DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		345177	B. WING				C 01/04/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		01/04/2015
				20	95 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 565 SS=E	Resident/Family Grou CFR(s): 483.10(f)(5)(F	565			2/1/19
	and participate in res (i) The facility must pr group, if one exists, v reasonable steps, wit to make residents an upcoming meetings in (ii) Staff, visitors, or or resident group or fam the respective group' (iii) The facility must p person who is approve group and the facility providing assistance requests that result fr (iv) The facility must of resident or family gro the grievances and re groups concerning is in the facility. (A) The facility must of facility must impleme request of the residen §483.10(f)(6) The resident §483.10(f)(7) The resident family member(s) or of	ther guests may attend hily group meetings only at s invitation. provide a designated staff red by the resident or family and who is responsible for and responding to written om group meetings. consider the views of a up and act promptly upon ecommendations of such sues of resident care and life the for such response. the construed to mean that the int as recommended every and or family group. hident has a right to roups.					
	residents in the facilit This REQUIREMENT by:	is not met as evidenced			E EGE		
		esident interviews and			F 565		
	DIRECTOR'S OR PROVIDER/: cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE 01/28/2019

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.

		MEDICAID SERVICES				. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING		с	
		345177	B. WING			,)4/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/0	J4/2019
				205 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETIO DATE
F 565	Continued From page	e 1	F 56	5		
	record review, the fac	cility failed to effectively				
		uncil (RC) grievances for 3				
		and November 2018) of 3		Address how corrective action wi		
		RC grievances. The facility		accomplished for those residents		
		I to RC grievances within 5		have been affected by the deficie	nt	
		eptember, and November viewed for RC grievances.		practice; The Administrator presented a re-	solution	
	The findings included	-		to the Resident Council President		
				1/25/19 for the grievance of answ		
	Review of the facility'	s policy dated revised May		call lights timely to include monitor	-	
	2017 titled Grievance	s/Complaints, Filing read in		call lights on each unit, each shift	3 times	
	part that upon receipt	-		a week for 4 weeks, to assure ca	-	
		review and investigate the		are answered timely. The resolution	ion was	
		it a written report of the		accepted by the resident council		
	findings to the Admin			committee on 1/25/19. The Social		
		ving the grievances. The ng the grievance will be		Service Director (SSD) provided a letter of follow up to the Resident		
		ngs of the investigation		President on 1/25/19 to be share		
		s of filing the grievance.		the next Resident Council meetin	g on	
	Review of the Senter	nber RC minutes dated		1/25/19. The Administrator prese resolution to the Resident Council		
		ievance dated 9/26/18		President on 1/25/19, for the grie		
		ot being answered in a timely		cold food to include monitoring fo		
		on was to increase the		temperatures on the tray line for		
		tone of the call bells. The		breakfast, lunch and dinner 5 time		
	grievance indicated v			week for 4 weeks and monitoring		
	completed with the R	C members on 9/28/18.		temperature during meal pass in		
	Poviow of the Sector	nhar PC minutas datad		dining room and hallways, for bread lunch and dinner 5 times a week,		
		nber RC minutes dated ievance dated 9/26/18		assure food temperatures remain		
		the dining room and on the		acceptable temperature range of		
		vas staff education with		degrees or resident preference. T		
		completed with the RC		resolution was accepted by the re		
	members on 10/23/18	8 (17 days).		council committee. The SSD pro	vided a	
				written letter of follow up to the R		
	Review of the Octobe			Council President on 1/25/19, to		
		prievance dated 10/24/18		shared during the next resident c	ouncil	
	regarding the nursing trays timely resulting	staff not passing the meal		meeting on 1/251/9.		

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 02/06/20 ORM APPROVE NO: 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTI		(X3) DATE SURVE COMPLETED		
		345177	B. WING			C 01/04/2019		
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRE	ESS, CITY, STATE, ZIP CODE	E		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACT			(X5) COMPLETIO DATE	
F 565	Continued From page		F 5		how the facility will id	lantify other		
	address the meals tra timely. The grievance	npleted on 10/25/18 to ays not being passed out indicated follow up was C members on 10/25/18		residents affected b	how the facility will id having the potential by the same deficient facility residents have	to be t practice;		
	completed with the RC members on 10/25/18. Review of the November RC minutes dated 11/28/18 included a grievance dated 11/28/18			potential deficient	to be affected by the practice of the facility resolution and follow	same y failure to		
	regarding call bells no manner. The resolution	ot being answered in a timely on was a new camera . The grievance indicated		grievance meetings	es voiced during resid s. The Administrator a iewed grievances rec	dent council and/or the		
		eted with the RC members		the Resid	dent Council group fro per 2018 through Dec te that resolutions we	om æmber 2018,		
	AM, Resident #21 co			group wa	ed, and the resident on as given a follow up le	etter		
	bell response time an	sident. She stated long call nd unappetizing food had		other grie	g the resolution. The evances identified that	at were not		
		while and that the RC grievance on several p no improvements		facility pro	ited and followed up a otocol. what measures will b			
		3/19 at 10:40 AM, the Social		place or s	systemic changes manat the deficient pract	ade to		
	when it was received				inistrator provided ed			
	•	artment responsible for the on and written notice.		(IDT), wh	for the Interdisciplina nich consists of the Di (DON), Assistant Dire	irector of		
	In an interview on 1/4 Administrator stated	she reviewed each		Nursing ((SSD), Di	(ADON), Social Servio Dietary Manager (DM)	ice Director), Activities		
	grievance after the co investigation and reso grievance was addres			Maintena	(AD), Rehab Manage ance director (MD), re e with resolution to gri	egarding		
	provided within the sp	becified 5 working day. She the root cause as to why		and follow	with resolution to gri w up letter within 5 da the grievance.			
	addressed with reside	ere not effectively and timely ent notice of the resolution.		grievance	vities Director will doc es received during re	sident		
		ited it was her expectation licy and procedure be lent grievance.		Grievance	neetings on the appro e form and will forwa e form to the SSD to	ard the		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 01/04/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION
F 565	Manager (DM) was u temperature monitorin which indicated the for temperature. The pro- monitoring beginning and lunch meals. In an interview on 1/4 Director of Nursing (D to provide evidence of compliance after the until one audit comple shift, another audit co shift and on 12/10/18 was also unable to pr monitoring that the m	A/19 at 10:40 AM, the Dietary nable to provide any food ng completed after 9/8/18 bod was served at the proper vided tray delivery times 12/10/18 of the breakfast	F 5	 onto the Resident Council Griev The SSD will then forward the of form to the Administrator, who we the appropriate IDT member to and provide resolution to the gri The Grievance form, along with investigation information and re will be given to the Administrator and approve, then the SSD will follow up letter to the Resident of president and/or group within 5 the receipt of the grievance. A follow up letter will be kept with monthly resident council meeting Indicate how the facility plans to its performance to make sure the solutions are sustained; The Administrator and/or the Di Nursing will review resident council grievances log 5 x a week for 4 then weekly for 5 months, to vate grievances received from the re- council group were investigated resolution was initiated/completed follow up letter was provided to resident council president and/or group within 5 days of receiving grievances. The Administrator and/or the Di Nursing will review the audits to patterns/trends and will adjust to necessary. The Administrator we the plan during the monthly QA and audits will continue at the of the QAPI committee. 	grievance will give to investigate rievance. In the esolution for to review submit a Council days of copy of the the ag minutes. In the source days of copy of the the ag minutes. In the ag minutes. In the ag minutes. In the ag minutes irector of uncil weeks subidate that esident d, a ted and a the or resident g the irector of D identify the plan as will review PI meeting

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/06/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMF	
		345177	B. WING				C / 04/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 205 RATTLESNAKE TI	, ,	<u> </u>	
				PINEHURST, NC 28	3374		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	Continued From page	2 4	F 56	55			
				Indicate dates be completed;	when corrective action v	will	
				February 1, 20	19		
F 585 SS=E			F 58	35			2/1/19
	facility must make pro	ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph.					
		ility must make information ance or complaint available					
	of all grievances rega contained in this para provider must give a o to the resident. The g include: (i) Notifying resident in	sure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED
		345177	B. WING		01/04/2019
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, 2	-
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATI IENCY)
F 585	Continued From page	e 5	F 5	85	
	facility of the right to f				
		in writing; the right to file usly; the contact information			
		al with whom a grievance			
		is or her name, business email) and business phone			
		e expected time frame for			
		v of the grievance; the right			
	grievance; and the co	cision regarding his or her ontact information of			
	independent entities	with whom grievances may			
	-	ertinent State agency,			
		Organization, State Survey ng-Term Care Ombudsman			
		and advocacy system;			
	(ii) Identifying a Griev				
	-	eeing the grievance process, g grievances through to their			
		any necessary investigations			
	by the facility; mainta	ining the confidentiality of all			
	information associate	U			
		of the resident for those anonymously, issuing			
	•	sisions to the resident; and			
		e and federal agencies as			
	necessary in light of s	specific allegations; ing immediate action to			
		tial violations of any resident			
	right while the alleged	•			
	investigated;	402.42(a)(4) immediately			
		483.12(c)(1), immediately violations involving neglect,			
		ies of unknown source,			
		on of resident property, by			
		rvices on behalf of the histrator of the provider; and			
	as required by State I	-			
	, ,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		345177	B. WING			4/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
THE GRE	ENS AT PINEHURST REI	AB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 585	summary statement of the steps taken to inv summary of the pertin regarding the resident as to whether the grie confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat accordance with Stat of the residents' right or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issu decision. This REQUIREMENT by: Based on observation interviews and record effectively resolve gri providing showers for Resident #13) of 4 re grievances. The facility daily menus for 1 res residents reviewed for also failed to respond filing a grievance for #13 and Resident #6 grievances. The facility	prievance was received, a of the resident's grievance, restigate the grievance, a nent findings or conclusions t's concerns(s), a statement evance was confirmed or not ctive action taken or to be s a result of the grievance, en decision was issued; e corrective action in e law if the alleged violation s is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement I law enforcement agency or any of these residents' of responsibility; and ence demonstrating the s for a period of no less than ance of the grievance - is not met as evidenced ns, staff and resident I review, the facility failed to evances regarding staff not 2 (Resident #9 and sidents reviewed for ty failed to resolve a he facility not following the idents (Resident #6) of 4 or grievances. The facility I within 5 working days of 3 (Resident #9 and Resident) of 4 residents reviewed for	F 5	F 585 Address how corrective ac accomplished for those res have been affected by the practice; The facility provided a shor Resident #9 on 1/4/19, foll exit, and has received shor _Tuesdays and Friday, per shower schedule. The Dir (DON) discussed the show and resolution with Reside as a resolution to the griev documented 11/28/18, sho offered and given by the co assistant (CNA) on the sch	sidents found to deficient wer for owing survey wers every r residents' ector of Nursing ver schedule ent #9 on 1/4/19, rance owers will be ertified nursing	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 MAPPROVED O. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345177	B. WING			C 01/04/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				20	05 RATTLESNAKE TRAIL			
				Ρ	INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	х		BE	(X5) COMPLETION DATE	
F 585	ENS AT PINEHURST REHAB & LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 part that upon receipt of a grievance, the Grievance Officer will review and investigate the allegations and submit a written report of the findings to the Administrator within five (5) working days of receiving the grievances. The resident or person filing the grievance will be informed on the findings of the investigation within 5 working days of filing the grievance. 1. Resident #9 was admitted on 7/6/08 with cumulative diagnoses of Cerebral Vascular Accident (CVA) with Hemiplegia. Resident #9's undated electronic Kardex read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Resident #9's care plan last revised 7/28/18 read she required staff assistance for showers every Tuesday and Friday on second shift and as needed. Review of the facility grievance log revealed a grievance dated 11/28/18 which read Resident #9 was not getting her showers. The grievance read notification was provided on 12/20/18 (16 days) and resolution was that new shower sheets were created for documentation to include education was provided to nurses and aides. Resident #9's quarterly Minimum Data Set (MDS) dated 12/15/18 indicated she was cognitively intact and exhibited no behaviors. She was coded		F	585	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
		ice with bathing. entation from 11/1/18 to dent #9 only received one			Current facility residents have the potential to be affected by the same deficient practice of the facility failur provide resolution and follow up to grievances. The Administrator and/or			

