) had am in pain at an 8 ou MAR revealed on 4/1 (Acetaminophen) had On 4/10/18 at 5:40 P made aware of the re Record review of the	t and pain. The resident n and Tylenol I been given earlier but "I still t of 10 level." Review of the 0/18 at 12 noon Tylenol					
	4/11/18 at 12:01 AM of pain. The response Oxycodone was code represented effective Observation and inte with Resident #118 re bed awake. Residen her medication and re pain and felt "better." Interview on 4/12/18 Administrator and Dir	and 6:10 AM for complaints be and effectiveness of the ed as 1 (one) which rview on 4/11/18 at 3:08 PM evealed resident was lying in t #118 stated the facility got eccived her Oxycodone for at 9:15 AM with the					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/22/2 FORM APPRO OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C 04/13/2018	
		345144	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CC		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET HE APPROPRIATE DATE	
F 697 F 725 SS=D	manner to manage th Interview on 4/13/18 revealed if a control s pain relief "I would ca them call the physicia back-up pharmacy or another method of pa Interview on 4/13/18 Practitioner (NP) who book for non-emerge nurses' station. The N needing a hard script with the NP revealed facility 5 (five) days a Sufficient Nursing Sta CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each res resident assessments and considering the r diagnoses of the facil accordance with the fa at §483.70(e).	rder medications in a timely ne resident's pain. at 7:3:30 am with Nurse #3 substance was needed for all the pharmacy to have an for a script, use the r call the physician for ain relief." at 9:18 AM with the Nurse o stated a communication ncies was located at the NP stated she was told about on 4/9/18. Further interview she was available at the week. aff (2) Staff. e sufficient nursing staff with retencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility must provide services of each of the following a 24-hour basis to provide sidents in accordance with	F 697		5/14/18	

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			(1/0) 1/11/1	ייטי			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	PLETED
						С	
		345144	B. WING			04/	/13/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER			6 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	- 21	E 7	725			
0		sonnel, including but not		25			
	limited to nurse aides	-					
	§483.35(a)(2) Except	when waived under					
		section, the facility must					
		nurse to serve as a charge					
	nurse on each tour of						
	This REQUIREMENT	is not met as evidenced					
	by:						
		iews, observations, resident			An acceptable plan of correction must		
		ctitioner (NP) interview and			contain the following elements:		
		acility failed to provide			The plan of correcting the specific		
		f to provide showers as			deficiency. The plan should address the	e	
	-	mpled residents reviewed for			processes that lead to the deficiency		
	-	esident #36) and complete			cited;		
		ensive assessment for			The procedure for implementing the	е	
	Resident #118 in 1 of	•			acceptable plan of correction for the		
	assessments reviewe Findings included:	20.			specific deficiency cited;The monitoring procedure to ensur		
	•	ecord review and resident			that the plan of correction is effective ar		
		the facility failed to honor a			that specific deficiency cited remains	iu -	
		s regarding the frequency of			corrected and/or in compliance with the		
		1 of 4 sampled residents			regulatory requirements;		
	-	ermination (Resident #36).			The title of the person responsible	for	
	2. F636: Based on re				implementing the acceptable plan of		
		failed to complete the			correction.		
		e assessment for Resident					
		ent in 1 of 4 comprehensive			F725		
	assessments reviewe	ed.					
					The plan of correcting the specific		
		at 6:17 PM with Nurse #8			deficiency		
		1 4/3/18 and 4/4/18 with only					
		stant (NA) and "did the best			The position of Pine Ridge Nursing and		
		idents were left in bed			Rehabilitation center regarding the		
		t use the hydraulic lift to			process that lead to this deficiency - the		
		cause two (2) people were			facility failed to provide sufficient nursing		
		. At his time Nurse #8			staff to provide showers as preferred an	nd	
		ure which residents were not			to complete the annual comprehensive assessment for resident #118.		
	transferred out of her	 Continued interview with 	1		anagement for regident #110		1

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		MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-0
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
			AL DOLEDING		с
		345144	B. WING		04/13/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				706 PINEYWOOD ROAD	
PINE RIDO	GE HEALTH AND REHAB	SILITATION CENTER		THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETI
F 725	Continued From page	e 22	F 72	5	
		e unit had four (4) residents			
		on staff for feeding and they		On 4/14/18, resident # 36 received	a
	were fed.			shower per resident preference by t	he
				CNA on the hall.	
		at 6:25 PM with NA #7			
		d that she worked the facility NA and unable to do rounds		Annual comprehensive assessment resident #118 was completed on 4/	
	and provide care for i			by a corporate MDS consultant and	
		f must transfer residents		accepted on 4/11/18 by the national	
		en 7 PM because some staff		repository.	
	leave at 7 PM. NA #7	7 stated additional staff was			
	needed for resident c	are. Administration (unsure			
		ut staff on the schedule that		The procedure for implementing the	
	were not assigned to			acceptable plan of correction for the	e
		form. "I was placed on the		specific deficiency cited	
		assigned to work." Further revealed she was not sure of		On 4/13/18, the facility signed a cor	otract
	the actual dates.			with a staffing agency to provide suf nursing staffing.	
	Interview on 4/11/18 a	at 6:15 AM with NA #8 who			
		the 100 and 200 resident		On 5/4/18, the facility began offering	ga
		on 4/8/18. She reported she		sign on bonus for certified nursing	
		sident's needs to provide answer call lights in a timely		assistants, licensed practical nurses registered nurses.	s, and
		ducted on 4/11/18 at 7:00		On 4/10/18, a second Certified Nurs	sing
		ouring the interview, Nurse		Assistant (CNA) was hired to join th	
	#9 reported she had	worked at the facility with 1		shower team.	
	(one) NA on 100/200			On 4/18/18, the facility consultant	
		one) nurse to oversee 3		in-serviced the director of nursing (I	DON)
		ninistering medications. with Nurse #9 stated the		on providing showers per resident	
	impact of not having e			preference On 4/18/18, the Staff Development	
		aborated by saying the		Coordinator (SDC) was in-serviced	by the
		changed as often or may not		DON on providing showers per resid	
		r meals like they should.		preference.	
				By 5/14/18, all nursing staff, includin	
	Interview on 4/12/18			newly hired nursing staff, and agend	
	Administrator stated I	Resident #007 was		be in-serviced by the SDC on provid	hina

