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	345144	A. BUILDING _____ B. WING _____	R-C 04/13/2018

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PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A revisit was conducted by the Divison of Health Service Regulation, Nursing Home Licensure and Certification Section on 4/10/18-4/13/18. The deficiency at F641 from the complaint survey on 3/1/18 was corrected effective 4/13/18. However, the facility remained out of compliance with the following deficiencies re-cited during the revisit: F600, F684, F686, F725 and F835. Deficiencies were also re-cited from the revisit for a RE/CI from 2/1/18 (Event ID #928912). Additional deficiencies were identified for a new complaint investigation conducted in conjunction with the revisit (Event ID #3S4811). On 5/14/18 the initial comments were amended to indicate F684 was in compliance as of 4/13/18.	F 000		
{F 600} SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	{F 600}	An acceptable plan of correction must	5/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/07/2018

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{F 600}	Continued From page 1 interviews, interview with the pharmacist, interview with the nurse practitioner and record review the facility neglected to provide pain relief for a resident that was ordered for scheduled pain medication. The resident went without pain relief for two days.(Resident #118) This was for 1 of 3 residents reviewed for pain management. Resident #18 was in a soiled brief for three hours after notifying staff of the incontinence. This was for 1 out of three residents reviewed for activities of daily living. Findings included: a. Resident #118 was admitted to the facility on 4/16/15 with cumulative diagnoses which included depression, anxiety disorder, cerebrovascular accident with left sided hemiparesis, pain in joints of left hand and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/17 revealed Resident #118 was assessed as noted below: " No long term or short-term memory loss. " Modified independence with decision making in new situations. " On a scheduled and PRN (whenever necessary) pain management. " No non-medication intervention. " Vocal complaints of pain. " Indicators of pain or possible pain observed daily. Review of the pain assessment dated 3/1/18 and signed on 3/5/18 revealed resident's daily pain level was 7 (seven)and the pain site was front left shoulder and generalized pain. Described the pain as dull, worse at night, interferes with repositioning and transfers. The assessment indicated that repositioning, positioning devices and medication made the pain better. Continued review of the pain assessment revealed resident	{F 600}	contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F600 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency □ facility failed to provide pain relief for a resident that was ordered for scheduled pain medication and failed to provide timely incontinence care □ was failure to follow established policies. The provider was notified of the need of a hard prescription on 4/9/18 the hall nurse for resident #118□s oxycodone. Oxycodone was ordered from the pharmacy on 4/10/18 and received by facility on 4/11/18 for Resident #118 to manage resident□s breakthrough pain.	

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{F 600}	Continued From page 2 had prn medication orders and was effective in relieving pain. Review of the care plan targeted date of 3/29/18 revealed in part, a focus of potential for actual acute and chronic pain. The goal included the resident would voice a minimal level of pain daily through the next review date. The interventions included acknowledgement of the presence of pain and discomfort, administer pain medication as ordered, note effectiveness, document/report complaints and non-verbal signs of pain. Record review of the April 2018 monthly physician orders included: " Acetaminophen 325 milligrams (mg) po (by mouth) daily (QD) and Acetaminophen 325 mg (2 tablets) po every 4 hours prn for pain or temperature above 100 degrees Fahrenheit. A drug used for the management of mild to moderate pain and fever reducer. " Oxycontin 10 mg CR 1 tablet twice a day po. Oxycontin is a controlled-release opioid analgesic. " Oxycodone 10 mg every 6 hours PRN. Oxycodone is a semisynthetic opioid used to treat moderate to severe pain. Interview on 4/10/18 at 2:50 PM with Resident #118 who stated that the facility ran out of her Oxycodone for several days and they (referring to the nurse) gave me Tylenol (Acetaminophen) and it did not help. Resident #118 stated the intensity of pain level on a scale of 0 (no pain) to 10 (worst pain imaginable) was an eight before and after the administration of Tylenol (Acetaminophen). "I was still in pain." Continued interview with Resident #118 revealed "I get the Oxycodone for chronic pain in my left arm and legs and "every time I ask them (referring to the staff) they tell me the Oxycodone has not come yet "from the pharmacy. Resident #118 stated Oxycodone	{F 600}	Resident #18 received incontinence care on 4/11/18 by the CNA on the hall On 4/13/18, the facility signed a contract with a staffing agency to help staff the building to aide in meeting resident needs. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/19/18, the facility began utilizing agency staff to fill holes in the schedule. The Director of Nursing (DON) sends the agency two weeks worth of needs for them to help fulfill. On 3/9/18 the facility consultant in-serviced the DON on providing timely incontinence care and pain assessment, including documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective. On 3/9/18 the Staff Development Coordinator (SDC) was in-serviced by the DON on providing timely incontinence care and pain assessment, including documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective By 5/14/18 all nursing staff, including the newly hired nursing staff, including agency staff, will be in-serviced by the SDC on providing timely incontinence care and pain assessment, including	