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 02/06/201 DRM APPROVE NO. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED	
		345177	B. WING			C 01/04/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER			RATTLESNAKE TRAIL EHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 585	 Continued From page 8 In an interview on 1/3/19 at 10:40 AM, the Social Worker stated she logged each grievance as to when it was received and forwarded the grievance to the department responsible for the investigation, resolution and written notice. In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time. She stated she completed a grievance but there had been no improvement in receiving her showers. Resident #9 appeared clean, absent of odors and dressed for season. 		F 5		SSD reviewed grievances receiv October 1, 2018 through Januar 2019, to validate that resolutions initiated or obtained and the resid and/or resident representative w a follow up letter regarding the re with in 5 days of receiving the gri There were (5) grievances docun December that were investigated etter of follow up was sent later to required 5 days. All other grievan were investigated and follow up low within 5 days.	y 17, were dent as given esolution evance. nented in I but a than the nces		
	investigation and rest grievance was addre provided within the sp was unable to explain the Resident #9's grid addressed with timely days. The Administrat expectation that the g procedure be followed In an interview on 1/4 Director of Nursing (I to provide documentat compliance with Rest She stated it was her	she reviewed each ompletion of any grievance olution to ensure the ssed and notice was pecified 5 working day. She in the root cause as to why evance was not effectively y follow up within 5 working itor stated it was her grievance policy and d for any resident grievance. 4/19 at 12:43 PM, the DON) stated she was unable ation of monitoring for ident #9's shower schedule. • expectation that grievances id with written follow up		4 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Address what measures will be p place or systemic changes made ensure that the deficient practice recur; The Administrator provided educa 1/23/19, to the Interdisciplinary T (IDT), which consists of the Direct Nursing (DON), Assistant Director Nursing (ADON), Social Service I (SSD), Dietary Manager (DM), Ad Director (AD), Rehab Manager (F Maintenance director (MD), regar response with resolution to grieva and follow up letter within 5 days receiving the grievance. The Administrator and/or the DOP completed education on 1/25/19 hursing staff to include licensed r and certified nursing assistants, a all days including weekends and regarding completion of grievanc	to will not will not ation on Feam ctor of Director ctivities RM) and rding ances of N for all nurses all shifts, prn staff, e forms		
	2. Resident #13 was readmitted 6/29/18 w CVA, Diabetes and C		f	when a grievance is voiced and p for reporting the grievance to the supervisor. Nursing staff will be regarding the Grievance policy a	educated			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			01	C / 04/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 585	indicated moderate c behaviors. She was c assistance with bathi Resident #13's undat she required staff ass Wednesday and Satu needed. Resident #13's care p read she required stat every Wednesday an and as needed. Review of the docum 1/4/19 indicated Resi shower on 12/12/18, 12/26/18. Review of the facility grievance dated 11/2 #13 was not getting h read notification was days) and resolution were created for docu education was provid In an interview on 1/3 Worker stated she log when it was received grievance to the depa investigation, resoluti In an interview and of	erly MDS dated 11/25/18 ognitive impairments with no coded as requiring total staff ng. red electronic Kardex read sistance for showers every urday on second shift and as olan last revised on 11/27/18 off assistance with showers d Saturday on second shift entation from 11/1/18 to dent #13 only received a 12/15/18, 12/22/18 and grievance log revealed a 8/18 which read Resident her showers. The grievance provided on 12/20/18 (16 was that new shower sheets umentation to include led to nurses and aides. 8/19 at 10:40 AM, the Social gged each grievance as to and forwarded the artment responsible for the on and written notice. bservation on 1/3/19 at 4:50	F	585	process during new hire orientation. When staff members receive a grieval from a resident and/or resident representative, they will assist the resi and/or representative as needed to with grievance on the grievance form to the to be logged onto Grievance log. The SSD will then forward the grievance for to the Administrator, who will give to the appropriate IDT member to investigate and provide resolution to the grievance the Grievance form, along with the investigation information and resolution will be given to the Administrator to re- and approve, then the SSD will subm follow up letter to the resident and/or resident representative within 5 days the receipt of the grievance. Indicate how the facility plans to moni- its performance to make sure that solutions are sustained; The Administrator and/or the Director Nursing will review the grievance log week for 4 weeks then weekly for 2 months, to validate that grievances received were investigated, a resolution was initiated/completed, and a follow letter was provided to the resident and resident representative within 5 days receiving the grievance. The Administrator and/or the Director Nursing will review the audits to ident patterns/trends and will adjust the plan necessary. The Administrator will rev- the plan during the monthly QAPI me- and audits will continue at the discretion	ident rite and SSD orm he e e. on view it a of tor of 5 x a on up d/or of of ify n as iew eting		
	In an interview and o	bservation on 1/3/19 at 4:50 ated she had not been			the plan during the monthly QAPI me	eting		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 02/06/2019 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345177	B. WING			C 01/04/2019		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		205	EET ADDRESS, CITY, STATE, ZIP CO RATTLESNAKE TRAIL EHURST, NC 28374	DDE	-	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 585	receiving her showers clean, absent of odor In an interview on 1/4 Administrator stated s grievance after the co- investigation and reso grievance was addres provided within the sp was unable to explain the Resident #13's gr addressed with timely days. The Administra expectation that the g procedure be follower In an interview on 1/4 Director of Nursing (I to provide documenta compliance with Resi She stated it was her be effectively resolve within 5 working days 3. Resident #6 was a cumulative diagnoses Pulmonary Disease a Resident #6's annual indicated she was co- no behaviors. She w with eating. Review of the facility grievance dated 10/4 meal tray did not mat The grievance read m	e with little improvement in s. Resident #13 appeared s and dressed for season. 4/19 at 10:30 AM, the she reviewed each ompletion of any grievance oblution to ensure the ssed and notice was becified 5 working day. She in the root cause as to why rievance was not effectively / follow up within 5 working tor stated it was her grievance policy and d for any resident grievance. 4/19 at 12:43 PM, the DON) stated she was unable ation of monitoring for dent #13's shower schedule. expectation that grievances d with written follow up s. dmitted on 6/26/17 with s of Chronic Obstructive and a Colostomy.	F 58	l	Indicate dates when correct be completed; February 1, 2019	tive action v	vill	

If continuation sheet Page 11 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345177	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 585	was to review the me Review of the facility grievance dated 10/12 meal tray did not mate The grievance read n 10/23/18 (8 days) and education. In an interview on 1/2 Manager (DM) stated September 2018 thro was out, the Chef ove stated the Chef did no process that resulted food. The DM stated menus were not being the food remotely whi In an interview on 1/2 stated the facility gave menu, but they did no an ongoing problem t grievances about with #6 stated completing any resolutions, so sh complete grievances. was all she had to loo Colostomy, there wer eat. In an interview and of AM, Resident #6 was not feel well and was breakfast. Her breakfa and grits. The tray tick her tray.	nus with the dietary staff. grievance log revealed a 2/18 which read Resident #6 ch what on the daily menu. otification was provided on d resolution was staff 2/19 at 11:20 AM, the Dietary she was out on leave in ugh 10/29/18 and while she ersaw ordering the food. She ot "catch on" to the ordering in the facility running out of she was aware that the g followed so she ordered lie on leave. 2/19 at 3:00 PM, Resident #6 e her a copy of the daily ot follow it. She stated it was	F	585			

	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345177	B. WING		01/04/2019
AME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	÷
HE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		05 RATTLESNAKE TRAIL	
			F	PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLE
F 585	Continued From pag	je 12	F 585		
		bgged each grievance as to			
	when it was received				
		artment responsible for the			
	investigation, resolut	tion and written notice.			
	la an interview an Al				
	Administrator stated	4/19 at 10:30 AM, the			
		completion of any grievance			
		solution to ensure the			
	•	essed and notice was			
	provided within the s	specified 5 working day. She			
	-	in the root cause as to why			
		ievance was not effectively			
		ly follow up within 5 working			
	-	ator stated the facility started			
		s' concerns with the food.			
		monthly and was aware of			
	•	ated to the kitchen not			
	•	. The Administrator stated			
		ast fall where the food was			
	•	prrectly because the DM was			
		dministrator stated it was her grievance policy and			
		ed for any resident grievance.			
F 607		Abuse/Neglect Policies	F 607		2/1/19
SS=D	CFR(s): 483.12(b)(1	•			
		ity must develop and			
	implement written po	blicies and procedures that:			
	\$483,12(b)(1) Prohib	pit and prevent abuse,			
		ation of residents and			
	misappropriation of r				
	§483.12(b)(2) Estab	lish policies and procedures			

Event ID: PHHC11

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C 1 04/2019	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER	205 RATTLESNAKE TRAIL					
				Р	PINEHURST, NC 28374		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 607	Continued From page	e 13	F	607				
		e training as required at		007				
	paragraph §483.95,	s canning as required at						
		is not met as evidenced						
	by:							
		iew, resident interview, staff			F 607			
	· · ·	y interview for one (Resident						
		I residents, the facility failed			Address how corrective action will be			
	U U U	port to the state agency an			accomplished for those residents four	nd to		
	allegation of resident	esident's funds and personal			have been affected by the deficient practice;			
	belongings. The findi	-			The facility completed a 24-hour repo	rt on		
					1/4/19, and 5-day investigation was			
	Record review reveal	led Resident # 4, who was			completed on 1/9/19 for Resident #4,			
		admitted to the facility on			regarding resident exploitation and			
	4/20/18. One of the r	esident's diagnoses included			misappropriation of resident funds and	d		
		legenerative disorder which			personal belongings. This was a situa	ation		
	is known to affect bra	in activity.			that occurred with Resident #4's cons	ent		
					while he was competent with a BIMS			
	Record review reveal				score of 15. This is an ongoing			
		ent was responsible for			investigation by the police outside of t	he		
	himself. A family mer	nder was listed as an			facility.	hor		
	emergency contact.				Address how the facility will identify of residents having the potential to be	liner		
	Review of Resident #	4's admission minimum			affected by the same deficient practic	<u>م</u> .		
		ssment, dated 4/27/18,			The Administrator and/or the Social	ς,		
		was assessed to have a			Service Director (SSD) reviewed the			
		ental Status (BIMS) score of			grievance logs from July 2018- Janua	ry		
		act score is considered 13 to			21, 2019, to identify concerns regarding	ng		
		is also assessed to have			resident exploitation and/or			
	signs of depression of	on the MDS.			misappropriation, to validate that an			
					investigation was completed and was			
		ssessment was completed			reported to the state agency. There v			
	upon "change of ther score was assessed	apy." The resident's BIMS			no other concerns identified that had			
	Score was assessed	IU DE 13.			been investigated and/or reported to t state agency.	ine.		
	Review of nursing no	tes revealed an entry on			The Administrator, Director of Nursing	1		
		oting the resident was found			(DON), Assistant Director of Nursing)		
		staff he had slid to the floor			(ADON) and Social Service director (S	SSD)		
		The physician was notified,			completed interviews with current stat			