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/22/2018 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345144	B. WING			C 04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHAE			70	6 PINEYWOOD ROAD		
				TH	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 725	transferred to bed at the assigned NA was wanted to put her to b mechanical lift was re- Interview was conduc 4:45 PM. During the she did showers for re- reported there was a the nursing station to residents. NA #9 repor- may not have time to	5:00 PM on 4/6/18 because leaving at 7PM so staff bed early because a equired. ted with NA #6 on 4/12/18 at interview, NA #6 reported esidents at the facility. She shower schedule located at indicate the shower days for orted the NAs on the floor	F	725	showers per resident choice and the documentation of showers given. This in-service will be part of the orientatio process for all newly hired nursing statincluding agency staff. From 4/11/18 until 4/12/18 and 4/17/1 until 4/19/18, two corporate MDS consultants assisted the facility to achtimely submission of comprehensive Minimum Data Set (MDS) assessment On 4/13/18 and 4/20/18, one corporate MDS consultant to assist the facility in achieving timely submission of comprehensive MDS comprehensive MDS assessments. On 4/13/18 and 4/20/18, one corporate MDS consultant to assist the facility in achieving timely submission of comprehensive MDS assessments. On 4/20/18, the facility consultant in-serviced the MDS Nurse on complet assessments timely. This in-service we be provided to any newly hired MDS Nurses during orientation. By 5/14/18, all comprehensive assessments will be submitted timely will accurately reflect each individual resident. The monitoring procedure to ensure to the plan of correction is effective and specific deficiency cited remains correct and/or in compliance with the regulator requirements The DON, SDC, QI nurse and/or wee manager on duty will audit a minimum 20 residents a week x 4 weeks and th 10 residents a week x 4 weeks and th 10 residents a week x 4 weeks to ensishowers are provided per resident chart in audit will be documented on the Resident Care Audit Tool. The Administrator and/or DON will autit a minimum 20 resident for the fact of the fact o	n ff, 8 ieve ts. e ting ill and that ected ory kend of en ure pice.	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/22/2018 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION		E SURVEY IPLETED
		345144	B. WING			04	C //13/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 07	10/2010
	GE HEALTH AND REHAI			70	6 PINEYWOOD ROAD		
				Tł	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 725	Continued From pag	e 24	F	725	all completed MDS 100% weekly x 4 weeks then 50% of completed MDS assessments are completed timely. T audit will be documented on the MDS audit tool. The staffing scheduler will report in morning meeting the staffing for the current day and report vacant shifts for the week and the status of the filling of vacancies. The SDC and/or DON will share weekly with the Department heat team the open nursing positions that center is currently advertising to fill, he many applicants have applied and the number of new employees hired in the past week. The facility will utilize the contract age to fill vacant tracks of time until perma employees can be hired and oriented. facility will follow the attendance policy address tardies and absences. The fa will offer incentive bonuses to employ who sign up for extra shifts to help fulf the facilities staffing needs. We will maintain sufficient staff by utilizing sta members who normally do not provide direct patient care but have the trainin and/or license to provide direct care in event the facility does not have sufficient staffing. The monthly QI committee will review results of the Resident Care Audit tool MDS audit tool monthly for 3 months f identification of trends, actions taken, to determine the need for and/or frequency of continued monitoring, an make recommendations for monitoring	r f the ad ow ncy nent The / to cility ses ill ff e g the ent the and or and d g for	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/22/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345144	B. WING		04/13/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0
PINE RID(GE HEALTH AND REHAB	BILITATION CENTER		06 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 725	Continued From page		F 725	and/or DON will present the findings recommendations of the monthly QI committee to the quarterly executive committee for further recommendatio 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.	QA ns
SS=C	CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g) 1) Data re- must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following catego unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must post (ii) Data must be post (A) Clear and readable	-(4) affing Information. equirements. The facility and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. post the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows:			

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PINE RIDGE (X4) ID PREFIX TAG F 732 C re § s	ORRECTION VIDER OR SUPPLIER HEALTH AND REHAB SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page esidents and visitors. 6483.35(g)(3) Public a	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDIN B. WING _ ID PREFID TAG	NG STR 706 TH(CONSTRUCTION REET ADDRESS, CITY, STATE, ZIP CODE S PINEYWOOD ROAD OMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	
F 732 C	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page esidents and visitors. (483.35(g)(3) Public a staffing data. The fac	ILITATION CENTER	ID PREFIX TAG	706 TH(×	S PINEYWOOD ROAD OMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA	04/1	(X5) COMPLETIO
PINE RIDGE (X4) ID PREFIX TAG F 732 C re § s	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page esidents and visitors. (483.35(g)(3) Public a staffing data. The fac	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	706 TH(×	S PINEYWOOD ROAD OMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(X4) ID PREFIX TAG F 732 F 732 S S	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From page esidents and visitors. (483.35(g)(3) Public a staffing data. The fac	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	TH(OMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
F 732 C	(EACH DEFICIENC) REGULATORY OR L Continued From page esidents and visitors. (483.35(g)(3) Public a staffing data. The fac	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
F 732 C	(EACH DEFICIENC) REGULATORY OR L Continued From page esidents and visitors. (483.35(g)(3) Public a staffing data. The fac	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
re § s	esidents and visitors. 483.35(g)(3) Public a taffing data. The fac		F 7	732			
re § s	esidents and visitors. 483.35(g)(3) Public a taffing data. The fac			-			
S	staffing data. The fac	access to posted nurse					
1	•	ility must, upon oral or					
	available to the public exceed the communit	for review at a cost not to y standard.					
re p	osted daily nurse sta	data retention cility must maintain the iffing data for a minimum of irred by State law, whichever					
is T	s greater.	is not met as evidenced					
E	-	ew and staff interviews the staff posting data.			An acceptable plan of correction must contain the following elements: " The plan of correcting the specific		
R		3/18 of the daily staff			deficiency. The plan should address the processes that lead to the deficiency	e	
F		o staff posting data for			cited; " The procedure for implementing the	ne	
 (/	ADON) on 4/13/18 at	sistant Director of Nurses 2:30 PM revealed the			acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of procedure is effective.		
a s	and filing of the forms scheduler resigned ar	sible for the daily posting . However, on 4/13/18 the nd the Director of Activities			that the plan of correction is effective a that specific deficiency cited remains corrected and/or in compliance with the		
P s	PM on 4/13/18, the Al she was unable to loc	responsible. Later at 2:45 DON returned who indicated ate the above missing staff			regulatory requirements; " The title of the person responsible implementing the acceptable plan of	for	
n	oosting and expected naintained. On 4/23/18 an email v	the staff posting be vas received from the			correction. F732		
a s	administrator with atta staffing for February 1	achments of the daily nurse I-12, 2018, February 17-28,			The plan of correcting the specific		
	2018 and March 2018 posting for 2/13/18-2/	 There was no daily staff 16/18. 			deficiency The position of Pine Ridge Nursing and		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/22/2018 1 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345144	B. WING				_ 13/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 01	
PINE RID	GE HEALTH AND REHAB	ILITATION CENTER			6 PINEYWOOD ROAD		
	-			TI	HOMASVILLE, NC 27360		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 732	Continued From page	227	F	732	Rehabilitation center regarding the process that lead to this deficiency □ facility failed to retain staff posting data was knowledge deficit. On 4/22/18, the Activities Director (AD was able to locate the missing nurse staffing posting information for the mor of February 2018 and March 1st throug the 14th of 2018 excluding dates 2/13/ to 2/16/18. Administrator sent staff posting information to survey team lead for February 2018 and March 1st - 14th, 2 excluding 2/13/18 to 2/16/18 on 4/23/1 The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/20/18, the facility consultant in-serviced the director of nursing (DO and Administrator on posted nurse staff information retention. On 4/20/18, the Assistant Director of Nursing (ADON) and AD were in-service by the DON/Administrator on posted nurse staffing information retention. By 5/14/18 all people involved with scheduling (ADON and AD), will be in-serviced by the Administrator, DON and/or SDC on retention of staff postin information. This in-service will be part the orientation process for all newly hir staff involved with scheduling. The monitoring procedure to ensure th the plan of correction is effective and tf specific deficiency cited remains correct) nth gh 18 018 8. N) ffing ced g of red at nat	

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Facility ID: 923017

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/22/2018 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/13/2018	
		345144	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHAE	SILITATION CENTER		70	6 PINEYWOOD ROAD		
				TH	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	Continued From page	e 28	F 7	732	and/or in compliance with the regulator requirements The DON, SDC, QI nurse and/or Administrator will audit staff posting retention weekly x 12 weeks, to include weekends, to ensure all dates are accounted for and nurse staffing information is posted and accurate. Thi information will be recorded on the Staffing Posting Potention Audit tool)	
					Staffing Posting Retention Audit tool. The monthly QI committee will review to results of the Staffing Posting Retention audit tool monthly for 3 months for identification of trends, actions taken, at to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrate and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QC committee for further recommendations and oversight.	n Ind for or nd A	
					The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible f implementing the acceptable plan of correction.	for	
F 755 SS=E	CFR(s): 483.45(a)(b) §483.45 Pharmacy S The facility must prov	ervices ride routine and emergency to its residents, or obtain	F 7	755			5/14/18