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{F 600}	Continued From page 3 "relieved my pain." Review of the Medication Administration Record (MAR) revealed on the back of the record indicated Oxycodone 10 mg po was administered on 4/7/18 at 2:30 AM or PM (illegible). On the front of the MAR for 4/8/18 were the initials of Nurse #5-who documented twice without a time-that Oxycodone 10 mg had been administered. The block under Nurse #5 initials was superimposed with an x-mark. Review of the progress notes did not have documentation of the administration times associated with Nurse #5. Continued review of the MAR revealed Acetaminophen 650 mg po was initialed as administered at 12 AM, 6 AM and 12PM on 4/9/18 and 4/10/18 at 12 PM. The response to the Acetaminophen was coded as #3 which indicated slightly effective. Review of the progress notes revealed no indication that staff attempted to relieve the resident's pain when Acetaminophen was not effective. Nurse #5 (who administered the Acetaminophen at 12 AM, 6 AM on 4/9/18 and 4/10/18 at 12 PM) was not available for interview. Interview on 4/10/18 at 2:55 PM with Nurse #1 revealed she was unaware of the lack of Oxycodone or the reordering because she just returned to work. Interview via the phone on 4/10/18 at 3:36 PM with the pharmacist from the contracted pharmacy was conducted regarding the ordering of controlled substances. The pharmacist stated a new hard copy prescription was required. Further interview with the pharmacist who stated that the Oxycodone was processed and filled on 4/10/18. and would leave the pharmacy around 6:30 PM-7:30 PM. Interview on 4/10/18 at 5:20 PM with Medication	{F 600}	documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective. This in-service will be part of the orientation process for all newly hired licensed nursing staff, and agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, staff development coordinator, quality assurance nurse and/or weekend manager on duty will audit a minimum of 20 residents a week x 4 weeks and then 10 residents a week x 8 weeks to ensure incontinence care provided timely. This audit will be documented on the Resident Care Audit Tool. The DON, SDC, QI nurse and/or Administrator will audit all progress notes 3 times weekly x 12 weeks, to include weekends, to identify if a resident has pain and that the appropriate interventions were taken and documented either on in the progress notes or on the MAR. This audit will documented on the Progress Note Review Audit Tool. The monthly QI committee will review the results of the Resident Care Audit tool, and progress note review audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator	

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{F 600}	Continued From page 4 Assistant #3 stated she was unaware of Oxycodone not being available. Observation on 4/10/18 at 5:30 PM revealed Resident #118 had facial grimacing and moaning suggestive of pain. The resident stated she was in pain and Tylenol (Acetaminophen) had been given earlier. "I still am in pain at an 8 out of 10 level." Review of the MAR revealed on 4/10/18 at 12 noon Tylenol (Acetaminophen) had been administered. On 4/10/18 at 5:40 PM the administrator was made aware of the resident's expressions of pain. Record review of the MAR revealed the resident was administered Oxycodone 10 mg po on 4/11/18 at 12:01 AM and 6:10 AM for complaints of pain. The response and effectiveness of the Oxycodone was coded as 1 (one) which represented effective. Observation and interview on 4/11/18 at 3:08 PM with Resident #118 revealed resident was lying in bed awake. Resident #118 stated the facility got her medication and received her Oxycodone for pain and felt "better." Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses was conducted. The Administrator indicated that she expected staff to reorder medications in a timely manner to manage the resident's pain. Interview on 4/13/18 at 9:18 AM with the Nurse Practitioner (NP) who stated a communication book for non-emergencies was located at the nurses' station. The NP stated she was told about needing a hard script on 4/9/18. Further interview with the NP revealed she was available at the facility 5 (five) days a week. b. Resident #18 was admitted to the facility on 4/18/17 with cumulative diagnoses which included cerebral vascular accident, diabetes, anemia and a stage 4 sacral wound.	{F 600}	and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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{F 600}	Continued From page 5	{F 600}		