Facility ID: 923320

					OMB NO. 0		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUF COMPLET	COMPLETED	
					С		
		345177	B. WING		01/04/2	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL			
	I			PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CONTRACTION SHOULD SHO	(X5) OMPLETIC DATE	
F 607	Continued From page	<u>-</u> 14	F 60	7			
		n for labs to be completed.	1 00	1/25/19, regarding know	ledge of resident		
	According to the reco			abuse, exploitation and i	-		
		in and a Gabapentin drug		that has not been previo			
		abs that was ordered on		There were no other alle			
	8/21/18. (Gabapentir	n is a drug commonly used		that were not investigate			
		ures, and which includes					
	-	ness and fatigue). The result		Address what measures			
	-	vel revealed Resident # 4's		place or systemic chang			
		th a result of 48.3. (Normal		ensure that the deficient	practice will not		
	could contribute to ele	report noted renal function		recur; The Administrator and/o			
		evaled levels.		completed education on			
	Record review reveal	ed Resident # 4 was		facility staff, all shifts, all			
		2/18 to 8/28/18 secondary to		weekends and prn staff,			
	renal failure. Hospital			reporting and investigation			
	-	sident had delirium and		abuse. The education w			
	memory disturbance	upon his 8/22/18 hospital		new hire orientation.			
	admission date.			The staff will report imme			
				abuse officer any allegat			
		ed on 9/10/18 a readmission		include resident exploita			
		s completed and Resident #		misappropriation. The a			
		ave a BIMS score of 11. The led on this MDS to have		submit the 24-hour report			
	signs of depression.	ied on this MDS to have		agency and an investiga that time and within 5 da			
	signs of depression.			allegation the abuse offic	-		
	Record review reveal	ed on a 10/21/18 quarterly		5-day investigative report			
		esident # 4 was assessed to		agency.			
		f 15. The resident was also					
	coded on this MDS as	ssessment to have signs of		Indicate how the facility			
	depression.			its performance to make	sure that		
				solutions are sustained;			
		member was interviewed on		The Administrator, DON			
		ne family member stated he		will interview 5 staff men			
	had taken action to be	# 4 in the past several		weeks then 10 staff men 2 months, to validate that	-		
	months. According to			abuse were reported to t	-		
		en exploited by a facility		and an investigation was			
		member named Employee		reported to the state age			
		o had exploited and stolen		The Administrator and/o			

Facility ID: 923320

ATEMENT C	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING		C	
		345177	B. WING		01/04/2019	
NAME OF PF	ROVIDER OR SUPPLIER		\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	INS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO	
F 607	the following details. admission, Resident a facility. During Resider former facility, an emp him," and the other fa employee. When Res current facility, the em 4 and obtained a job. member, the employed and drugs to take adv steal from him. The e dollars of money from accounts. The employ Resident # 4's social sign his car over to he Motor Vehicles). Duri employee became pa check she did not pay responsible. The fam reported his concerns anything about it. The give definitive dates v when he had reported had transpired in app months. Resident # 4 was inter AM. Resident # 4 was whether an employee taken advantage of h head and stated, "I ju	he family member reported Prior to his April 2018 facility # 4 had resided at another ent # 4's residency at the ployee had "taken a liking to acility had terminated the sident # 4 moved to the nployee followed Resident # According to the family ee allegedly used alcohol vantage of Resident # 4 and mployee took thousands of n Resident # 4's bank yee arranged to become security payee, and had him er at the DMV (Division of ng the time that the ayee of his social security y his bills for which he was	F 607	Nursing will review the grievance week for 4 weeks then weekly for months, to validate that grievance missing items and/or care concer investigated and reported to the S agency as required, if the items w misappropriated or abuse situation identified. The Administrator and/or the Dire Nursing will review the audits to in patterns/trends and will adjust the necessary. The Administrator will the plan during the monthly QAPI and audits will continue at the dis the QAPI committee. Indicate dates when corrective act be completed; February 1, 2019	2 es of ns were State vere ns were ctor of dentify e plan as I review meeting cretion of	

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						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY
			A. BUILDING			С
		345177	B. WING		01/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	1/04/2013
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO
F 607	Continued From pag	e 16	F 60	7		
		A new employee orientation	1 00			
		d been completed on 6/8/18.				
		ination date was 7/25/18.				
		view with the administrator				
		M, this indicated Employee #				
	1 had worked for the	facility for at least 48 days.				
		and for Desident # 4. Norse				
		ared for Resident # 4. Nurse on 1/4/19 at 9:10 AM. Nurse				
		wing. Employee # 1 would				
	-	t of the facility while she was				
		ity, and this "went on for				
		employee's actions were				
	reported to the admir					
	administrator "put a s	stop to it." Employee # 1 quit				
		and continued to be involved				
	with Resident # 4. S					
		times would take Resident #				
	4 out of the facility. N					
		give Resident # 4 some sort				
		st while he was away. Nurse esident # 4 returned after				
	-	bloyee #1, the resident would				
		urse # 1 suspected the				
		e of drugs and/or alcohol.				
	•	was aware Resident # 4 had				
		nes after returning from an				
		e # 1. On one of these				
		# 4 fell off of his motorized				
		# 1 stated the resident was				
	-	ambulatory, and he just fell				
		reason. Nurse # 1 stated				
	-	e facility thought Employee # age of Resident # 4 after she				
		led to visit the resident, but				
	-	ry alert and oriented and did				
		t. Nurse # 1 stated he tried to				
		but Resident # 4 made his				
		ared alert and oriented, and	1			

Facility ID: 923320

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	STOR MEDICARE &	MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
						С
		345177	B. WING		0	1/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	θE	
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION
F 607	Continued From page	e 17	F 60	07		
		at he was doing during the				
		e # 1 was visiting and taking				
		1 also stated Resident # 4				
		that he missed his deceased				
		ad observed that Resident #				
		eract with young women.				
		1, Resident # 4 did not have				
	a good relationship w					
		,				
	The facility business	administration employee				
	was interviewed on 1	/4/19 at 9:33 AM. The facility				
	business administrati	ion employee reported the				
	following. Resident #	4 routinely paid his bill to the				
	facility himself up unt	il August, 2018. Upon his				
	August hospital return	n, his September balance				
	was due and he had	not had the money to pay for				
		t time Employee # 1 was no				
		e facility and had been				
		t # 4 when the business				
	-	yee discussed Resident #				
	-	usiness administration				
		ident # 4 tell Employee # 1				
		et, and she heard Employee				
	-	given it to her. The business				
	-	yee stated Resident # 4's				
		became involved and was				
		torney on 8/31/18. According				
		nistration employee, adult as contacted and the police				
	were notified. Accord	•				
		yee, she had witnessed				
		ery confused in August, 2018				
		inger pay his bill. She				
		int as falling off his motorized				
		when he had returned to				
	the facility one day at					
		she continued to take him				
		wing her resignation. The				
			1			1

Facility ID: 923320

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DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MEDI					FORM	2: 02/06/2019 1 APPROVED 2: 0938-0391
STATEMENT OF DEFICIENCIES (X1) F	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
	345177	B. WING		_	(01/	; 04/2019
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE GREENS AT PINEHURST REHAB &	LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607 Continued From page 18 Resident # 4 had made Em security payee and had als to her at some point. Acco administration employee it that Resident # 4 had been when he had signed the pa nothing that could be done The social worker (SW) wa 1/4/19 at 9:10 AM. The SW following. The resident was oriented prior to August, 20 had come to the facility's a # 1 was driving the residen employed at the facility. Th interviewed regarding this, Employee # 1's car was br facility staff he was letting B car, and she also helped hi stated the resident "pretty n own business." According to 1 was confronted with the or regarding the situation and employee continued to visi out of the facility. In late Au resident became ill and wa Following the hospitalizatio member informed the admi that the employee had bee resident. On 9/10/18 Adult was called, and a police re stated the resident # 4's mone also stated he had been es family during the time this w The administrator was inter 8:40 AM and again on 1/4/	bo signed over his car ording to the business had been determined of "in his right mind" apers, and there was the sinterviewed on V reported the sinterviewed staff that oken. He also told the Employee # 1 use his im with things. The SW much said to mind your to the SW, Employee # conflict of interest opted to resign. The t and sign Resident # 4 ugust, 2018, the sinterviewed on the Protective Services port was filed. The SW eff and oriented and o the things she did y disappeared. She stranged from his was occurring. rviewed on 1/4/19 at	F 60)7			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C / 04/2019
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 607	documentation into an alleged exploitation an Resident # 4, and she state agency. The ad Employee # 1 was sti facility, she had hear Employee # 1 was tak car which he kept at to occasions the administ resident, and the reside occasion she spoke to Resident # 4 informed car was not working a his to take him places she met with Employe was not appropriate b decided to quit. After resigned, the employe Resident # 4 and take administrator stated F himself out with her, a would "appear differe hospitalized in August became more alert, h administrator that Em him a white pill when On 1/4/19 at 1:45 PM administrator that the regarding the incident on 9/11/18. On this da protective services wa resident's family mem noted in the resident's facility documentation documentation of inter	d the following. She had no n investigation into the nd misappropriation of a had not reported it to the liministrator stated while II under employment at the d from other employees that king Resident # 4 out in his he facility. On the first two strator had questioned the dent denied it. On the third to Resident # 4 again, and d her that Employee # 1's and he allowed her to use 5. The administrator stated ee # 1 and informed her this behavior, and Employee # 1 the employee voluntarily ee continued to visit e him out of the facility. The Resident # 4 would sign and when he returned he nt." After Resident # 4 was t, 2018, recovered, and e had informed the ployee # 1 had been giving she was with him. it was confirmed with the only documentation t was in the resident's record ate, the SW noted adult as notified on behalf of the uber. The reason was not as record or on any other b. The facility had no rviews with staff who had between Resident # 4 and	F	607	7		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C 104/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607 F 609 SS=D	himself" after Resider Employee # 1. There the date on which the aware Employee # 1 of the facility, and ste There was no docume family member made misappropriation and documentation regard to the police departme services regarding the the administrator she responsible for invest allegation to the state had been made follow resignation. Reporting of Alleged Y CFR(s): 483.12(c)(1)(§483.12(c) In respons neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negle mistreatment, includir source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to t adult protective service	that all alleged violations et a callegations of abuse, or mistreatment, the facility		607			2/1/19

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				2	05 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		P	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 609	accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi interviews, and family # 4) of three sampled to submit a 24 hour a state agency regardin exploitation and misa funds and personal be included: Record review reveal 86 years of age, was 4/20/18. One of the re a progressive neurod is known to affect bra Review of Resident # data set (MDS) asses revealed the resident Brief Interview for Me 10. (A cognitively inta 15). The resident was signs of depression o On 6/11/18 a MDS as	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified a action must be taken. I is not met as evidenced ew, resident interview, staff r interview for one (Resident residents, the facility failed and five day report to the ag an allegation of resident popopriation of resident's elongings. The findings ed Resident # 4, who was admitted to the facility on esident's diagnoses included egenerative disorder which in activity. 4's admission minimum asment, dated 4/27/18, was assessed to have a ntal Status (BIMS) score of ct score is considered 13 to s also assessed to have n the MDS.	F	609	F 609 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; The facility completed a 24-hour report 1/4/19, and 5-day investigation was completed on 1/9/19 for Resident #4, regarding resident exploitation and misappropriation of resident funds and personal belongings. This was a situal that occurred with Resident #4's conse while he was competent with a BIMS score of 15. This is an ongoing investigation by the police outside of th facility. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice The Administrator and/or the Social Service Director (SSD) reviewed the grievance logs from July 2018- Januar 21, 2019, to identify concerns regardin resident exploitation and/or misappropriation, to validate that an investigation was completed and was	: on tion ent ner ; y	