Facility ID: 923017

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		ID HUMAN SERVICES MEDICAID SERVICES			F	PRINTED: 05/22/2018 FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED		
		345144	B. WING			C 04/13/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE			
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE		
F 755	personnel to administ permits, but only und a licensed nurse. §483.45(a) Procedure pharmaceutical servic that assure the accur dispensing, and admi biologicals) to meet th §483.45(b) Service C must employ or obtai pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility. §483.45(b)(2) Establi receipt and dispositio sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on observatio pharmacy, consultant interviews, the facility accurate accounting of for 1 of 4 sampled res reviewed who received prescribed on an as r	lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. Consultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of in of all controlled drugs in able an accurate hines that drug records are in count of all controlled drugs riodically reconciled. T is not met as evidenced ins, record review and t pharmacist, and staff f failed to maintain an of all controlled medications sidents (Resident #118) ed a controlled medication heeded basis.	F 7	An acceptable plan o contain the following e " The plan of corre deficiency. The plan s processes that lead to cited; " The procedure fo acceptable plan of corre	f correction must elements: cting the specific should address the o the deficiency or implementing the prection for the			
		needed basis.		" The procedure fo acceptable plan of co specific deficiency cite	rrection for the			

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						O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	i		С
		345144	B. WING			-
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04	4/13/2018
	KONDER OR SOLT EIER			706 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETIC DATE
F 755	Continued From page	e 30	F 75	5		
		dmitted to the facility on		that the plan of correction is effe	ective and	
		Resident #118 's medication		that specific deficiency cited ren		
		vsician 's order was written		corrected and/or in compliance		
		igrams (mg) oxycodone (an		regulatory requirements;		
		n) to be given as one tablet		" The title of the person resp	onsible for	
	by mouth every 6 hou	irs as needed. Oxycodone		implementing the acceptable pla	an of	
	is a controlled medica	ation.		correction.		
	A review of Resident	#118 ' s February 2018		F755		
	Medication Administra					
		10 mg oxycodone were		The plan of correcting the speci	fic	
	administered to the re	esident from 2/13/18 to		deficiency		
	2/28/18 on the followi	ing dates:				
	On 2/13/18, 3 doses	s of oxycodone were		The position of Pine Ridge Nurs	ing and	
	documented as admin	nistered;		Rehabilitation center regarding	the	
	On 2/14/18, 3 doses	s of oxycodone were		process that lead to this deficier	ncy □	
	documented as admin	nistered;		failure to maintain an accurate a	accounting	
	On 2/15/18, 2 doses	s of oxycodone were		of all controlled medications for	1 of 4	
	documented as admin	nistered;		resident s sampled- was failure	e to follow	
	On 2/16/18, 2 doses			established policy.		
	documented as admin	nistered;				
	On 2/17/18, 3 doses			On 4/10/18, resident #118 had o	•	
	documented as admin			reordered from the pharmacy and		
	On 2/18/18, 1 dose	-		arrived on 4/11/18 with the prop		
	documented as admin			documentation of medication re		
	On 2/19/18, 1 dose	5		and the correct receipt/count sh		
	documented as admin			started by the RN hall nurse and	a the RN	
	On 2/20/18, 3 doses	-		supervisor.		
	documented as admin			The procedure for implementing	the	
	On 2/21/18, 2 doses	-		The procedure for implementing acceptable plan of correction fo		
	documented as admined as admined as admined as admined as a documented as a do			specific deficiency cited		
	documented as admin	-		specific denoiency cited		
	On 2/23/18, 2 doses			On 4/10/18 and 4/11/18, the fac	ility	
	documented as admin	-		consultants, director of nursing,	•	
	On 2/24/18, 1 dose			director of nursing, and staff de		
	documented as admin	-		coordinator completed and audi		
		es of oxycodone were		controlled substances ensuring		
		So of oxycouolic were			Sound	

Event ID: 3S4811

Facility ID: 923017

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 05/22/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING		04/1	; 13/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	On 2/26/18, 1 dose documented as admi On 2/27/18, 3 doses documented as admi On 2/28/18, 3 doses documented as admi On 2/28/18, 3 doses documented as admi indicated 43 doses of administered to the re dates: On 3/1/18, 2 doses documented as admi On 3/2/18, 2 doses documented as admi On 3/2/18, 1 dose of documented as admi On 3/4/18, no doses documented as admi On 3/5/18, 1 dose of documented as admi On 3/6/18, 3 doses documented as admi On 3/8/18, 3 doses documented as admi On 3/9/18, 2 doses	of oxycodone was nistered; s of oxycodone were nistered: s of oxycodone were nistered. #118 's March 2018 MAR f 10 mg oxycodone were esident on the following of oxycodone were nistered; of oxycodone were nistered; s of oxycodone were	F 75	 Any negative findings were addressed/investigated immed the auditor, including notification physician as appropriate. On 4/16/18, the facility consult in-serviced the director of nurse on controlled substances and documentation. On 4/16/18, the Staff Develop Coordinator (SDC) was in-sere DON on controlled substances documentation. By 5/14/18, all licensed nurses medication aides, including the hired licensed nurses and mediades and agency staff, will be by the SDC on controlled substances or newly hired licensed nurses, no aides, and agency staff. The monitoring procedure to eat the plan of correction is effecting specific deficiency cited remai and/or in compliance with the requirements The DON, SDC, and/or MDS naudit all medication carts 3 tim 12 weeks to ensure the controlled audit tool. The monthly QI committee will results of the controlled medic tool monthly for 3 months for it of trends, actions taken, and the need for and/or frequency 	on of the tant sing (DON) proper ment viced by the s and proper s and e newly dication e in-serviced stances and -service will ess for all nedication ensure that tive and that ns corrected regulatory nurse will nes a week x olled luding be medication I review the cation audit dentification o determine	

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				ECONSTRUCTION		0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY IPLETED
			A. BOILDING			С
		345144	B. WING		04	./13/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· _ ·	
				706 PINEYWOOD ROAD		
	GE HEALTH AND REHAE			THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 755	Continued From page	a 32	F 75			
1 7 55				-		
	On 3/15/18, 2 doses documented as admi			continued monitoring, and make recommendations for monitoring		
		es of oxycodone were		continued compliance. The adm		
	documented as admi	-		and/or DON will present the find		
	On 3/17/18, 1 dose	-		recommendations of the monthl	•	
	documented as admi	-		committee to the quarterly exec		
	On 3/18/18, 1 dose			committee for further recommer		
	documented as admi	-		and oversight.		
	On 3/19/18, 1 dose	of oxycodone was				
	documented as admi	nistered;		The title of the person responsit		
	On 3/20/18, 2 doses			implementing the acceptable pla	an of	
	documented as admi			correction.		
	On 3/21/18, 3 doses			The Director of Nursing is respo		
	documented as admi			implementing the acceptable pla	an of	
		es of oxycodone were		correction.		
	documented as admi On 3/23/18, 1 dose					
	documented as admi	5				
	On 3/24/18, 1 dose	-				
	documented as admi					
		es of oxycodone were				
	documented as admi	-				
		es of oxycodone were				
	documented as admi	nistered;				
	On 3/27/18, 1 dose	of oxycodone was				
	documented as admi					
	On 3/28/18, 2 doses	-				
	documented as admi					
	On 3/29/18, 1 dose	-				
	documented as admi	-				
	On 3/30/18, 1 dose	-				
	documented as admi On 3/31/18, 1 dose					
	documented as admi	-				
	A roviow of Bosidant	#118 ' a April 2019 MAD an				
		#118 ' s April 2018 MAR on doses of 10 mg oxycodone				
		the resident thus far during				
	the month:	the resident thus lat during				