Review of the significant change Minimum Data Set (MDS) dated 1/22/18 revealed resident had short- term and long-term memory problems. He had the memory and recall of staff names, faces and he resided in a nursing home. The MDS was coded 3/2 for personal hygiene which required extensive assistance of one staff and was coded 4/2 for bathing which required total assistance of one staff, always incontinent of bladder and stool and required extensive assistance of 2 staff for bed mobility (turning side to side in bed).
Review of the revised care plan dated 2/16/18 revealed a focus of resident at risk for further pressure ulcer development. The interventions in part included to cleanse perineal area well with each incontinence episode and to apply barrier cream per physician orders.
Observation on 4/11/18 at 9:35 AM was made from the hallway of Resident #18's room as he was lying in bed with the covers over him and motioned to come into the room. The resident stated he was "wet" and had been waiting for 2 hours to get changed. His statement was repeated twice. When asked what time he first asked for assistance, the resident reported around 7:00 AM.
Interview on 4/11/18 at 9:37 AM with Resident #18 who stated he was waiting for someone to help him because he had an incontinent episode and had not received care since the night shift. When asked how he knew the timing, he referred to the large clock on the wall.
Interview on 4/11/18 at 9:40 AM with Nurse # 4 revealed she only had one Nursing Assistant (NA) on the unit because the other scheduled NA was late for work. Further interview with Nurse #4 who stated administration (referring to the Director of Nurses and Administrator) was made aware that we needed another aide and the response was

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{F 600}	Continued From page 6 the scheduled NA was running late and no additional staff was provided. Interview on 4/11/18 at 9:54 AM with NA #1 revealed she just arrived at the facility (no time provide) because she was delayed. Interview on 4/11/18 at 10:01 AM with NA #2 revealed she positioned the resident and fed him. NA # 2 stated "I did not change him because I have not had a chance. Been the only aide since 7 AM. Several residents were calling for assistance needing care but was not able to get to everyone." Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses (DON) was conducted who both stated they were not aware only one NA was on the unit for direct care on 4/11/18. Continued interview revealed the Administrator revealed her expectation was residents to receive proper and timely incontinence care.	{F 600}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	{F 686}		5/14/18

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{F 686}	Continued From page 7 by: Based on observation, record review and staff interview the facility failed to document the assessment of pressure ulcers on admission and on a weekly basis. The facility failed to obtained physician orders for the treatment of advanced pressure ulcers. The facility failed to perform dressing changes in a manner to promote ulcer healing. (Resident #003). The facility failed to document the assessment of pressure ulcers of the feet on a weekly basis. (Resident #2). This was evident in 2 of 3 residents reviewed for pressure sore management. Findings included: 1. Resident #003 was admitted to the facility on 3/9/18 with cumulative diagnoses which included Myasthenia gravis (disease that causes weakness in the muscles) and pressure ulcers to right buttock and left heel. Review of the nursing admission note and re-entry evaluation form dated 3/9/18 revealed a pressure ulcer to the right hip (buttock) and left heel. There was no documented assessment or description of these pressure ulcers. Nurse #7 who authored this assessment was not available for interview. Review of the admission Minimum Data Set (MDS) assessment dated 3/16/18 revealed the resident was alert and oriented who required extensive assistance of (2) two staff members for mobility. The resident was noted with advanced pressure sores. Review of the wound ulcer flowsheet dated 3/16/18 revealed a left heel unstagable pressure ulcer that measured 3.4 centimeters (cm) in length X 3.0 cm in width. At the time of the survey there was no measurement assessment for the right buttocks pressure area. Review of the wound ulcer flowsheet revealed on	{F 686}	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F686 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency □ facility failed to document the assessment of pressure ulcers on admission and on a weekly basis; failed to obtain physician orders for the treatment of advanced pressure ulcers; failed to perform dressing changes in a manner to promote ulcer healing; and failed to document the assessment of pressure ulcers of the feet on a weekly basis- was knowledge deficit. Resident #003 had right hip and left heel assessed on 4/4/18 by the treatment	