Event ID: PHHC11

Facility ID: 923320

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	1 (67)	DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	l` '	G	· · ·	OMPLETED
			A. BOILDING	·		С
		345177	B. WING			01/04/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	••
				205 RATTLESNAKE TRAIL		
THE GREE	INS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 609	Continued From page	- <u>-</u>	F 00			
F 009	Continued From page		F 60		-	
	Record review reveal			reported to the state ager no other concerns identified	•	
	renal failure. Hospital	2/18 to 8/28/18 secondary to		been investigated and/or		
		sident had delirium and		state agency.		
		upon his 8/22/18 hospital		The Administrator, Directo	or of Nursina	
	admission date.			(DON), Assistant Director	-	
				(ADON) and Social Servio	•	
	Record review reveal	led on 9/10/18 a readmission		(SSD)completed interview	s with current	
		is completed, and Resident		staff on 1/25/19, regarding		
		have a BIMS score of 11.		resident abuse, exploitation		
		o coded on this MDS to have		misappropriation, that has		
	signs of depression.			previously reported. Ther		
	Deview of the regider	atta aliniaal record revealed		allegations reported that w	vere not already	
		nt's clinical record revealed I worker on 9/11/18 noting		investigated.		
		services had been contacted		Address what measures v	vill be put into	
		s to the resident and on		place or systemic change		
		's family member. There		ensure that the deficient p		
	was no explanation re			recur;		
	·	0 0		The Administrator and/or	the DON	
	Record review reveal	led on a 10/21/18 quarterly		completed education on 1	/25/19, for all	
	MDS assessment, Re	esident # 4 was assessed to		facility staff, all days, all s	hifts including	
		f 15. The resident was also		weekends and prn staff,		
		ssessment to have signs of		reporting and investigating		
	depression.			abuse. The education wil	I be included in	
	Resident # 1's family	member was interviewed on		new hire orientation. The staff will report immed	diately to the	
	-	member was interviewed on ne family member stated he		abuse officer any allegation		
		e appointed power of		include resident exploitati		
		# 4 in the past several		misappropriation. The ab		
	months. According to	-		submit the 24-hour report		
		en exploited by a facility		agency and an investigati		
		mily member had reported		that time and within 5 day		
		lity administrator but nothing		allegation the abuse office		
		t. The family member named		5-day investigative report	to the state	
		person who had exploited		agency.		
	and stolen from Resid	-		Indiants Issuelly for 199		
		following details. Prior to his nission, Resident # 4 had		Indicate how the facility pl	ans to monitor sure that	

Facility ID: 923320

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/06/2019 RM APPROVED IO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345177	B. WING _		0,	C 01/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
				205 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 609	residency at the form "taken a liking to him terminated the employ moved to the current followed Resident # 4 According to the fam allegedly used alcoha advantage of Reside The employee took th money from Residen employee arranged t social security payee over to her at the DW Vehicles). During the became payee of his did not pay his bills for The family member of when all of this occur it, but stated the ever approximately the lass Resident # 4 was inte AM. Resident # 4 was whether an employee taken advantage of h head and stated, "I ju know." He would not 4's affect was observ As he shook his head avoided further conver Review of Employee she was 29 years of on the personnel file. competency form hav The employee's term According to an inter	cility. During Resident # 4's her facility, an employee had ," and the other facility had byee. When Resident # 4 facility, the employee 4 and obtained a job. ily member, the employee of and drugs to take nt # 4 and steal from him. housands of dollars of tt # 4's bank accounts. The to become Resident # 4's e, and had him sign his car IV (Division of Motor e time that the employee a social security check she for which he was responsible. could not give definitive dates tred or when he had reported ints had transpired in st six months. erviewed on 1/4/19 at 11:25 is interviewed regarding e had ever stolen from him or him. Resident # 4 shook his ust don't know. I just don't expound further. Resident # ved to be flat and depressed. d, he looked away and	F6	 solutions are sustained; The Administrator, DON and/will interview 5 staff members weeks then 10 staff members 2 months, to validate that alle abuse were reported to the all and an investigation was initia reported to the state agency. The Administrator and/or the Nursing will review the grieva week for 4 weeks then weekly months, to validate that grieva missing items and/or care cor investigated and reported to t agency as required, if the item misappropriated or abuse situ identified. The Administrator and/or the Nursing will review the audits patterns/trends and will adjus necessary. The Administrato the plan during the monthly G and audits will continue at the the QAPI committee. Indicate dates when correctiv be completed; February 1, 2019 	a weekly for 4 a monthly for gations of ouse officer ated and Director of nce log 5 x a y for 2 ances of ncerns were he State ns were uations were discretion of to identify t the plan as r will review API meeting a discretion of		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/06/2019 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C / 04/2019	
	ROVIDER OR SUPPLIER ENS AT PINEHURST REI	HAB & LIVING CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 RATTLESNAKE TRAIL 2INEHURST, NC 28374	•		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	The social worker (SV 1/4/19 at 9:10 AM. The following. The resident oriented prior to Augu had come to the facili # 1 was driving the re- employed at the facili interviewed regarding. Employee # 1's car we facility staff he was le- car, and she also hel stated the resident "po- own business." Accound the stuation employee continued for out of the facility. In laresident became ill and Following the hospital member informed the that the employee has resident. On 9/10/18 was called, and a pol stated the resident we allowed Employee # when Resident # 4's also stated he had be family during the time. The administrator was 8:40 AM and again of administrator reported documentation into a alleged exploitation and Resident # 4. The add Employee # 1 was sti	facility for at least 48 days. <i>W</i>) was interviewed on the SW reported the the was very alert and list, 2018. At some point It ity's attention that Employee esident's car while she was ity. The resident was g this, and informed staff that vas broken. He also told the titing Employee # 1 use his ped him with things. The SW wretty much said to mind your rding to the SW, Employee # the conflict of interest n and opted to resign. The to visit and sign Resident # 4 ate August, 2018, the nd was hospitalized. lization, the resident's family e administrator of concerns d been stealing from the Adult Protective Services ice report was filed. The SW as alert and oriented and 1 to do the things she did money disappeared. She een estranged from his	F	609				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE	
		345177	B. WING				C 04/2019
NAME OF PF	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER			RATTLESNAKE TRAIL EHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 609	car which he kept at t occasions the admini- resident, and the resid occasion she spoke to Resident # 4 informed car was not working a his to take him places she met with Employe was not appropriate to decided to quit. After resigned, the employe Resident # 4 and take administration stated himself out with her, a would "appear differe hospitalized in Augus became more alert, h administrator that Em him a white pill when On 1/4/19 at 1:45 interviewed again. It w administrator that adu notified on 9/10/18 or family member regard exploitation and misa did not submit a 24 he the state agency. Acc she was not aware sh investigating and repo state agency since th alleged events the ad	king Resident # 4 out in his he facility. On the first two strator had questioned the dent denied it. On the third o Resident # 4 again, and d her that Employee # 1's and he allowed her to use s. The administrator stated ee # 1 and informed her this behavior, and Employee # 1 the employee voluntarily ee continued to visit e him out of the facility. The Resident # 4 would sign and when he returned he nt." After Resident # 4 was t, 2018, recovered, and e had informed the ployee # 1 had been giving she was with him. PM the administrator was was confirmed with the ult protective services was n behalf of Resident # 4's ding the allegation of ppropriation, but the facility our report or 5 day report to cording to the administrator ne was responsible for orting the allegation to the e allegation dealt with iministrator felt transpired perpetrator's resignation of	F6	609			
F 677 SS=E	ADL Care Provided for	or Dependent Residents	F 6	677			2/1/19

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CC	OMPLETED	
		345177	B. WING		C 01/04/2019		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		0110-112010	
THE GRE	ENS AT PINEHURST REH	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 26	F 67	77			
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio interviews and record provide showers as s daily living (ADL) dep (Resident #9, Reside 6 residents reviewed included 1. Resident #9 was a cumulative diagnoses Accident (CVA) with F Resident #9's undate she required staff ass Tuesday and Friday on needed. Resident #9's care pl she required staff ass Tuesday and Friday on needed. Review of the facility grievance dated 11/2 was not getting her sl Resident #9's quarter dated 12/15/18 indica	 is not met as evidenced in, staff and resident d review, the facility failed to scheduled for activities of bendent residents for 3 nt #13 and Resident #21) of for ADLs. The findings dmitted on 7/6/08 with s od Cerebral Vascular delectronic Kardex read sistance for showers every on second shift and as an last revised 7/28/18 read sistance for showers every on second shift and as grievance log revealed a 8/18 which read Resident #9 howers. rly Minimum Data Set (MDS) ated she was cognitively to behaviors. She was coded 		F 677 Address how corrective action accomplished for those reside have been affected by the defi practice; The facility provided a shower Resident #9 on1/4/19, followin exit, and has received shower _Tuesday and Friday per resid shower schedule. The Directo (DON) discussed the shower s and resolution with Resident # as a resolution to the grievand documented 11/28/18, shower offered and given by the certifi assistant (CNA) on the schedu days and documented on the sheet. The Licensed nurse wi shower was given and docum Medication administration reco The facility provided a shower Resident #13 on 1/5/19, follow exit, and has received shower Wednesday and Saturday per shower schedule. The DON of the shower schedule and reso Resident #13 on 1/4/19, as a n the grievance documented on showers will be offered and gir CNA on the scheduled shower	Ints found to icient for og survey s every dents' or of Nursing schedule 49 on 1/4/19, ce rs will be ied nursing uled shower shower Il validate ent on the ord (MAR). for ving survey s every residents' liscussed olution with resolution to 11/28/18, ven by the		
		entation from 11/1/18 to sident #9 received one		CNA on the scheduled shower documented on the shower sh Licensed nurse will validate sh	neet. The		

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C / 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REP	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page	e 27	F	677			
	shower on 12/21/18. Review of the facility	grievance log revealed a		••••	given and document on the MAR. The facility provided a shower for Resident #21 on 1/5/19, following sur	vey	
	was still not getting h				exit, and has received showers every Saturdays on first shift and Wednesda on second shit per residents' shower schedule. The DON discussed the	ау	
	In an interview and observation on 1/3/19 at 1:40 PM, Resident #9 stated she had not been receiving her scheduled showers for some time. She stated she completed multiple grievances but				shower schedule and resolution with Resident #21 on 1/4/19, as a resolution the grievance documented on 12/27/1		
	there had been no im	provement in receiving her appeared clean, absent of			showers will be offered and given by the CNA on the scheduled shower days a documented on the shower sheet. The	he Ind	
	In an interview on 1/3 Assistant (NA) #1 sta	/19 at 11:47 AM, Nursing ted she had issues			Licensed nurse will validate shower w given and document on the MAR.	as	
	. ,	nment and completing her			Address how the facility will identify or residents having the potential to be affected by the same deficient practic		
		3/19 at 3:45 PM, NA #2 n several occasions she was			Current facility residents have the potential to be affected by the same		
		Il her assigned showers due			deficient practice of not receiving shores as scheduled.	wers	
	stated the facility was	9/19 at 5:00 PM, NA #7 9 often understaffed. She			The DON and ADON's completed an audit on 1/21/19, of shower documentation for current facility		
		get her showers done on her ated there were three aides at present.			residents, to identify residents that ha received a shower as scheduled. The were 3 residents identified. Those residents were offered a shower on		
	stated she worked on	6/19 at 5:05 PM, NA #5 a an as needed basis on t. NA #5 stated it was difficult ake residents to the			1/21/19 and will be offered showers g forward according to shower schedule	-	
	In an interview on 1/4	ete her assigned showers. /19 at 6:35 AM, NA #3			Address what measures will be put in place or systemic changes made to ensure that the deficient practice will a		
		been short staff for about 1 had difficulty answering call			recur; The DON and/or ADON's provided		