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/22/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		X3) DATE COMP	SURVEY PLETED
		345144	B. WING					C 13/2018
	ROVIDER OR SUPPLIER GE HEALTH AND REHAE	BILITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CO 706 PINEYWOOD ROAD THOMASVILLE, NC 27360	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	E	(X5) COMPLETION DATE
F 755	 On 4/1/18, 1 dose of documented as admi On 4/2/18, 2 doses documented as admi On 4/3/18, 2 doses documented as admi On 4/3/18, 2 doses documented as admi On 4/4/18, 3 doses documented as admi On 4/5/18, 2 doses documented as admi On 4/6/18, 3 doses documented as admi On 4/7/18, 3 doses documented as admi On 4/8/18, 3 doses documented as admi On 4/8/18, 3 doses documented as admi On 4/8/18, 3 doses documented as admi -On 4/10/18 at 3:05 P Nursing (DON) was a Controlled Substance declining inventory reoxycodone. The Corr Receipt/Count Sheet be located. A telephone interview at 3:56 PM with Phar represented the phar facility to dispense m interview, the pharma 	of oxycodone was nistered to Resident #118; of oxycodone were nistered; of oxycodone were nistered. conducted on 4/10/18 at 3:05 edication cart. The there were no oxycodone dy stored on the cart for M, the facility ' s Director of asked for the most recent e Receipt/Count Sheet (a ecord) for Resident #118 ' s ntrolled Substance for the oxycodone could not was conducted on 4/10/18 macist #1. Pharmacist #1 macy contracted by the edications. During the acist reported a prescription mg oxycodone was last	F	755				

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/22/2018 FORM APPROVED //B NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345144	B. WING				C 04/13/2018
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	06 PINEYWOOD ROAD		
	E HEALTH AND REHAE	SILITATION CENTER		т	THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	on 4/11/18 at 10:00 A Administrator and Co Administrator reporte last night (4/10/18) fo all of the medication of facility was currently in cart in question on the Administrator reporte the doses of oxycodo administered (accord #118. A follow-up interview 11:14 AM with the Ad Consultant #2. The A were 26 - 10 mg table oxycodone that could 2/13/18 to date). The would be notifying the 5-day report with the Enforcement Agency controlled medication An interview was con PM with Corporate Co Consultant #2, and C During the interview, process they followed missing oxycodone ta reported 94 tablets of documented on the M Resident #118 from 2 in February, 43 doses April). A review of the indicated 120 tablets	n interview was conducted M with the facility 's rporate Consultant #2. The d an initial audit was done r controlled medications on carts. She reported the re-auditing the medication e 200 Hall. The d they were also counting ne documented as ing to the MAR) for Resident was conducted on 4/11/18 at ministrator and Corporate Administrator reported there ets of Resident #118 's not be accounted for (from e Administrator reported she e police, filing a 24-hour, State, and notifying the Drug (DEA) of the missing ducted on 4/11/18 at 4:17 onsultant #1, Corporate orporate Consultant #3. the consultants detailed the t to determine the number of ablets. The consultants i 10 mg oxycodone were IAR as administered to /13/18 to 4/8/18 (33 doses is in March, and 18 doses in e pharmacy records of 10 mg oxycodone were of 2/12/18, which left 26 or. The consultants	F	755			

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		ID HUMAN SERVICES			PRINTED: 05/ FORM APP	ROVE
STATEMENT C	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE COMPLETED	ΞY
		345144	B. WING		C 04/13/20	18
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				706 PINEYWOOD ROAD		
PINE RIDG	E HEALTH AND REHAE	SILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COM THE APPROPRIATE	(X5) PLETION DATE
F 755	Continued From page	a 35	F 75	55		
	Receipt/Count Sheet		170			
	oxycodone could not					
	An interview was con	ducted on 4/12/18 at 11:15				
	-	s consultant pharmacist.				
		the consultant pharmacist she had in the reconciliation				
		ions at the facility. The				
		each month she review the				
narcotic books on the halls. When asked if she						
		ncerns regarding controlled sultant pharmacist stated her				
		in regards to the "holes" on				
		lining inventory (referring to				
	missing documentation	-				
	•	e included information on				
	the facility 's Adminis	d in her monthly reports to strator and DON.				
		ducted on 4/13/18 at 2:00				
		uring the interview, the DON				
	reported she would e	rount Sheet to be retrievable				
	-	ications to allow for the				
	0	dications. The DON also				
		ect the documentation on a				
	resident 's MAR to m	hatch the declining inventory				
	Receipt/Count Sheet					
F 842		dentifiable Information	F 84	42	5/14/	/18
SS=E	CFR(s): 483.20(f)(5),	483.70(i)(1)-(5)				
	§483.20(f)(5) Resider	nt-identifiable information.				
	(i) A facility may not r	elease information that is				
	resident-identifiable to	•				
	(ii) The facility may re resident-identifiable to	elease information that is				
		ntract under which the agent				

Facility ID: 923017

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/22/20 MAPPROVE O. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345144	B. WING		04	C / 13/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHA		7	06 PINEYWOOD ROAD		
		BIEITATION CENTER	1	THOMASVILLE, NC 27360		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 36	F 842			
1 012	1.0	disclose the information	1 042			
		the facility itself is permitted				
	§483.70(i) Medical re	ecords. rdance with accepted				
		ds and practices, the facility				
	•	al records on each resident				
	that are-					
	(i) Complete;					
	(ii) Accurately docum (iii) Readily accessible					
	(iv) Systematically or					
	all information contai	cility must keep confidential ned in the resident's records,				
	records, except wher	n or storage method of the				
	(i) To the individual, o					
		e permitted by applicable law;				
	(ii) Required by Law;					
		yment, or health care tted by and in compliance S:				
		activities, reporting of abuse,				
	neglect, or domestic	violence, health oversight				
	-	administrative proceedings,				
		poses, organ donation purposes, or to coroners,				
		uneral directors, and to avert				
	a serious threat to he	ealth or safety as permitted				
	by and in compliance	e with 45 CFR 164.512.				
		ility must safeguard medical gainst loss, destruction, or				
		I records must be retained				
	1		1			1

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345144	B. WING			0	C)4/13/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				70	06 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	 (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under State §483.70(i)(5) The ment (i) Sufficient informati (ii) A record of the rese (iii) The comprehension provided; (iv) The results of any and resident review of determinations condut (v) Physician's, nurse professional's progret (vi) Laboratory, radio services reports as reserved. 	required by State law; or he date of discharge when ent in State law; or ars after a resident reaches e law. edical record must contain- tion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening evaluations and ucted by the State; b's, and other licensed	F	842			
	and accurate docume administration of com Medication Administra Controlled Substance declining inventory re residents reviewed w opioid pain medicatio needed basis (Reside Resident #005, and F The findings included	actitioner, and staff failed to maintain consistent entation regarding the trolled medications on the ation Record (MAR) and e Receipt/Count Sheet (a ecord) for 4 of 4 sampled who received oxycodone (an on) prescribed on an as ent #118, Resident #009, Resident #004). d: s admitted to the facility on			An acceptable plan of correction mu contain the following elements: "The plan of correcting the speci deficiency. The plan should address processes that lead to the deficiency cited; "The procedure for implementing acceptable plan of correction for the specific deficiency cited; "The monitoring procedure to en that the plan of correction is effective that specific deficiency cited remains corrected and/or in compliance with regulatory requirements; "The title of the person responsite implementing the acceptable plan of	fic the the the sure and s the ble for	