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{F 686}	Continued From page 8 3/25/18 the left heel pressure ulcer measured 3.5 cm length X.3 cm width X.1 cm deep. The right side of the buttocks measured 3.8 cm in length X 1.5 cm in width X 1.2 cm in depth. Review of the care plan revised on 3/26/18 revealed a goal to show positive healing with a reduction in the size with interventions that included to toilet frequently, change position and use of a wound vacuum (negative-pressure therapy) for pressure ulcer healing. Review of a verbal physician order dated 3/26/18 revealed a treatment to the left heel with Santyl ointment (a chemical debridement agent) and wrap with kling daily. Review of the monthly physician orders for April 2018 revealed no physician orders for Santyl ointment and kling. Nor were there physician orders since admission for the use of the wound vacuum and wound vacuum setting to treat the right buttock pressure ulcer. Review of the Treatment Administration Record revealed Santyl ointment with Kling treatment and wound vacuum treatments were done from 4/1/18 to 4/11/18. Review of the wound ulcer flowsheet revealed on 4/4/18 the left heel wound measured 3.5 cm length X 3.1 cm in width and 0.2 cm in depth with yellowish colored exudate, 60% yellowish tissue and 40% granulated tissue. The right buttock measured 6.9 cm in length X 3.4 cm in width X 1.1 cm in depth. There was no documented updated assessment of the left heel or right buttock pressure ulcers since 4/4/18. Interview on 4/10/18 at 1:09 PM with the wound care nurse revealed on Mondays Resident #003 attended the Wound clinic who performed the dressing and wound vacuum change. On Wednesdays and Fridays, the facility changed the wound vacuum and dressings.	{F 686}	nurse. Physician orders were clarified on 4/12/18 for wound vacuum and setting for resident #003. Physician orders were obtained on 4/12/18 for Santyl ointment and kling for resident #003. Resident #2 had right heel wound assessed on 4/4/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/12/18, the wound care nurse was in-serviced by corporate wound care specialist on aseptic technique. On 5/7/18, the wound care nurse was in-serviced on completing wound assessments every seven days by the DON. On 4/20/18, the facility consultant in-serviced the director of nursing (DON) on wound assessment, including documentation, and obtaining physician orders or physician clarification. On 4/20/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on wound assessment, including documentation, and obtaining physician orders or physician clarification. By 5/14/18 all licensed nurses and medication aides, including newly hired licensed nurses and medication aides including agency staff, will be in-serviced by the SDC on wound assessment,	

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{F 686}	Continued From page 9 Observation of the wound care on 4/11/18 at 11:35 AM through 12:15 PM performed by the wound care nurse revealed the wound care nurse set up her supplies for changing the wounds. In a plastic cup (5) five white gauze pads were wet with normal saline. The left heel ulcer soiled dressings were removed and a brownish colored thick drainage was noted. One of the wet normal saline gauzes were obtained from the plastic cup to cleanse the wound from the outer portion of skin and perimeter of the wound into the wound bed. The gauze was then folded and the heel ulcer was again cleansed but in an up and down direction. The wound care nurse obtained another wet gauze and again cleansed the heel ulcer in the same manner as noted above. Santyl cream and kling were applied. Her gloves were removed and her hands were washed. The wound vacuum was detached and the wound dressings were removed. The wound care nurse was in the process of using the wet gauze in the container to cleanse the buttock pressure sore that had been used to treat the draining left heel ulcer until an inquiry was made. After the inquiry the wet gauzes were throw away and new gauzes wet with normal saline were prepared. The ulcer on the buttock was cleansed with normal saline wet gauze from the outer portion of skin and wound edges into the wound bed. Another wet gauze was obtained and again the pressure ulcer was cleansed from the outer portion of skin and wound edges into the wound bed. The gauze was then folded and the ulcer was cleansed in a back and forward motion. The wound dressings were applied and the wound vacuum was reattached. The setting was for the wound vacuum was 125 millimeter of mercury (mmHg). Continued record review of the physician orders dated 4/12/18 revealed "Clarification of orders"	{F 686}	including documentation, and obtaining physician orders or physician clarification. This in-service will be part of the orientation process for all newly hired licensed nurses and medication aides, including agency staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 4/20/18, the treatment nurse had follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, aseptic technique, and obtaining physician orders/clarification. The DON, SDC, QI nurse and/or weekend manager on duty will audit all treatment administration records (TARs) 7 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR Audit tool. The DON, SDC, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the Wound Audit tool. The DON, SDC, and/or QI nurse will observe the wound care nurse provide treatments two times a week x 12 weeks to ensure aseptic technique is being	