Facility ID: 923320

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						NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED	
						С	
		345177	B. WING			01/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE	
F 677	Continued From page	e 28	F 67	77			
		her ADL rounds due to short		education beginning on 1/ licensed nurses and CNA' days, including weekends	s , all shifts, all		
		DON) stated she felt that the		regarding providing showed	chedule, with		
	was not a personnel	ng their scheduled showers issue that rather a staffing third shift. The DON stated		documentation by the CN sheet, and the licensed nu shower was given and do	urse will validate		
	second and third shif	red several aides for both t. She stated the facility has		residents MAR. When a r a shower, the CNA will rep	port to the		
	holes in the schedule	as needed staff to fill staffing The DON stated it was her esidents receive their		licensed nurse and the lice follow up with the resident refusal or acceptance of the	t and document		
	showers as schedule			the MAR. The education will be prov			
	readmitted 6/29/18 w	admitted on 1/15/18 and ith cumulative diagnoses of		hired staff during new hire Indicate how the facility pl	ans to monitor		
	CVA, Diabetes and C (CHF).	ongestive Heart Failure		its performance to make s solutions are sustained; The DON and/or the ADO			
	-	erly MDS dated 11/25/18 ognitive impairments with no		shower sheets and MARS for 4 weeks then 3 times a	5 times a week		
		coded as requiring total staff		months to validate that sh documented as given/refu	owers are ised.		
		ed electronic Kardex read sistance for showers every		The DON and/or the ADO and/or observe 10 resider weeks then 20 residents r	nts weekly for 4		
	-	irday on second shift and as		months, to validate that sh as scheduled, as evidence oriented resident voicing	nowers are given		
	read she required sta	blan last revised on 11/27/18 Iff assistance with showers		confirmation,and/ or obser impaired residents during	shower.		
	and as needed.	d Saturday on second shift		The Director of Nursing w audits to identify patterns/ adjust the plan as necessa	trends and will		
	present indicated Res	entation from 11/1/18 to sident #13 only received a 12/15/18, 12/22/18 and		will review the plan during QAPI meeting and audits the discretion of the QAPI	the monthly will continue at		

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/06/2019 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING			C 01/04/2019		
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D5 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 677	grievance dated 12/2 #13 was not getting h In an interview on 1/3 Assistant (NA) #1 sta completing her assign assigned showers du In an interview on 1/3 stated there had been unable to complete a to staffing issues. In an interview and of PM, Resident #13 sta receiving her schedul She stated she comp had been no improve showers. Resident #1 odors and dressed fo In an interview on 1/3 stated the facility was stated she could not g assignment. NA #7 st working on all floors a In an interview on 1/3 stated she worked on second and third shift to answer call bells, t bathroom and complet In an interview on 1/4 stated the facility has year. She stated she	grievance log revealed a 8/18 which read Resident her showers. 3/19 at 11:47 AM, Nursing ted she had issues ment and completing her e to short staffing. 3/19 at 3:45 PM, NA #2 n several occasions she was II her assigned showers due bservation on 1/3/19 at 4:50 ated she had not been led showers for some time. leted a grievance but there ment in receiving her 13 appeared clean, absent of r season. 3/19 at 5:00 PM, NA #7 s often understaffed. She get her showers done on her tated there were three aides at present. 3/19 at 5:05 PM, NA #5 n an as needed basis on t. NA #5 stated it was difficult	F	677	Indicate dates when corrective action be completed; February 1, 2019	will		

Facility ID: 923320

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	-	ID HUMAN SERVICES				FORI	M APPROVED
STATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		345177	B. WING				C / 04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	staffing. In an interview on 1/4 Director of Nursing (E resident's not receivir was not a personnel i issue on second and the facility recently hi second and third shift been utilizing a lot of holes in the schedule expectation that the r showers as schedule 3. Resident #21 was cumulative diagnoses and Diabetes. Resident #21's quarte indicated she was con no behaviors. She was staff assistance with I Resident #21's undat she required staff ass Wednesday and Satu needed. Resident #21's care p read she required staf every Wednesday an and as needed. Review of the facility	 d/19 at 12:43 PM, the DON) stated she felt that the ng their scheduled showers ssue that rather a staffing third shift. The DON stated red several aides for both a. She stated the facility has as needed staff to fill staffing The DON stated it was her esidents receive their d and as needed. admitted on 1/6/12 with s of Coronary Artery Disease erly MDS dated 10/16/18 gnitively intact and exhibited as coded as requiring total bathing. ed electronic Kardex read sistance for showers every urday on second shift and as blan last revised on 12/24/18 ff assistance with showers d Saturday on second shift grievance log revealed a 7/18 which read Resident 	F	677			
		entation from 11/1/18 to sident #21 only received a					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILD	NG _			C
		345177	B. WING				04/2019
NAME OF PI	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	12/30/18.	12/19/18, 12/22/18 and	F	677	7		
	AM, Resident #21 con Resident Council Pre not been receiving he some time. She state grievance and brough Resident Council meet improvement in receiv	sident. She stated she had r scheduled showers for					
	Assistant (NA) #1 sta	nment and completing her					
	stated there had beer	/19 at 3:45 PM, NA #2 n several occasions she was Il her assigned showers due					
	stated the facility was stated she could not g	/19 at 5:00 PM, NA #7 often understaffed. She get her showers done on her ated there were three aides at present.					
	stated she worked on second and third shift to answer call bells, ta bathroom and comple	ete her assigned showers.					
		/19 at 6:35 AM, NA #3 been short staff for about 1					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C 104/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677 F 725 SS=D	year. She stated she bells and completing staffing. In an interview on 1/4 Director of Nursing (E resident's not receivir was not a personnel i issue on second and the facility recently hi second and third shift been utilizing a lot of holes in the schedule expectation that the r showers as schedule 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 at practicable physical, i well-being of each res resident assessments and considering the r diagnoses of the facil accordance with the f	had difficulty answering call her ADL rounds due to short /19 at 12:43 PM, the DON) stated she felt that the ng their scheduled showers ssue that rather a staffing third shift. The DON stated red several aides for both . She stated the facility has as needed staff to fill staffing . The DON stated it was her esidents receive their d and as needed.		725			2/1/19
	by sufficient numbers types of personnel or nursing care to all res resident care plans:	cility must provide services of each of the following a 24-hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and					

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 01/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	ENS AT PINEHURST REF		:	205 RATTLESNAKE TRAIL	
				PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 725	Continued From page (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio interviews and record provide sufficient staf (Resident #, Residem residents who require showers and failed to 1 resident (Resident # required assistance w included: 1. Resident #9 was a cumulative diagnoses Accident (CVA) with H Resident #9's undate she required staff ass Tuesday and Friday of needed. Resident #9's care pla she required staff ass Tuesday and Friday of needed. Review of the facility	e 33 sonnel, including but not when waived under section, the facility must nurse to serve as a charge duty. T is not met as evidenced ns, resident and staff review, the facility failed to fing to provide showers for 3 t 13 and Resident #21) of 6 ed staff assistance with answer call bells timely for #4) of 1 resident who with toileting. The findings dmitted on 7/6/08 with s of Cerebral Vascular Hemiplegia. d electronic Kardex read sistance for showers every on second shift and as an last revised 7/28/18 read sistance for showers every on second shift and as	F 725	F 725 Address how corrective action will be accomplished for those residents fou have been affected by the deficient practice; The facility provided a shower for Resident #9 on 1/4/19, following survexit, and has received showers every Tuesday and Friday per residents' sh schedule. The Director of Nursing (I discussed the shower schedule and resolution with Resident #9 on 1/4/19 a resolution to the grievance docume 11/28/18, showers will be offered and given by the certified nursing assista (CNA) on the scheduled shower day documented on the shower sheet. T Licensed nurse will validate shower of given and document on the Medicati administration record (MAR). The facility provided a shower for Resident #13 on 1/5/19, following su exit, and has received showers every Wednesday and Saturday per resider	e ind to /ey / hower DON) D, as ented d nt s and he was on rvey / nts'
	was not getting her sl Resident #9's quarter	ly Minimum Data Set (MDS)		shower schedule. The DON discuss the shower schedule and resolution Resident #13 on 1/4/19, as a resolut the grievance documented on 11/28/	with ion to /18,
	uated 12/15/18 Indica	ted she was cognitively		showers will be offered and given by	uie

Facility ID: 923320

If continuation sheet Page 34 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C / 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ENS AT PINEHURST REI	AB & LIVING CENTER		20	05 RATTLESNAKE TRAIL		
				Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From page	> 34	Í FZ	725			
1 120		o behaviors. She was coded		25	CNA on the scheduled shower days a	and	
	for total staff assistan				documented on the shower sheet. The		
		ee mar zeemig.			Licensed nurse will validate shower w		
	Review of the docum	entation from 11/1/18 to			given and document on the MAR.		
		sident #9 only received one			The facility provided a shower for		
	shower on 12/21/18.				Resident #21 on 1/5/19, following sur		
	Peview of the facility	grievance log revealed a			exit, and has received showers every Wednesday and Saturday per resider		
		8/18 which read Resident #9			shower schedule. The DON discusse		
	was still not getting h				the shower schedule and resolution v		
					Resident #21 on 1/4/19, as a resolution	on to	
		bservation on 1/3/19 at 1:40			the grievance documented on 12/27/		
	PM, Resident #9 stat				showers will be offered and given by		
		ed showers for some time.			CNA on the scheduled shower days a		
	-	leted multiple grievances but provement in receiving her			documented on the shower sheet. The Licensed nurse will validate shower w		
		appeared clean, absent of			given and document on the MAR.	145	
	odors and dressed fo				Resident #4 requires assistance with		
					toileting. The Director of Nursing pro	vided	
	In an interview on 1/3	3/19 at 11:47 AM, Nursing			in service education on 1/22/19, for the		
	Assistant (NA) #1 sta				nursing staff regarding answering cal		
		nment and completing her			lights timely to include not to turn call	light	
	assigned showers du	e to short stalling.			off until resident needs are met.		
	In an interview on 1/3	/19 at 3:45 PM, NA #2			Address how the facility will identify o	ther	
		n several occasions she was			residents having the potential to be		
	-	ll her assigned showers due			affected by the same deficient practic	e;	
	to staffing issues.				Current facility residents that require		
	la an intervie da da				assistance with ADLS (showers/toilet		
		3/19 at 5:00 PM, NA #7 3 often understaffed. She			have the potential to be affected by the	ie	
	· · · ·	get her showers done on her			deficient practice. The DON and ADON's completed an		
		ated there were three aides			audit on 1/21/19, of shower		
	working on all floors a				documentation for current facility		
	-				residents, to identify residents that ha	id not	
		3/19 at 5:05 PM, NA #5			received a shower as scheduled. The	ere	
		an as needed basis on			were 3 residents identified. Those		
		t. NA #5 stated it was difficult			residents were offered a shower on		
to answer call bells, take residents to the					1/21/19 and will be offered showers g	joing	