Facility ID: 923017

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	FIPLE	CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING			LETED
		345144	B. WING				C 13/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E HEALTH AND REHAE			70	06 PINEYWOOD ROAD		
	DE REALTH AND REHAL	SENATION CENTER		T	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 842	Continued From page	a 38		842			
1 0 7 2				542	5040		
		ligrams (mg) oxycodone to et by mouth every 6 hours as			F842		
		is a controlled medication.			The plan of correcting the specific deficiency		
	A review of the last 3	0 days of documentation					
		stration of 10 mg oxycodone			The position of Pine Ridge Nursing ar	nd	
	to Resident #118 was	s conducted. The Controlled			Rehabilitation center regarding the		
		count Sheet for the 10 mg			process that lead to this deficiency \square		
	•	vailable for this period of			facility failed to maintain consistent ar		
		Substance Receipt/Count			accurate documentation regarding the		
		nventory record which would			administration of controlled medication		
	•	In the date and number of			the Medication Administration Record		
	medication inventory	thdrawn from the controlled			(MAR) and Controlled Substance Receipt/Count sheet- was failure to for	llow	
		Idition, Resident #118 's			policy and procedure.		
	March 2018 and Apri						
	•	d (MAR) were identified to			On 4/10/18, resident #118 had oxycod	done	
		on each of the following			reordered from the pharmacy and it		
	dates:				arrived on 4/11/18 with the proper		
	On 3/17/18, 1 dose	of oxycodone was			documentation of medication received	t	
		nistered on the front of the			and the correct receipt/count sheet wa	as	
		loses of oxycodone were			started by RN hall nurse and RN		
		nistered to the resident on			Supervisor.		
	the back of the MAR. On 3/18/18, 1 dose				On 1/10/18 resident # 000 hes		
		nistered on the front of the			On 4/10/18, resident # 009 has oxycodone reordered from the pharm	acv	
		doses of oxycodone were			and it arrived on 4/10/18 with the prog	•	
		nistered to the resident on			documentation of medication received		
	the back of the MAR.				and the correct receipt/count sheet wa		
	On 3/21/18, 3 doses				started by LPN hall nurse and RN		
		nistered on the front of the			supervisor.		
		ose of oxycodone was			On 4/10/18, resident #005⊡s Medicat		
		nistered to the resident on			administration record and declining co		
	the back of the MAR.				sheet for oxycodone were reviewed b		
	On 3/27/18, 1 dose	-			Staff Development Coordinator to ens		
		nistered on the front of the			as of 4/10/18 the declining narcotic co		
		loses of oxycodone were			sheet was correct to match the number	er ot	
	uocumented as admi	nistered to the resident on			pills currently present.		

Facility ID: 923017

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TEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) D	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	OMPLETED
						С
		345144	B. WING			04/13/2018
ME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	SE HEALTH AND REHAB			706 PINEYWOOD ROAD		
				THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIC DATE
F 842	Continued From page	39	F 84	2		
	On 3/29/18, no dose			administration record and	declinina count	
		nistered on the front of the		sheet for oxycodone were	-	
	MAR. However, 1 do	se of oxycodone was		Director of Nursing to ensu	•	
		nistered to the resident on		4/10/18 the declining narco		
	the back of the MAR.			was correct to match the n	umber of pills	
	On 3/30/18, 1 dose			currently present.		
		nistered on the front of the oses of oxycodone were		The procedure for impleme acceptable plan of correcti	-	
		nistered to the resident on		specific deficiency cited		
	the back of the MAR.			specific densiency cited		
	On 3/31/18, 1 dose	of oxycodone was		On 4/10/18 and 4/11/18, th	e facility	
		nistered on the front of the		consultants, director of nur		
		oses of oxycodone were		director of nursing, and sta		
		nistered to the resident on		coordinator completed and		
	the back of the MAR	f ovverdene wee		controlled substances ensu	-	
	On 4/3/18, 1 dose of	nistered on the front of the		were correct with correct d Any negative findings were		
		ses of oxycodone were		addressed/investigated im		
		nistered to the resident on		the auditor, including notifi		
	the back of the MAR.			physician, pharmacy, and		
	On 4/8/18, 3 doses	-		as appropriate.		
		nistered on the front of the		On 4/16/18, the facility con		
		oses of oxycodone were		in-serviced the director of r	0 ()	
	the back of the MAR.	nistered to the resident on		on controlled substances a documentation.	and proper	
				On 4/16/18, the Staff Deve	lonment	
	An interview was con	ducted on 4/12/18 at 11:15		Coordinator (SDC) was in-		
		consultant pharmacist.		DON on controlled substar		
	During the interview,	the consultant pharmacist		documentation.		
		identified any concerns		By 5/14/18, all licensed nu		
		nedications. The consultant		medication aides, including		
	pharmacist stated her regards to the "holes"	biggest concern was in		hired licensed nurses and aides and agency staff, wil		
	declining inventory (re			by the SDC on controlled s		
		consultant pharmacist		proper documentation. Thi		
		formation on the concerns		be part of the orientation p		
	identified in her month	nly reports to the facility ' s		newly hired licensed nurse		
	Administrator and DO	N		aides, and agency staff.		

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							<u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	E SURVEY PLETED
			A. DOILDING	<u> </u>			С
		345144	B. WING				U /13/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 04	13/2010
					6 PINEYWOOD ROAD		
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		TH	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 842	Continued From nor	- 40		40			
F 042	p3-		F 84	42	-		
		ducted on 4/13/18 at 9:20			The monitoring procedure to ensure the		
		actitioner (NP) who helped			the plan of correction is effective and t		
		he facility. During the keeping discrepancies			specific deficiency cited remains corre and/or in compliance with the regulato		
		he MAR, the back of the			requirements	'' y	
	MAR, and the Contro						
		were discussed. When			The DON, SDC, and/or MDS nurse wi	11	
	•	f information she used in the			audit all medication carts 3 times a we		
	decision-making proc	ess to care for the			12 weeks to ensure the controlled		
	residents, the NP rep	orted she would sometimes			substance documentation is correct. T	his	
	use the declining inve	entory sheet in the narcotic			audit will be documented on the control	olled	
		rt (the Controlled Substance			medication audit tool.		
); and sometimes the front of			The monthly QI committee will review		
		ig back to a previous month			results of the controlled medication au		
		of resident 's medication			tool monthly for 3 months for identifica		
		ed she was not aware there s between these records.			of trends, actions taken, and to determ the need for and/or frequency of	line	
		s between these records.			continued monitoring, and make		
	An interview was con	ducted on 4/13/18 at 2:00			recommendations for monitoring for		
		uring the interview, the DON			continued compliance. The administra	tor	
		s she expected nursing staff			and/or DON will present the findings a		
	to follow when admin				recommendations of the monthly QI		
		needed basis. The DON			committee to the quarterly executive Q	QA	
	stated the resident ne	eeded to be assessed and			committee for further recommendation	IS	
		be sure a current order was			and oversight.		
		g was appropriate to give					
	the medication prior t				The title of the person responsible for		
	medication. Once the				implementing the acceptable plan of		
		propriate for administration, ted to pull the medication			correction. The Director of Nursing is responsible	for	
	-	gn the med out on the			implementing the acceptable plan of	101	
		e Receipt/Count Sheet, and			correction.		
		o the resident. When the					
	•	med cart, she was expected					
		ication administration by					
		the front of the MAR. The					
	DON also indicated s	he expected the nurse to					
		he MAR the date/time the					
	med was given, the n	ame of the medication, the					1