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{F 686}	Continued From page 10 which included wound vacuum to the right buttock at 125 mmHg setting. Wound vacuum to be changed on Mondays at the wound clinic, Wednesdays and Thursdays at the facility. Interview on 4/12/18 at 9:15 AM with the Administrator and Director of Nurses (DON) was conducted. The DON stated she expected nurses to use clean supplies for each wound separate ulcer cleaning. Interview on 4/13/18 at 8:45 AM with the wound care nurse revealed she was unaware that she was not cleansing the wounds in the correct manner. The wound nurse stated that she was in serviced 4/12/18 and now she understood. An inquiry was made about the missing updated wound assessment and the response was she had to conduct skin checks on residents and did not get a chance to complete the pressure sore assessments. Interview on 4/13/18 at 9:45 AM with the Administrator and (2) two Corporate Representatives was held. The Administrator stated the wound care nurse was expected to have completed the wound assessment. Interview on 4/13/18 at 10:05 AM with the wound care nurse who stated there were no physician orders in April 2018 for wound care, the wound vacuum and wound settings so clarification orders were obtained. 2. Resident #2 was admitted to the facility on 4/18/17 with cumulative diagnoses which included Alzheimer's disease. Record review of the quarterly Minimum Data Set (MDS) dated 3/20/18 coded the resident as totally dependent on one staff for activities of daily living except for eating. The MDS indicated the resident had advanced pressure sores Review of the care plan created on 4/5/18 revealed the focus included ulceration of	{F 686}	followed. Any negative findings will be addressed by the auditor immediately. The audit will be documented on the Treatment Observation Audit tool. The monthly QI committee will review the results of the TAR Audit tool, Wound Audit tool, and treatment observation tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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{F 686}	Continued From page 11 structural integrity of the layers of the skin caused by prolong pressure. The interventions included treatments as ordered and turn and reposition frequently. Review of the wound ulcer flow sheet revealed: On 11/13/2017 an open blister (Stage 2 pressure ulcer) on the right heel developed. By 3/22/18 the right heel pressure ulcer measured 2.5 centimeters (cm) in length X 2.2 cm with no depth. There was no updated skin assessment until 4/4/18 when the right heel ulcer measured 1.0 cm in length X 1.5 cm in width. Interview on 4/13/18 at 8:45 AM with the wound care nurse about the missing updated wound assessment documentation and the response was she had to conduct skin checks on residents and did not get a chance to complete the pressure sore assessments. Interview on 4/13/18 at 9:45 AM with the Administrator and (2) two Corporate Representatives was held. The Administrator stated the wound care nurse was expected to have completed the wound assessment.	{F 686}		
{F 725} SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	{F 725}		5/14/18

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{F 725}	Continued From page 12 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident interviews, nurse practitioner (NP) interview and staff interviews, the facility failed to provide sufficient nursing staff to provide showers as preferred in 1 of 4 sampled residents reviewed for self-determination (Resident #36) and complete the annual comprehensive assessment for Resident #118 in 1 of 4 comprehensive assessments reviewed. Findings included: 1. F561: Based on record review and resident and staff interviews, the facility failed to honor a resident's preferences regarding the frequency of showers provided for 1 of 4 sampled residents reviewed for self-determination (Resident #36). 2. F636: Based on record review and staff interviews the facility failed to complete the annual comprehensive assessment for Resident #118. This was evident in 1 of 4 comprehensive assessments reviewed. Interview on 4/10/18 at 6:17 PM with Nurse #8	{F 725}	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F725 The plan of correcting the specific deficiency	