Event ID: PHHC11

Facility ID: 923320

If continuation sheet Page 35 of 75

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 02/06/2019 /I APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		345177	B. WING			C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	a 35	F 72	5		
1 7 20			F 725		bodulo	
	bathroom and comple	ete her assigned showers.		forward according to shower so	nequie.	
	In an interview on 1/4	l/19 at 6:35 AM, NA #3				
		been short staff for about 1		Address what measures will be		
	-	had difficulty answering call		place or systemic changes mad		
		her ADL rounds due to short		ensure that the deficient practic	ce will not	
	staffing.			recur;	-ll	
	In an interview on 1/4	1/10 at 12:43 PM the		The DON and/or ADON's provi education beginning on 1/22/19		
		DON) stated she felt that the		licensed nurses and CNA's, all		
		ng their scheduled showers		days including weekends and p		
		issue that rather a staffing		regarding providing showers to		
	•	third shift. The DON stated		according to the shower sched		
	the facility recently hi	red several aides for both		documentation by the CNA on	the shower	
	second and third shif	t. She stated the facility has		sheet, and the licensed nurse v		
	•	as needed staff to fill staffing		shower was given and docume		
		. The DON stated it was her		residents MAR. When a reside		
		esidents receive their		a shower, the CNA will report to		
		d and as needed and the		licensed nurse and the licensed		
		e staffing on all three shifts.		follow up with the resident and refusal or acceptance of the sh		
	2 Resident #13 was	admitted on 1/15/18 and		the MAR. This education will be		
		ith cumulative diagnoses of		to newly hired nursing staff dur	•	
		Congestive Heart Failure		hire orientation.		
	(CHF).	-		The Director of Nursing provide	ed in	
				service education on 1/22/19, f		
	-	erly MDS dated 11/25/18		nursing staff all shifts, all days	-	
		ognitive impairments with no		weekends and prn staff, regard		
		coded as requiring total staff		answering call lights timely to in		
	assistance with bathing	ng.		to turn call light off until residen met. This education will be pro		
	Resident #13's undat	ed electronic Kardex read		newly hired nursing staff during		
		sistance for showers every		orientation.		
	-	urday on second shift and as		The Administrator and/or the D	ON will hire	
	needed.	-		nursing staff to fill open position	ns as they	
				occur in order to provide suffici	•	
	-	plan last revised on 11/27/18		meet resident care needs.		
		iff assistance with showers				
	every Wednesday an	d Saturday on second shift		Indicate how the facility plans to	o monitor	

Facility ID: 923320

If continuation sheet Page 36 of 75
TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	COMPL	
					C	
		345177	B. WING		•	4/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
THE GREI	ENS AT PINEHURST REP	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 725	Continued From page	36	F 72	5		
1720	and as needed.	50		its performance to make	sure that	
				solutions are sustained;		
	Review of the docum	entation from 11/1/18 to		The DON and/or the AD		
	•	sident #13 only received a		shower sheets and MAR		
		12/15/18, 12/22/18 and		for 4 weeks then 3 time		
	12/26/18.			months to validate that		
	Review of the facility	grievance log revealed a		documented as given/re The DON and/or the AI		
		8/18 which read Resident		interview and/or observ		
	#13 was not getting h			weekly for 4 weeks ther	n 20 residents	
				monthly for 5 months, to		
		8/19 at 11:47 AM, Nursing		showers are given as so		
	Assistant (NA) #1 sta	nment and completing her		evidenced by alert and voicing confirmation, an		
	assigned showers du			cognitively impaired res	-	
		3/19 at 3:45 PM, NA #2		The DON and/or ADON		
		n several occasions she was		answering of call lights		
	unable to complete al to staffing issues.	II her assigned showers due		week for 4 weeks then 3 2 months, to validate ca		
	to stanning issues.			answered timely to mee	•	
	In an interview and ol	bservation on 1/3/19 at 4:50		needs.		
	PM, Resident #13 sta	ated she had not been		The DON and/or ADON	's will interview 10	
		led showers for some time.		residents weekly for 4 w		
		ed clean, absent of odors		residents monthly for 5		
	and dressed for seas	on.		validate that call lights a answered timely to mee		
	In an interview on 1/3	8/19 at 5:00 PM, NA #7		needs.		
		s often understaffed. She		The Administrator and/	or the DON will	
	stated she could not	get her showers done on her		monitor staffing needs of	-	
		tated there were three aides		and assure that sufficien		
	working on all floors a	at present.		to meet resident care ne	eeas.	
	In an interview on 1/3	8/19 at 5:05 PM, NA #5		The Director of Nursing	will review the	
		an as needed basis on		audits/monitors/intervie		
		t. NA #5 stated it was difficult		patterns/trends and will	adjust the plan as	
	to answer call bells, ta			necessary. The DON w		
	bathroom and comple	ete her assigned showers.		during the monthly QAF		
				audits will continue at th	e discretion of the	

Event ID: PHHC11

Facility ID: 923320

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE		
	CORRECTION	IDENTIFICATION NUMBER:					LETED	
							C	
		345177	B. WING			01/	04/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GREI	ENS AT PINEHURST REF	AB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON (X5)		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B	BE COMPLETION		
TAG	REGULATORT OR I	SCIDENTIFTING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)			
F 725	Continued From page	e 37	F	725				
		/19 at 6:35 AM, NA #3			QAPI committee.			
		been short staff for about 1 had difficulty answering call						
		her ADL rounds due to short			Indicate dates when corrective action v	vill		
	staffing.				be completed;			
					February 1, 2019			
	In an interview on 1/4 Director of Nursing (OON) stated she felt that the						
		ig their scheduled showers						
	-	ssue that rather a staffing						
		third shift. The DON stated						
		red several aides for both She stated the facility has						
		as needed staff to fill staffing						
		. The DON stated it was her						
	expectation that the re	esidents receive their data and the						
		e staffing on all three shifts.						
		admitted on 1/6/12 with						
	cumulative diagnoses and Diabetes.	s of Coronary Artery Disease						
	Pesident #21's quarte	erly MDS dated 10/16/18						
	-	gnitively intact and exhibited						
	no behaviors. She wa	is coded as requiring total						
	staff assistance with t	bathing.						
	Resident #21's undat	ed electronic Kardex read						
	she required staff ass	istance for showers every						
	-	rday on second shift and as						
	needed.							
	Resident #21's care p	blan last revised on 12/24/18						
		ff assistance with showers						
	every Wednesday an and as needed.	d Saturday on second shift						
	Review of the facility	grievance log revealed a						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE			
		345177	B. WING				C / 04/2019		
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 725	grievance dated 12/2 #21 was not getting h Review of the docump present indicated Res shower on 12/15/18, 12/30/18. In an interview and of AM, Resident #21 con Resident Council Pre not been receiving he some time. She state grievance and brough Resident Council meet improvement in receiv #21 appeared clean, for season. In an interview on 1/3 Assistant (NA) #1 sta completing her assign assigned showers du In an interview on 1/3 stated there had beer unable to complete al to staffing issues. In an interview on 1/3 stated the facility was stated she could not g assignment. NA #7 st working on all floors a In an interview on 1/3 stated she worked on	7/18 which read Resident er showers. entation from 11/1/18 to sident #21 only received a 12/19/18, 12/22/18 and oservation on 1/3/19 at 8:45 nfirmed she was the sident. She stated she had er scheduled showers for d she completed a nt the lack of showers in etings but there had been no ving her showers. Resident absent of odors and dressed 7/19 at 11:47 AM, Nursing ted she had issues ment and completing her e to short staffing. 7/19 at 3:45 PM, NA #2 n several occasions she was I her assigned showers due 7/19 at 5:00 PM, NA #7 often understaffed. She get her showers done on her rated there were three aides at present. 7/19 at 5:05 PM, NA #5 a n as needed basis on t. NA #5 stated it was difficult	F 7	725					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C / 04/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 725	bathroom and completing In an interview on 1/4 stated the facility has year. She stated she bells and completing staffing. In an interview on 1/4 Director of Nursing (D resident's not receivir was not a personnel i issue on second and the facility recently hill second and third shift been utilizing a lot of holes in the schedule expectation that the m showers as schedule facility have adequate 4. Resident #4 was ar cumulative diagnoses and Parkinson's Dise Resident #4's quarter indicated he was cog no behaviors. He was assistance with toileti Resident #4 was care assistance with his Al In an observation on #4's call bell was obs required staff assistant	ete her assigned showers. /19 at 6:35 AM, NA #3 been short staff for about 1 had difficulty answering call her ADL rounds due to short /19 at 12:43 PM, the OON) stated she felt that the ng their scheduled showers ssue that rather a staffing third shift. The DON stated red several aides for both 1. She stated the facility has as needed staff to fill staffing . The DON stated it was her esidents receive their d and as needed and the e staffing on all three shifts. dmitted 12/10/14 with s of Congestive Heart Failure ase. Ity MDS dated 10/21/18 nitively intact and exhibited s coded for extensive staff ng. e planned for staff DLs. 1/3/19 at 4:40 PM, Resident erved lite to signify he	F	725			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345177	B. WING _				C 104/2019	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER	PINEHURST, NC 28374					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 725 F 804 SS=E	the hall outside the do stated required assist and his call bell had b minutes. Resident #4 getting timely assistant In an interview on 1/3 stated the facility was stated she could not g assignment. NA #7 st working on all floors a In an observation a 1/2 retrieved the mechan assist Resident #4. S as needed basis on s stated it was difficult t residents to the bath assigned showers. In an interview on 1/4 Director of Nursing (D resident's not receivir was not a personnel i issue on second and the facility recently his second and third shift been utilizing a lot of holes in the schedule expectation that the r showers as scheduled facility have adequate Nutritive Value/Appea CFR(s): 483.60(d) Food and	borway of his room. He cance going to the bathroom been ringing for over 10 stated he had difficulty ince with his ADLs. /19 at 5:00 PM, NA #7 often understaffed. She get her showers done on her ated there were three aides at present. /3/19 at 5:05 PM, NA #5 ical lift and proceeded to he stated she worked on an econd and third shift. NA #5 o answer call bells, take oom and complete her /19 at 12:43 PM, the OON) stated she felt that the ing their scheduled showers ssue that rather a staffing third shift. The DON stated red several aides for both . She stated the facility has as needed staff to fill staffing . The DON stated it was her esidents receive their d and as needed and the e staffing on all three shifts. ar, Palatable/Prefer Temp (2)		725			2/1/19	

Facility ID: 923320

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/06/2019 RM APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _			0.	C 1/04/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	_ . [S	TREET ADDRESS, CITY, STATE, ZIP CODE	DE	
THE GREE	ENS AT PINEHURST RE	HAB & LIVING CENTER		20	05 RATTLESNAKE TRAIL		
				P	INEHURST, NC 28374		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 804	Continued From page	e 41	F	304			
		prepared by methods that		-00			
		lue, flavor, and appearance;					
	§483.60(d)(2) Food a attractive, and at a sa	and drink that is palatable, afe and appetizing					
		Γ is not met as evidenced					
		ons, resident interviews and ecord review, the facility			F 804		
		ood served was palatable			Address how corrective action will be		
		petizing temperature for 5			accomplished for those residents fou	nd to	
		ent #10, Resident #21,			have been affected by the deficient		
	Resident #22 and Re	esident #24) of 5 hts reviewed for palatable			practice; The Administrator presented a resolution	ution	
	food. The findings inc	-			to the Resident Council President on 1/25/19, for the grievance of cold for		
					include monitoring food temperatures	son	
		mber 2018 Resident Council 9/26/18 included a grievance			the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks ar	hd	
		ling cold food in the dining			monitoring food temperature during r		
		s. The resolution was staff			pass in the dining room and hallways		
	education.				breakfast, lunch and dinner 5 times a		
					week, to assure food temperatures		
		er 2018 RC minutes dated			remain within acceptable temperature range at the point of service of 125	Ð	
		grievance dated 10/24/18 g staff not passing the meal			degrees or resident preference. The		
		in cold food. The resolution			resolution was accepted by the reside		
	was an in-service co	mpleted on 10/25/18 to			council on 1/25/19.		
		ays not being passed out			The Administrator and/or the Director		
	timely.				Nursing (DON)and Dietary Manager	. ,	
	 1 Resident #0 was a	admitted on 7/6/08 with			met with Residents # 9, 10, 21,22, ar individually on 1/25/19, to present to		
		s od Cerebral Vascular			the new process for monitoring food		
	Accident (CVA) with				temperatures in the dining room and	on	
					the hallways. These residents accept		
	-	rly Minimum Data Set (MDS)			the new process.		
		ated she was cognitively			The Administrator, DON and/or DM v		
	intact and exhibited r	io penaviors.			interview Residents 9, 10, 21, 22 and	I 2 4,	