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/22/201 FORM APPROVEI MB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION		3) DATE SURVEY COMPLETED
		345144	B. WING				C 04/13/2018
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
				706	PINEYWOOD ROAD		
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		TH	OMASVILLE, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	indication, and the reaction of the DON stated she on a resident 's MAR the declining inventor Substance Receipt/C reported she expecte Receipt/Count Sheet controlled medication 2) Resident #009 wa 2/13/18. A review of F orders revealed a phy on 3/16/18 for 10 mill opioid pain medication by mouth every 6 hou Oxycodone is a contr A review of the last 30 related to the administ to Resident #009 was Substance Receipt/C oxycodone was not a time. The Controlled Sheet is a declining in provide information o oxycodone tablets with medication inventory Resident #009. In ad March 2018 and April Administration Recom- have discrepancies o dates: On 3/16/18, 1 dose documented as admini- the back of the MAR. On 3/18/18, 1 dose	sults or effectiveness of it. expected the documentation a to be consistent and match y record on the Controlled ount Sheet. The DON also d the Controlled Substance to be retrievable for all s. s admitted to the facility on Resident #009 ' s medication ysician ' s order was written igrams (mg) oxycodone (an n) to be given as one tablet urs as needed for pain. olled medication. 0 days of documentation stration of 10 mg oxycodone s conducted. The Controlled ount Sheet for the 10 mg vailable for this period of Substance Receipt/Count nventory record which would n the date and number of thdrawn from the controlled for administration to ldition, Resident #009 ' s 2018 Medication d (MAR) were identified to n each of the following of oxycodone was nistered on the front of the poses of oxycodone were nistered to the resident on	F	842			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/22/2018 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345144	B. WING				C 04/13/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP COL	DE	
	GE HEALTH AND REHAE			706	PINEYWOOD ROAD		
	SE NEALTH AND REHAD	SILITATION CENTER		TH	OMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 842	MAR. However, 2 dos documented as admit the back of the MAR. On 3/19/18, 1 dose documented as admit MAR. However, no do documented as admit the back of the MAR. On 3/20/18, 2 doses documented as admit MAR. However, 1 dos documented as admit the back of the MAR. On 3/21/18, 3 doses documented as admit MAR. However, no do documented as admit the back of the MAR. On 3/23/18, 2 doses documented as admit MAR. However, no do documented as admit MAR. However, no do documented as admit the back of the MAR. On 3/24/18, 1 dose documented as admit the back of the MAR. On 3/26/18, 2 doses documented as admit MAR. However, no do documented as admit the back of the MAR. On 3/26/18, 2 doses documented as admit MAR. However, 1 dos documented as admit MAR. However, no do	ses of oxycodone were nistered to the resident on of oxycodone was nistered on the front of the oses of oxycodone were nistered to the resident on s of oxycodone were nistered on the front of the se of oxycodone were nistered to the resident on s of oxycodone were nistered to the resident on s of oxycodone were nistered to the resident on s of oxycodone were nistered to the resident on of oxycodone was nistered to the resident on of oxycodone was nistered on the front of the oses of oxycodone were nistered on the front of the oses of oxycodone were nistered to the resident on of oxycodone was nistered to the resident on s of oxycodone were nistered to the resident on s of oxycodone were nistered to the resident on f oxycodone was nistered on the front of the oses of oxycodone was nistered to the resident on f oxycodone was nistered on the front of the oses of oxycodone were nistered to the resident on	F	842			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/22/2018 ORM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION		ATE SURVEY DMPLETED	
		345144	B. WING				04/13/2018	
	ROVIDER OR SUPPLIER	BILITATION CENTER		706	REET ADDRESS, CITY, STATE, ZIP CODE PINEYWOOD ROAD OMASVILLE, 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	MAR. However, 1 doc documented as admit the back of the MAR. On 4/6/18, 1 dose of documented as admit MAR. However, no do documented as admit the back of the MAR. On 4/7/18, 2 doses documented as admit MAR. However, 1 doc documented as admit the back of the MAR. On 4/8/18, 3 doses documented as admit MAR. However, 1 doc documented as admit the back of the MAR. On 4/8/18, 3 doses documented as admit MAR. However, 1 doc documented as admit the back of the MAR. On 4/8/18, 3 doses documented as admit the back of the MAR. On 4/8/18, 3 doses documented as admit the back of the MAR. An interview was com PM with the facility 's During the interview, was asked if she had regarding controlled in pharmacist stated he regards to the "holes" declining inventory (re documentation). The stated she included in identified in her mont Administrator and DC An interview was com AM with the Nurse Pr care for residents at to interview, the record-	nistered on the front of the se of oxycodone was nistered to the resident on of oxycodone was nistered on the front of the oses of oxycodone were nistered to the resident on of oxycodone were nistered on the front of the se of oxycodone were nistered to the resident on of oxycodone were nistered to the resident on of oxycodone were nistered on the front of the se of oxycodone was nistered to the resident on ducted on 4/12/18 at 11:15 s consultant pharmacist. the consultant pharmacist identified any concerns medications. The consultant r biggest concern was in " on the MAR and the eferring to missing e consultant pharmacist nformation on the concerns hly reports to the facility ' s DN.	F	342				

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		TE SURVEY
ND FLAN UF	UURREUTIUN	IDENTIFICATION NUMBER:	A. BUILDING	3		
						С
		345144	B. WING	· · · · · · · · · · · · · · · · · · ·	0	4/13/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Ε	
				706 PINEYWOOD ROAD		
	BE HEALTH AND REHAU	BEHATION CENTER		THOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION
F 842	Continued From page	e 44	F 84	2		
-		were discussed. When	101	-		
		f information she used in the				
	decision-making prod					
		ported she would sometimes				
		entory sheet in the narcotic				
	•	art (the Controlled Substance				
); and sometimes the front of				
	-	ng back to a previous month				
		of resident 's medication				
		ed she was not aware there				
		s between these records.				
	An interview was cor	nducted on 4/13/18 at 2:00				
		uring the interview, the DON				
		ss she expected nursing staff				
	to follow when admin					
		needed basis. The DON				
		eeded to be assessed and				
	the MAR checked to	be sure a current order was				
	in place and the timir	ng was appropriate to give				
	the medication prior	to administering the				
	medication. Once th	e medication was				
		propriate for administration,				
		ted to pull the medication				
		gn the med out on the				
		e Receipt/Count Sheet, and				
	0	o the resident. When the				
		med cart, she was expected				
		lication administration by				
		the front of the MAR. The				
		she expected the nurse to				
		he MAR the date/time the				
	•	name of the medication, the				
		sults or effectiveness of it.				
		expected the documentation				
		R to be consistent and match				
	-	ry record on the Controlled Count Sheet. The DON also				