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{F 725}	Continued From page 13 stated she worked on 4/3/18 and 4/4/18 with only 1 (one) Nursing Assistant (NA) and "did the best we could." Some residents were left in bed because we could not use the hydraulic lift to transfer residents because two (2) people were needed to use the lift. At his time Nurse #8 stated she was not sure which residents were not transferred out of bed. Continued interview with Nurse #8 revealed the unit had four (4) residents that were dependent on staff for feeding and they were fed. Interview on 4/10/18 at 6:25 PM with NA #7 stated every weekend that she worked the facility was short staffed for NA and unable to do rounds and provide care for incontinence. On the 400-resident unit staff must transfer residents back to bed earlier then 7 PM because some staff leave at 7 PM. NA #7 stated additional staff was needed for resident care. Administration (unsure of who she meant) put staff on the schedule that were not assigned to work that shift just to complete the staffing form. "I was placed on the schedule but was not assigned to work." Further interview with NA #8 revealed she was not sure of the actual dates. Interview on 4/11/18 at 6:15 AM with NA #8 who stated she worked on the 100 and 200 resident hall ways by herself on 4/8/18. She reported she could on meet the resident's needs to provide incontinent care and answer call lights in a timely manner. An interview was conducted on 4/11/18 at 7:00 AM with Nurse #9. During the interview, Nurse #9 reported she had worked at the facility with 1 (one) NA on 100/200 halls, and 1 (one) on 300/400 halls and 1 (one) nurse to oversee 3	{F 725}	The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency the facility failed to provide sufficient nursing staff to provide showers as preferred and to complete the annual comprehensive assessment for resident #118. On 4/14/18, resident # 36 received a shower per resident preference by the CNA on the hall. Annual comprehensive assessment for resident #118 was completed on 4/11/18 by a corporate MDS consultant and accepted on 4/11/18 by the national repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/13/18, the facility signed a contract with a staffing agency to provide sufficient nursing staffing. On 5/4/18, the facility began offering a sign on bonus for certified nursing assistants, licensed practical nurses, and registered nurses. On 4/10/18, a second Certified Nursing Assistant (CNA) was hired to join the shower team. On 4/18/18, the facility consultant in-serviced the director of nursing (DON) on providing showers per resident	

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{F 725}	Continued From page 14 medication aides administering medications. Continued interview with Nurse #9 stated the impact of not having enough staff was "Everything." She elaborated by saying the residents do not get changed as often or may not get assisted with their meals like they should. Interview on 4/12/18 at 3:05 PM with the Administrator stated Resident #007 was transferred to bed at 5:00 PM on 4/6/18 because the assigned NA was leaving at 7PM so staff wanted to put her to bed early because a mechanical lift was required. Interview was conducted with NA #6 on 4/12/18 at 4:45 PM. During the interview, NA #6 reported she did showers for residents at the facility. She reported there was a shower schedule located at the nursing station to indicate the shower days for residents. NA #9 reported the NAs on the floor may not have time to give showers to the residents but she herself cannot give showers to 120 residents.	{F 725}	preference On 4/18/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on providing showers per resident preference. By 5/14/18, all nursing staff, including the newly hired nursing staff, and agency will be in-serviced by the SDC on providing showers per resident choice and the documentation of showers given. This in-service will be part of the orientation process for all newly hired nursing staff, including agency staff. From 4/11/18 until 4/12/18 and 4/17/18 until 4/19/18, two corporate MDS consultants assisted the facility to achieve timely submission of comprehensive Minimum Data Set (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 completing assessments timely. This in-service will be provided to any newly hired MDS Nurses during orientation. By 5/14/18, all comprehensive assessments will be submitted timely and will accurately reflect each individual resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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{F 725}	Continued From page 15	{F 725}	The DON, SDC, QI nurse and/or weekend manager on duty will audit a minimum of 20 residents a week x 4 weeks and then 10 residents a week x 8 weeks to ensure showers are provided per resident choice. This audit will be documented on the Resident Care Audit Tool. The Administrator and/or DON will audit all completed MDS 100% weekly x 4 weeks then 50% of completed MDS weekly x 8 weeks to ensure all MDS assessments are completed timely. This 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 the vacancies. The SDC and/or DON will share weekly with the Department head team the open nursing positions that center is currently advertising to fill, how many applicants have applied and the number of new employees hired in the past week. The facility will utilize the contract agency to fill vacant tracks of time until permanent employees can be hired and oriented. The facility will follow the attendance policy to address tardies and absences. The facility will offer incentive bonuses to employees who sign up for extra shifts to help fulfill the facilities staffing needs. We will maintain sufficient staff by utilizing staff members who normally do not provide direct patient care but have the training and/or license to provide direct care in the event the facility does not have sufficient staffing.	