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938	
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	ŕ
		345177	B. WING		C 01/04/201	9
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, 2		
				205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMPL	(5) LETIO ATE
F 804	Continued From page	e 42	F 80	14		
	e e number i nem pag			weekly for 4 weeks, to	validate that food	
	In an interview on 1/2	2/19 at 11:20 AM, the Dietary		items were received at		
		I the facility was under new		temperature.		
	e ()	uly 2018 and there had been				
		menu. She stated the new		Address how the facility	/ will identify other	
	management did not	offer an "alternate" to what		residents having the po	tential to be	
	was on the main mer	nu but rather have a "Always		affected by the same de	eficient practice;	
		M). The DM stated the items		Current facility resident		
		grilled cheese sandwiches,		trays have the potential	-	
		den salad, hot dog, chips		the same deficient prac		
		She stated a lot of the		Address what measure	•	
		m the AAM but did not think		place or systemic change	-	
		od on the menu was not ated she was out on leave		ensure that the deficien recur;	it practice will not	
	•	8 to 10/29/18 and in her		The Director of Nursing	provided in	
	-	as in charge. She stated the		service education on 1/	-	
		n" to the ordering process		nursing staff, all days a		
		cility running out of food.		weekends and prn staff	-	
		as aware that the menus		passing of meal trays ti		
	were not being follow	ed so she ordered the food		at the point of resident	service within the	
	remotely while on lea	ve. She stated she was		acceptable temperature	e range of 125	
	aware of the complai	ns of cold food. The DM		degrees or resident pre	ference. This	
		ycle was scheduled to start		education will be provid	-	
		the residents would be		nursing staff during new		
	happy with the new n	nenu cycle.		The Dietary Manager co		
	In an interview and a	been ation on 1/2/10 at		education on 1/25/19, f		
		bservation on 1/2/19 at #9 was observed eating		all days, all shifts, inclue	•	
	•	om. She was served beef		prn staff , regarding ma acceptable food temper		
		es. Resident #9 stated the		degrees or greater on the		
	food was often serve			The Dietary Manager of	-	
				for the upcoming weekl		
	In an interview on 1/3	8/19 at 9:30 AM, the		always available menu.	-	
		there was some "tweaking"		the cook will validate da		
	of the menus a few m	-		are available for the foll	-	
	management did not	realize it would put the		and the Always Availab		
	-	ver budget. She stated the		is responsible for orderi		
		ge while the DM was on		and/or adjusting the me		
	leave but there was c	oversight provided by the		alternatives of equal nu	tritive value as	

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		MEDICAID SERVICES		LE CONSTRUCTION		<u>/IB_NO: 0938-03</u> 3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		(X.	COMPLETED
			AL DOILDING		_	С
		345177	B. WING			01/04/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
	ENS AT PINEHURST REI			205 RATTLESNAKE TR	RAIL	
THE GREE	ENS AT PINEHURST REI	HAD & LIVING CENTER		PINEHURST, NC 28	374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COP	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 804	Continued From page	a 43	F 80	1		
1 004	Director of Dining Se		FOU		commodato resident	
		the DDS was at the facility		-	ccommodate resident d to meet the nutritional	
		s. She stated the facility was		· · ·	etermined by the Dietician	
		nd that the Chef was not			vides an Always Available	
		ow to order food based on			ate menu, if the resident	
		nu. The Administrator she			want the food on the daily	
		of concerns in the dietary		menu.		
	department and the u	unhappiness of residents.			or ADON's will assign the dining area and	
	In an interview on 1/3	B/19 at 9:50 AM, Nursing			meal times to assure	
		ated she was aware that the			passed timely when they	
		ppy with the food served at		are sent from th		
	•	d the residents complained				
		tting what was on the menu				
		would run out of food. NA #6		Indicate how th	o facility plana to monitor	
		oticed any improvements or DM returned from leave.			e facility plans to monitor to make sure that	
	worodning onloc the l			solutions are su		
	In a telephone intervi	ew on 1/3/19 at 9:55 AM, the		The DM, the co		
	Chef stated he was n	o longer employed at the		Administrator w	vill monitor food	
		was aware the dietary staff			n the tray line for	
	-	e menus and that residents			n and dinner 5 times a	
	-	ut cold food. He stated he ned on the facility's ordering			ks, then 3 times a week fo lude weekends. Standard	r
		en frequently ran out of food.			each meal, ensuring	
	•	DDS came to the facility			at a temperature of above	
	every few weeks to a			140 degrees F.		
				The DM, the co	ook and/or the	
		the lunch meal in the main			vill monitor food	
	-	9 at 12:10 PM, the menu			ring meal pass in the	
	from the sampled res	nd no reports of cold food			d hallways, for breakfast, er 5 times a week for 4	
					mes a week for 5 months	
	In an interview on 1/3	3/18 at 11:35 AM, NA #4			ings and weekends, to	
		esidents often complained		assure food ten	nperatures at point of	
		partment regarding cold food,			within acceptable	
	-	hus and the taste of the food.			nge of 125 degrees or	
	She stated she freque	ently had to reheat food.		resident prefere		
				The DON and/o	or the ADON's will monitor	

Facility ID: 923320

			OMB NO. 093	8-0391	
/SUPPLIER/CLIA TION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞY	
345177	B. WING		_	19	
		STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTED		205 RATTLESNAKE TRAIL			
GENTER		PINEHURST, NC 28374			
EDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE COM	(X5) PLETION DATE	
as "horrible". d at the proper M, NA #2 acility. She e vocal about od. at 3:10 PM, the of leave, the harge of the e DDS stated in how to order it was tated he asked was on leave ing the etting certain of the M, NA #5 uently mperature of sidents ordered the food on AM, The ectation that epartment be temperature. tation that the	F 80	the dining area and hallways during times 5 times a week for 4 weeks times a week for 5 months include evenings and weekends, to valids staff are present in the dining are hallways and passing trays timely. The Administrator, DON and/or the manager will interview 5 resident for 4 weeks then 10 residents mod 5 months, to validate that food was delivered at an acceptable temper according to resident preference. The Administrator, Dietary Manage and/or the Director of Nursing will audits/monitors and interviews to patterns and trends and will adjust plan as necessary. The Administrator/Dietary manage will review the plan during month meeting and will continue the plan discretion of the QAPI committee	s, then 3 ing ate that a and y. ne dietary s weekly onthly for as erature ger I review identify st the ger/DON ly QAPIU n at the s.		
		A. BUILDING B. WING CENTER FICIENCIES CEDED BY FULL SINFORMATION) FICIENCIES CEDED BY FULL SINFORMATION) F 80 M, Resident #9 vas "horrible". ed at the proper M, NA #2 acility. She e vocal about bod. at 3:10 PM, the of leave, the harge of the e DDS stated on how to order t it was tated he asked e was on leave ting the petting certain e of the M, NA #5 uently mperature of sidents ordered I the food on AM, The bectation that epartment be temperature. ctation that the AM, the DM	345177 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE CENTER FICIENCIES ID PROVIDERS PLAN OF CORRE PREFIX PREFIX <td col<="" td=""><td>345177 B. WING C 01/04/20 CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374 CODE FROENCES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLO BE (EACH CORRECTIVE ACTION SHOLE ACTION SHOLE A</td></td>	<td>345177 B. WING C 01/04/20 CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374 CODE FROENCES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLO BE (EACH CORRECTIVE ACTION SHOLE ACTION SHOLE A</td>	345177 B. WING C 01/04/20 CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374 CODE FROENCES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLO BE (EACH CORRECTIVE ACTION SHOLE ACTION SHOLE A

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ED.		E CONSTRUCTION	(X3) DATE COMP	
A. BUILI	DING _			
B. WING				
	G			C 04/2019
	S	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	04/2013
	20	205 RATTLESNAKE TRAIL		
	Р	PINEHURST, NC 28374		
JLL PRE	FIX			(X5) COMPLETION DATE
Ment what ways items ches, ps think ot ave r d the ess	= 804			
	JLL PRE ION) TA	JILL ID JILL ID PREFIX TAG PREFIX TAG F 804 ance the ery f 804 ance the ery f 804 ance the ery f 804 ance the the the the the the the th	JUL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 804 F 804 ance the ery F 804 n nary d a dent d a dent He tment VM ent He tment what ways items ches, ps think ot axe r d the tsss	Image: Providers PLAN OF CORRECTION PREFIX D PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ance the ery F 804 and the ery F 804 and the ery F 804 and the ery F 804 and the ery F 804 ance the ery F 804 <t< td=""></t<>

Facility ID: 923320

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	
		345177	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 804	remotely while on lear aware of the complain stated a new menu cy on 1/7/19 and hoped happy with the new m In an interview on 1/3 Administrator stated t of the menus a few m management did not dietary department ov Chef was left in charg leave but there was o Director of Dining Ser Administrator stated t maybe every 2 weeks running out of food an properly trained on ho the food count or mer was currently aware of department and the u In an interview on 1/3 stated she was aware unhappy with the food stated the residents of not getting what was a kitchen would run out had not noticed any in since the DM returned In a telephone intervie Chef stated he was m facility. He stated he w were not following the had complained about was not properly trained	ed so she ordered the food we. She stated she was as of cold food. The DM ycle was scheduled to start the residents would be nenu cycle. /19 at 9:30 AM, the here was some "tweaking" onths ago and that realize it would put the yer budget. She stated the ge while the DM was on versight provided by the vices (DDS). The he DDS was at the facility was ad that the Chef was not ow to order food based on nu. The Administrator she of concerns in the dietary nhappiness of residents. /19 at 9:50 AM, NA #6 e that the residents were d served at the facility. She omplained that they were on the menu and that the of food. NA #6 stated she mprovements or worsening	F	804	4		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C /04/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 804	every few weeks to as In an interview on 1/3 stated her assigned m about the dietary dep following the menus as She stated she freque In an interview on 1/3 stated the facility ofter listed on the posted m for her. In an observation of the dining room on 1/3/19 was being followed as from the sampled res In an observation and at 12:20 PM, Resider grilled cheese sandwis she requested from the (AAM) since she did m served as the main m items on the AAM inc cheese sandwiches, s Resident #10 stated s the AAM since the food In an interview on 1/3 stated food was a pro- stated her assigned m the taste and temperal	DDS came to the facility ssist him. /18 at 11:35 AM, NA #4 esidents often complained artment, cold food, not and the taste of the food. ently had to reheat food. /19 at 12:00, Resident #10 in did not follow what was henu and it was frustrating he lunch meal in the main 0 at 12:10 PM, the menu ind no reports of cold food idents. I another interview on 1/3/19 at #10 received soup and a ich. She stated it was what he "Always Available Menu" not like what was being ieal choice. She stated luded soup and grilled salads and hot dog. she frequently ordered from bod was "so bad". 3/19 at 2:45 PM, NA #2 iblem at the facility. She esidents were vocal about	F	804			
	DDS stated while the Chef and the Adminis	DM was out of leave, the trator were charge of the e kitchen. The DDS stated					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	using the facility's systemes with the food while set the Chef was not completed he was not away cold food. In an interview on 1/3 stated her assigned me complained about the the food. She stated a from the AAM because the menu was "so back the menu was "so back the menu was "so back the food served from palatable and served She further stated it we menus be followed. In an interview on 1/4 was unable to provide monitoring completed which indicated the food served from 1/4 was unable to provide monitoring begi breakfast and lunch new served She further stated it we menus be followed. In an interview on 1/4 was unable to provide monitoring completed which indicated the food served from 1/4 was unable to provide monitoring completed which indicated the food served from 1/4 was unable to provide monitoring begi breakfast and lunch new served She further stated it we may served which indicated the food served from 1/4 was unable to provide monitoring begi breakfast and lunch new served She further stated it was a cumulative diagnoses and Diabetes. Resident #21's quarter served served from the food served from	tely training on how to order tem, but it was "proving to stated he asked the DM to he was on leave because upleting the inventory and tting certain items. He are of the complains about /19 at 5:05 PM, NA #5 esidents frequently taste and temperature of a lot of the residents ordered the they stated the food on d". /19 at 10:30 AM, The t was her expectation that the dietary department be at the proper temperature. /as her expectation that the /19 at 10:40 AM, the DM e any food temperature after 9/8/18 RC grievance bod was not served at the She provided tray delivery nning 12/10/18 of the	F	804			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/06/2019 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPI	SURVEY LETED
		345177	B. WING			C 01/0	, 04/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE,	, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 804	stated the facility was since July 2018 and tichanges to the menu, management did not was on the main men Available Menu" (AAM on the AAM included: soup, chef salad, gard and deli sandwiches. residents ordered from it was because the for palatable. The DM state from September 2018 absence, the Chef was Chef did not "catch or that resulted in the fac The DM stated she w were not being follow remotely while on lear aware of the complain stated a new menu cy on 1/7/19 and hoped happy with the new m In an interview on 1/3 Administrator stated t of the menus a few m management did not dietary department of Chef was left in charg leave but there was o Director of Dining Ser Administrator stated t maybe every 2 weeks running out of food ar properly trained on ho	 /19 at 11:20 AM, the DM under new management here had been some She stated the new offer an "alternate" to what u but rather have a "Always M). The DM stated the items grilled cheese sandwiches, den salad, hot dog, chips She stated a lot of the n the AAM but did not think od on the menu was not ated she was out on leave to 10/29/18 and in her as in charge. She stated the n" to the ordering process cility running out of food. as aware that the menus ed so she ordered the food ve. She stated she was ns of cold food. The DM vcle was scheduled to start the residents would be nenu cycle. /19 at 9:30 AM, the here was some "tweaking" onths ago and that realize it would put the ver budget. She stated the ie while the DM was on versight provided by the 	F 804				