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/22/2018 FORM APPROVEE B NO. 0938-039	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345144	B. WING				C 04/13/2018	
NAME OF PF	OVIDER OR SUPPLIER	·	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	E HEALTH AND REHAE			7	706 PINEYWOOD ROAD			
				ר	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	- 45		040				
1 042			F	842				
	controlled medication	to be retrievable for all s.						
	,	s admitted to the facility on Resident #005 ' s medication						
	orders revealed a phy	ysician ' s order was written grams (mg) oxycodone (an						
	-	n) to be given as one tablet						
		urs as needed for pain.						
	Oxycodone is a contr							
		0 days of documentation for						
	#005 was conducted.	5 mg oxycodone to Resident . Resident #005 ' s						
		ation Records (MAR) and						
		e Receipt/Count Sheet (a						
		cord) included discrepancies s on each of the following						
	dates:	s on each of the following						
	On 3/22/18, 1 dose	of oxycodone was						
		nistered on the front and						
	back of the MAR.							
	However, the Control							
	Receipt/Count Sheet	drawn from the controlled						
	medication inventory							
	On 3/24/18, 1 dose							
		nistered on the front of the						
		oses of oxycodone were						
		nistered to the resident on						
	Receipt/Count Sheet	The Controlled Substance						
	-	drawn from the controlled						
	medication inventory							
	On 3/25/18, 3 doses	s of oxycodone were						
		nistered on the front of the						
		oses of oxycodone were nistered to the resident on						
		The Controlled Substance						

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/22/2018 FORM APPROVED //B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		B) DATE SURVEY COMPLETED
		345144	B. WING				C 04/13/2018
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	GE HEALTH AND REHAE			70	6 PINEYWOOD ROAD		
	JE NEALTH AND REHAD	SILITATION CENTER		Tł	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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	Receipt/Count Sheet oxycodone were with medication inventory On 3/26/18, 1 dose documented as admin MAR. However, no d documented as admin the back of the MAR. Receipt/Count Sheet oxycodone were with medication inventory A review of Resident revealed the 5 mg ox was discontinued on received on 3/29/18 f given by mouth as on needed for pain rated scale of 0-10) and twi to be given by mouth pain rated as 6-10. On 3/30/18, no dose documented as admin of the MAR. However Receipt/Count Sheet oxycodone were with medication inventory On 4/1/18, 4 tablets documented as admin the back of the MAR. Receipt/Count Sheet at the time of the revi tablets were withdraw medication inventory On 4/2/18, 2 tablets	indicated 3 doses of drawn from the controlled for Resident #005. of oxycodone was histered on the front of the loses of oxycodone were histered to the resident on The Controlled Substance indicated 3 doses of drawn from the controlled for Resident #005. #005 ' s physician orders ycodone initiated on 3/20/18 3/27/18. A new order was or 5 mg oxycodone to be the tablet every 4 hours as a s 1-5 (on a pain rating to tablets of 5 mg oxycodone every 4 hours as need for es of oxycodone were histered on the front or back r, the Controlled Substance indicated 2 tablets of 5 mg drawn from the controlled for Resident #005. of oxycodone were histered on the front of the olets of oxycodone were histered on the front of the olets of oxycodone were histered to the resident on The Controlled Substance was not available for 4/1/18 ew to indicate how many <i>r</i> n from the controlled for Resident #005.	F	842			

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY
			A. BUILDIN	G		С
		345144	B. WING		04	4/13/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	+/13/2010
				706 PINEYWOOD ROAD		
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
=						
F 842			F 84	42		
		ablets of oxycodone were				
		nistered to the resident on				
		The Controlled Substance				
		was not available for 4/2/18				
		iew to indicate how many				
		vn from the controlled				
	medication inventory					
	On 4/3/18, 4 tablets	•				
		nistered on the front of the				
		blets of oxycodone were nistered to the resident on				
		The Controlled Substance				
		was not available for 4/3/18				
		iew to indicate how many				
		vn from the controlled				
	medication inventory					
	-	ts of oxycodone were				
		nistered on either the front				
		However, the Controlled				
		Count Sheet indicated 4				
		were withdrawn from the				
		inventory for Resident				
	#005.	······································				
	On 4/6/18, 4 tablets	of oxycodone were				
		nistered on the front of the				
		blets of oxycodone were				
		nistered to the resident on				
	the back of the MAR.	The Controlled Substance				
	Receipt/Count Sheet	indicated 6 tablets of				
		drawn from the controlled				
	medication inventory					
	On 4/7/18, 8 tablets	-				
		nistered on the front of the				
		blets of oxycodone were				
		nistered to the resident on				
		The Controlled Substance				
		indicated 10 tablets of				
	oxycodone were with medication inventory	drawn from the controlled				