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{F 725}	Continued From page 16	{F 725}	The monthly QI committee will review the results of the Resident Care Audit tool and MDS audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
{F 835} SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility's administration failed to provide leadership and management to ensure the needs of residents were met in the areas of neglect (Resident #118 and Resident #18), pain (Resident #118), the provision of assistance with Activities of Daily Living for dependent residents	{F 835}	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the	5/14/18

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{F 835}	Continued From page 17 (Resident #18), and pressure ulcer assessment and treatment (Resident #003 and Resident #2). The findings included: This tag is cross referenced to: F600: Based on observations, resident and staff interviews, interview with the pharmacist, interview with the nurse practitioner and record review the facility neglected to provide pain relief for a resident who was ordered scheduled pain medication. The resident went without pain relief for two days. This was for 1 of 3 residents reviewed for pain management (Resident #118). Resident #18 was in a soiled brief for three hours after notifying staff of the incontinence. This was for 1 out of three residents reviewed for activities of daily living. F697: Based on observations, resident and staff interviews, interview with the pharmacist, interview with the nurse practitioner and record review the facility failed to provide pain relief to Resident #118 for 2 (two) days. This was evident in 1 of 3 residents reviewed for pain management. F677: Based on observations, staff and resident interviews and record reviews the facility staff delayed incontinence care and failed to thoroughly cleanse the resident ' s skin after an incontinence episode (Resident #18) 2. The facility failed to follow the manufacturer ' s instruction to rinse the skin after use. (Resident #2). This was evident in 2 of 3 residents reviewed for incontinence care. F686: Based on observation, record review and	{F 835}	acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F835 The plan of correcting the specific deficiency The position of Pine Ridge Nursing and Rehabilitation center regarding the process that lead to this deficiency □ facility□s administration failed to provide leadership and management to ensure the needs of residents were met in the areas of neglect, pain, the provision of assistance with Activities of Daily Living for dependent residents, and pressure ulcer assessment and treatment- was failure to follow established policies. Pain medication for resident #118 was reordered on 4/10/18 and received by the facility on 4/11/18. Resident #18 was provided incontinence care on 4/11/18 by CNA on hall. Resident #2 was cleansed thoroughly after an incontinence episode on 4/11/18 CNA on hall.	

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{F 835}	Continued From page 18 staff interview the facility failed to document the assessment of pressure ulcers on admission and on a weekly basis. The facility failed to obtained physician orders for the treatment of advanced pressure ulcers. The facility failed to perform dressing changes in a manner to promote ulcer healing. (Resident #003). The facility failed to document the assessment of pressure ulcers of the feet on a weekly basis. (Resident #2). This was evident in 2 of 3 residents reviewed for pressure sore management. An interview was conducted on 4/13/18 at 4:00 with the facility ' s Administrator. During the interview, the Administrator was asked about the facility ' s progress on ensuring the residents ' needs were met in each of the areas of concern including neglect, the provision of assistance with Activities of Daily Living for dependent residents, pressure ulcer assessment and treatment, and pain. The Administrator reported insufficient progress had been made towards reaching the facility ' s goals because of their difficulty with staffing. She stated that without adequate staffing, call lights were not answered as timely as they should be, showers had "fallen to the wayside," incontinence care and turning/repositioning residents may not be provided as often as it should be done. Additionally, the Administrator stated nurses were having to help out on the halls to meet the resident ' s needs. She thought, perhaps, this may also have played a role with the medication issues the facility has had. The Administrator reported the facility just received approval on this date (4/13/18) to allow for the hiring of Agency (temporary) staff to help meet the staffing needs of the facility and to ensure the needs of the residents were met.	{F 835}	Resident #003 had a wound assessment completed on 4/4/18 by the treatment nurse. Physician orders were obtained/clarified for resident #003 on 4/12/18. Resident #003 had dressing change on 4/4/18 to promote ulcer healing by the treatment nurse. Resident #2 had a wound assessment completed on 4/4/18 by the treatment nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4/12/18, the wound care nurse was in-serviced by corporate wound care specialist on aseptic technique. On 5/7/18, the wound care nurse was in-serviced on completing wound assessments every seven days. On 4/20/18, the facility consultant in-serviced the director of nursing (DON) on wound assessment, including documentation, and obtaining physician orders or physician clarification. On 4/20/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on wound assessment, including documentation, and obtaining physician orders or physician clarification. By 5/14/18 all licensed nurses and medication aides, including newly hired licensed nurses and medication aides including agency staff, will be in-serviced by the SDC on wound assessment, including documentation, and obtaining physician orders or physician clarification. This in-service will be part of the	

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{F 835}	Continued From page 19	{F 835}	orientation process for all newly hired licensed nurses and medication aides, including agency staff. On 4/11/18 through 4/13/18, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) assessed all residents for pain using a questionnaire or the Wong-Baker faces pain rating scale. Any negative findings were immediately addressed by the auditor, including notification of the physician as appropriate. This audit ensures there is no unrelieved pain. By 5/14/18 all licensed nurses, including the newly hired licensed nurses and agency licensed nurses, will be in-serviced by the Staff Development Coordinator (SDC) on pain assessment, including documentation, completion of pain interventions, and notification of provider in the case that a medication needs to be reordered or the pain intervention is not effective. This in-service will be part of the orientation process for all newly hired licensed nurses, and agency staff. On 4/16/18, the facility consultant in-serviced the director of nursing on providing ADL care for dependent residents and following manufacturer□s instructions. On 4/16/18, the Staff Development Coordinator (SDC) was in-serviced by the DON on providing timely ADL care for dependent residents and following manufacturer□s instructions. By 5/14/18, all nursing staff, including the newly hired nursing staff and agency staff,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 835}	Continued From page 20	{F 835}	will be in-serviced by the SDC on providing timely ADL care for dependent residents and following manufacturer□s instructions. This in-service will be part of the orientation process for all newly hired nursing staff, and agency staff. On 5/7/18 the administrator was in-serviced by the facility consultant on a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including wound care, wound assessment, wound treatments, pain management, and incontinent care. On 5/10/18 the administrator reviewed all above audits and in-services. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 4/20/18, the treatment nurse had follow-up observation and in-servicing as appropriate by the corporate wound consultant, or facility consultant to ensure wound policies are being followed, including assessment, documentation, aseptic technique, and obtaining physician orders/clarification. The DON, SDC, QI nurse and/or weekend manager on duty will audit all treatment administration records (TARs) 7 times weekly x 12 weeks, to include weekends, to ensure no holes are present on the TAR. This audit will be documented on the TAR Audit tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	R-C 04/13/2018

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{F 835}	Continued From page 21	{F 835}	The DON, SDC, and/or QI nurse will audit all pressure and non-pressure wounds weekly x 4 weeks then 50% of pressure and non-pressure wounds weekly x 8 weeks to ensure wound assessments have been documented within the last 7 days. This audit will be documented on the Wound Audit tool. The DON, SDC, and/or QI nurse will observe the wound care nurse provide treatments two times a week x 12 weeks to ensure aseptic technique is being followed. Any negative findings will be addressed by the auditor immediately. The audit will be documented on the Treatment Observation Audit tool. The DON, SDC, quality assurance nurse and/or Administrator will audit all progress notes 3 times weekly x 12 weeks, to include weekends, to identify if a resident has pain and that the appropriate interventions were taken and documented either on in the progress notes or on the MAR. This audit will documented on the Progress Note Review Audit Tool. The Director of nursing, SDC, Quality assurance nurse and/or weekend manager on duty will audit a minimum of 20 residents a week x 4 weeks and then 10 residents a week x 8 weeks to ensure timely ADL care is provided to residents. This audit will be documented on the Resident Care Audit Tool. The monthly QI committee will review the results of the TAR, Wound, Treatment Observation, Progress note review, and resident care audit tools monthly for 3 months for identification of trends, actions taken, and to determine the need for	

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{F 835}	Continued From page 22	{F 835}	and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Corporate office will provide administrator oversight by visits to review progress toward and maintenance of the plan of correction by the Corporate Regional Vice President (RVP) and/or Corporate Clinical Consultants, and/or the Corporate MDS Consultants monthly for 6 months and then quarterly for 1 year. The consultants and or RVP will review QA Minutes from the monthly and Quarterly Executive QA meetings. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	