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		(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	COMPLETED	
						С	
		345144	B. WING		04	4/13/2018	
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COL	DE			
PINE RIDGE HEALTH AND REHABILITATION CENTER				06 PINEYWOOD ROAD HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 842 Continued From page 48 On 4/8/18, 7 tablets of oxycodone were documented as administered on the front of MAR. However, no tablets of oxycodone w documented as administered to the residen the back of the MAR. The Controlled Subst Receipt/Count Sheet indicated 6 tablets of oxycodone were withdrawn from the control medication inventory for Resident #005. On 4/9/18, 6 tablets of oxycodone were documented as administered on the front of MAR. However, no tablets of oxycodone w documented as administered to the residen the back of the MAR. The Controlled Subst Receipt/Count Sheet indicated 6 tablets of oxycodone were withdrawn from the control medication inventory for Resident #005. On 4/10/18, 4 tablets of oxycodone were documented as administered on the front of MAR. However, 3 tablets of oxycodone were documented as administered to the residen the back of the MAR. The Controlled Subst Receipt/Count Sheet indicated 2 tablets of oxycodone were withdrawn from the control medication inventory for Resident #005. On 4/10/18, 4 tablets of oxycodone were documented as administered to the residen the back of the MAR. The Controlled Subst Receipt/Count Sheet indicated 2 tablets of oxycodone were withdrawn from the control medication inventory for Resident #005. An interview was conducted on 4/12/18 at 1		of oxycodone were nistered on the front of the ablets of oxycodone were nistered to the resident on The Controlled Substance indicated 6 tablets of drawn from the controlled for Resident #005. of oxycodone were nistered on the front of the ablets of oxycodone were nistered to the resident on The Controlled Substance indicated 6 tablets of drawn from the controlled for Resident #005. to foxycodone were nistered on the front of the blets of oxycodone were nistered to the resident on The Controlled Substance indicated 2 tablets of drawn from the controlled for Resident #005.	F 842				
	During the interview, was asked if she had regarding controlled r pharmacist stated he regards to the "holes" declining inventory (r documentation). The stated she included in						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				CONCEPTION		OMB NO. 0938-039		
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE A. BUILDING	` '	(X3) DATE SURVEY COMPLETED			
			A. BUILDING		с			
	345144		B. WING		04/13/2018			
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		15/2010			
			70					
PINE RIDGE HEALTH AND REHABILITATION CENTER				IOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842			F 842					
	care for residents at t interview, the record- between the front of t MAR, and the Contro Receipt/Count Sheet asked what source of decision-making proc	were discussed. When f information she used in the						
	binder on the med ca Receipt/Count Sheet the MAR when lookin to review the history use. The NP indicate	entory sheet in the narcotic art (the Controlled Substance); and sometimes the front of ng back to a previous month of resident ' s medication ed she was not aware there s between these records.						
	PM with the DON. D discussed the process to follow when admin medication on an as stated the resident ne the MAR checked to in place and the timin the medication prior to	needed basis. The DON eeded to be assessed and be sure a current order was ng was appropriate to give to administering the						
	the nurse was expect from the med cart, sin Controlled Substance give the medication to nurse returned to the to document the medication	oropriate for administration, ted to pull the medication gn the med out on the e Receipt/Count Sheet, and o the resident. When the med cart, she was expected lication administration by the front of the MAR. The						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345144		B. WING			C 04/13/2018		
NAME OF P			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PINE RID	GE HEALTH AND REHAB	BILITATION CENTER			06 PINEYWOOD ROAD HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFIZ TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 842	The DON stated she on a resident 's MAR the declining inventor Substance Receipt/C reported she expecte Receipt/Count Sheet controlled medication 4) Resident #004 wa 3/15/18. A review of F orders revealed a phy on 3/15/18 for 5 millig opioid pain medicatio tablet (2.5 mg) by mo needed for pain. Oxy medication. A review of the last 30 the administration of 2 Resident #004 was co Medication Administra Controlled Substance declining inventory re over the past 30 days dates: On 3/21/18, no dose documented as admin of the MAR. However, the Control Receipt/Count Sheet oxycodone was withd medication inventory On 3/24/18, 1 dose documented as admin the back of the MAR. Receipt/Count Sheet	expected the documentation to be consistent and match y record on the Controlled ount Sheet. The DON also d the Controlled Substance to be retrievable for all s. s admitted to the facility on Resident #004 ' s medication ysician ' s order was written yrams (mg) oxycodone (an n) to be given as one-half uth every 8 hours as voodone is a controlled 0 days of documentation for 2.5 mg oxycodone to onducted. Resident #004 ' s ation Records (MAR) and e Receipt/Count Sheet (a cord) included discrepancies a on each of the following es of oxycodone were nistered on the front or back led Substance indicated 1 dose of frawn from the controlled for Resident #004. of oxycodone was nistered on the front of the ses of oxycodone were nistered on the front of the ses of oxycodone were nistered to the resident on The Controlled Substance	F	342			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/22/201 FORM APPROVE OMB NO. 0938-039		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345144		B. WING		C 04/13/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
PINE RID	GE HEALTH AND REHAE	BILITATION CENTER		706 PINEYWOOD ROAD THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 842	medication inventory On 3/29/18, no dose documented as admi MAR. However, 2 do documented as admi the back of the MAR. Receipt/Count Sheet oxycodone were with medication inventory On 3/30/18, 1 dose documented as admi MAR. However, no of documented as admi the back of the MAR. Receipt/Count Sheet oxycodone was without medication inventory On 3/31/18, 1 dose documented as admi MAR. However, no of documented as admi MAR. However, no of documented as admi medication inventory On 3/31/18, 1 dose documented as admi the back of the MAR. Receipt/Count Sheet oxycodone were with medication inventory On 4/2/18, 1 dose of documented as admi and back of the MAR Substance Receipt/C doses of oxycodone were controlled medication #004. On 4/3/18, no doses documented as admi of the MAR. However, the Control Receipt/Count Sheet	for Resident #004. es of oxycodone were nistered on the front of the oses of oxycodone were nistered to the resident on The Controlled Substance indicated 3 doses of drawn from the controlled for Resident #004. of oxycodone was nistered on the front of the loses of oxycodone were nistered to the resident on The Controlled Substance indicated 1 dose of drawn from the controlled for Resident #004. of oxycodone was nistered on the front of the loses of oxycodone were nistered to the resident on The Controlled Substance indicated 2 doses of drawn from the controlled for Resident #004. of oxycodone was nistered to the resident on The Controlled Substance indicated 2 doses of drawn from the controlled for Resident #004. of oxycodone was nistered on both the front . However, the Controlled ount Sheet indicated 2 were withdrawn from the inventory for Resident	F 842				

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	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			G	· · ·	IPLETED		
			A. DOILDIN			С	
345144		B. WING		0	4/13/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010		
				706 PINEYWOOD ROAD			
PINE RIDO	GE HEALTH AND REHAE	BILITATION CENTER		THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 842	Continued From non	- 52	F 0				
F 042			F 84	42			
	On 4/4/18, no doses						
	of the MAR.	nistered on the front or back					
	However, the Control	led Substance					
	Receipt/Count Sheet indicated 1 dose of						
		Irawn from the controlled					
	medication inventory	for Resident #004.					
	On 4/6/18, no doses	•					
		nistered on the front or back					
	of the MAR.	lad Subatanaa					
	However, the Control Receipt/Count Sheet						
	-	Irawn from the controlled					
	medication inventory						
	On 4/7/18, 2 doses						
		nistered on the front of the					
		loses of oxycodone were					
		nistered to the resident on					
	Receipt/Count Sheet	The Controlled Substance					
	· ·						
	oxycodone were withdrawn from the controlled medication inventory for Resident #004. On 4/8/18, 2 doses of oxycodone were						
		nistered on the front of the					
	MAR. However, no doses of oxycodone were						
	documented as administered to the resident on						
		the back of the MAR. The Controlled Substance					
	Receipt/Count Sheet						
	medication inventory	Irawn from the controlled					
	On 4/9/18, 2 doses						
		nistered on the front of the					
		loses of oxycodone were					
		nistered to the resident on					
		The Controlled Substance					
	Receipt/Count Sheet						
	oxycodone were with medication inventory	drawn from the controlled					
						1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						F	NTED: 05/22/2018 ORM APPROVED NO. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345144		B. WING			C 04/13/2018			
NAME OF PROVIDER OR SUPPLIER			•	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
PINE RID	GE HEALTH AND REHAB	BILITATION CENTER			9 PINEYWOOD ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	PM with the facility 's During the interview, was asked if she had regarding controlled r pharmacist stated heir regards to the "holes" declining inventory (re documentation). The stated she included in identified in her month Administrator and DC An interview was con AM with the Nurse Pr care for residents at t interview, the record- between the front of t MAR, and the Contro Receipt/Count Sheet asked what source of decision-making proc residents, the NP rep use the declining inve- binder on the med ca Receipt/Count Sheet to review the history of use. The NP indicate may be discrepancies An interview was con PM with the DON. Du discussed the process to follow when admin medication on an as a stated the resident ne-	ducted on 4/12/18 at 11:15 a consultant pharmacist. the consultant pharmacist identified any concerns medications. The consultant r biggest concern was in ' on the MAR and the eferring to missing consultant pharmacist nformation on the concerns hly reports to the facility ' s DN. ducted on 4/13/18 at 9:20 ractitioner (NP) who helped he facility. During the keeping discrepancies he MAR, the back of the lled Substance were discussed. When information she used in the ress to care for the orted she would sometimes entory sheet in the narcotic rt (the Controlled Substance); and sometimes the front of g back to a previous month of resident ' s medication ed she was not aware there is between these records. ducted on 4/13/18 at 2:00 uring the interview, the DON is she expected nursing staff	F	842					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/22/2018 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345144		B. WING		_	(04/') 13/2018
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	• • •	10/2010
PINE RIDO	GE HEALTH AND REHAB	ILITATION CENTER		06 PINEYWOOD ROAD			
				THOMASVILLE, NC 273			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page the medication prior to medication. Once the determined to be app the nurse was expect from the med cart, sig Controlled Substance give the medication to nurse returned to the to document the med putting her initials on DON also indicated s write on the back of th med was given, the n indication, and the res The DON stated she on a resident's MAR	e 54 b administering the e medication was ropriate for administration, ed to pull the medication on the med out on the Receipt/Count Sheet, and b the resident. When the med cart, she was expected ication administration by the front of the MAR. The he expected the nurse to he MAR the date/time the ame of the medication, the sults or effectiveness of it. expected the documentation to be consistent and match y record on the Controlled	F 842	D			

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