Facility ID: 923320

If continuation sheet Page 50 of 75

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345177	B. WING				C 04/2019
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
THE GREENS AT PINEHURST RE	HAB & LIVING CENTER			5 RATTLESNAKE TRAIL NEHURST, NC 28374		
PREFIX (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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
In an interview and o AM, Resident #21 co Resident Council Pre- members had comple about the food. She s RC members that with Manger, the food word there was not much i In an interview on 1/3 stated she was aware unhappy with the foo stated the residents of not getting what was kitchen would run out had not noticed any i since the DM returned In a telephone intervit Chef stated he was not facility. He stated he were not following the had complained about was not properly train system and the kitcher The Chef stated the I every few weeks to a In an interview on 1/3 stated her assigned r about the dietary dep following the menus a She stated she frequ	unhappiness of residents. bservation on 1/3/19 at 8:45 infirmed she was the esident. She stated the RC eted several grievances stated it was the hope of the th return on the Dietary uld improve but to date, mprovement. 3/19 at 9:50 AM, NA #6 e that the residents were d served at the facility. She complained that they were on the menu and that the t of food. NA #6 stated she mprovements or worsening d from leave. was aware the dietary staff e menus and that residents ut cold food. He stated he hed on the facility's ordering en frequently ran out of food. DDS came to the facility	F	804			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER			RATTLESNAKE TRAIL IEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	stated food was a prostated her assigned in the taste and temperal In a telephone intervie DDS stated while the Chef and the Adminis daily operations of the the Chef was adequa using the facility's sys be unsuccessful." He order the food while sis the Chef was not com the facility was not ge stated he was not aw cold food. In an interview on 1/3 stated her assigned in complained about the the food. She stated a from the AAM becaus the menu was "so bar In an interview on 1/4 Administrator stated it the food served from palatable and served She further stated it v menus be followed. In an interview on 1/4 was unable to provide monitoring completed	idents. 2/19 at 2:45 PM, NA #2 bblem at the facility. She esidents were vocal about ature of the food. ew on 1/3/19 at 3:10 PM, the DM was out of leave, the strator were charge of the e kitchen. The DDS stated tely training on how to order stem, but it was "proving to stated he asked the DM to she was on leave because hpleting the inventory and etting certain items. He are of the complains about 3/19 at 5:05 PM, NA #5 esidents frequently e taste and temperature of a lot of the residents ordered se they stated the food on d". 3/19 at 10:30 AM, The t was her expectation that the dietary department be at the proper temperature. was her expectation that the 2/19 at 10:40 AM, the DM e any food temperature a fater 9/8/18 RC grievance	F	304			
	was unable to provide monitoring completed which indicated the fo	e any food temperature					

Facility ID: 923320

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			PLETED
		345177	B. WING				C 104/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	04/2013
				20	05 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REF	TAB & LIVING CENTER		Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	cumulative diagnoses Accident and Diabete Resident #22's annua indicated she was con no behaviors. In an interview on 1/2 stated the facility was since July 2018 and t changes to the menu management did not was on the main men Available Menu" (AAN on the AAM included: soup, chef salad, gard and deli sandwiches. residents ordered from it was because the fo palatable. The DM sta	inning 12/10/18 of the neals. admitted 12/27/17 with s of Cerebral Vascular es. al MDS dated 12/7/18 gnitive intact and exhibited 2/19 at 11:20 AM, the DM s under new management here had been some . She stated the new offer an "alternate" to what u but rather have a "Always M). The DM stated the items grilled cheese sandwiches, den salad, hot dog, chips She stated a lot of the m the AAM but did not think od on the menu was not ated she was out on leave	F	304			
	absence, the Chef wa Chef did not "catch or that resulted in the far The DM stated she w were not being follow remotely while on lea aware of the complain stated a new menu cy on 1/7/19 and hoped happy with the new m	/19 at 9:30 AM, the here was some "tweaking"					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 804	dietary department ov Chef was left in charg leave but there was o Director of Dining Ser Administrator stated t maybe every 2 weeks running out of food an properly trained on ho the food count or mer was currently aware of department and the u In an interview on 1/3 stated she was aware unhappy with the food stated the residents of not getting what was a kitchen would run out had not noticed any in since the DM returned In a telephone intervie Chef stated he was no facility. He stated he was were not following the had complained about was not properly train system and the kitche The Chef stated the D every few weeks to as In an interview on 1/3 stated her assigned re about the dietary dep following the menus a She stated she freque	realize it would put the ver budget. She stated the ge while the DM was on versight provided by the vices (DDS). The he DDS was at the facility s. She stated the facility was hd that the Chef was not ow to order food based on hu. The Administrator she of concerns in the dietary nhappiness of residents. /19 at 9:50 AM, NA #6 e that the residents were d served at the facility. She complained that they were on the menu and that the of food. NA #6 stated she mprovements or worsening d from leave. ew on 1/3/19 at 9:55 AM, the o longer employed at the was aware the dietary staff e menus and that residents it cold food. He stated he need on the facility's ordering en frequently ran out of food. DDS came to the facility	F	304			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345177	B. WING				C 04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	was being followed ar from the sampled resi In an interview on 1/3 #22 stated she regular meetings and the food stated management w resident's disliked the the facility was "terrib frequently ordered fro food on the menu was In an interview on 1/3 stated food was a pro stated her assigned re the taste and temperar In a telephone intervie DDS stated while the Chef and the Adminis daily operations of the the Chef was adequa using the facility's sys be unsuccessful." He order the food while s the Chef was not com the facility was not ge stated he was not awa cold food. In an interview on 1/3 stated her assigned re complained about the the food. She stated a	 at 12:10 PM, the menu and no reports of cold food idents. /19 at 1:50 PM, Resident any attended the RC d committee meetings. She vas aware of that the food and stated the food at le." Resident #22 stated she om the AAM because the s not palatable. /19 at 2:45 PM, NA #2 oblem at the facility. She esidents were vocal about ature of the food. ew on 1/3/19 at 3:10 PM, the DM was out of leave, the trator were charge of the e kitchen. The DDS stated tely training on how to order other, but it was "proving to stated he asked the DM to othe was on leave because apleting the inventory and otting certain items. He are of the complains about /19 at 5:05 PM, NA #5 esidents frequently e taste and temperature of a lot of the residents ordered are they state the food on the 	F	804			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 04/2019
NAME OF PI	345177 NAME OF PROVIDER OR SUPPLIER THE GREENS AT PINEHURST REHAB & LIVING CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 804 Continued From page 55 Administrator stated it was her expectation that the food served from the dietary department be palatable and served at the proper temperature. She further stated it was her expectation that the menus be followed. In an interview on 1/4/19 at 10:40 AM, the DM was unable to provide any food temperature monitoring completed after 9/8/18 RC grievance which indicated the food was not served at the			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER		P	PINEHURST, NC 28374		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	Administrator stated in the food served from palatable and served She further stated it w menus be followed. In an interview on 1/4 was unable to provide monitoring completed which indicated the for proper temperature. St times monitoring begi breakfast and lunch m 5. Resident #24 was a Chronic Renal Diseas Resident #24's annua indicated she was cog no behaviors. In an interview on 1/2 stated the facility was since July 2018 and the changes to the menu, management did not was on the main men Available Menu" (AAM on the AAM included: soup, chef salad, gard and deli sandwiches. residents ordered from it was because the for palatable. The DM sta from September 2018 absence, the Chef was Chef did not "catch or	t was her expectation that the dietary department be at the proper temperature. /as her expectation that the /19 at 10:40 AM, the DM e any food temperature after 9/8/18 RC grievance bod was not served at the She provided tray delivery nning 12/10/18 of the neals. admitted 11/28/17 with se and Diabetes. I MDS dated 11/2/18 gnitive intact and exhibited /19 at 11:20 AM, the DM under new management here had been some	F	804			
	that resulted in the fac						

Facility ID: 923320

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	
		345177	B. WING				04/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 804	remotely while on lear aware of the complain stated a new menu cy on 1/7/19 and hoped happy with the new m In an interview on 1/3 Administrator stated t of the menus a few m management did not dietary department ov Chef was left in charg leave but there was o Director of Dining Ser Administrator stated t maybe every 2 weeks running out of food ar properly trained on ho the food count or mer was currently aware of department and the u In an interview on 1/3 stated she was aware unhappy with the food stated the residents of not getting what was a kitchen would run out had not noticed any in since the DM returned In a telephone intervie Chef stated he was m facility. He stated he w were not following the had complained about was not properly trained	ed so she ordered the food we. She stated she was as of cold food. The DM ycle was scheduled to start the residents would be nenu cycle. /19 at 9:30 AM, the here was some "tweaking" onths ago and that realize it would put the yer budget. She stated the ge while the DM was on versight provided by the vices (DDS). The he DDS was at the facility was ad that the Chef was not ow to order food based on nu. The Administrator she of concerns in the dietary nhappiness of residents. /19 at 9:50 AM, NA #6 e that the residents were d served at the facility. She omplained that they were on the menu and that the of food. NA #6 stated she mprovements or worsening	F	804	4		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345177	B. WING				04/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	every few weeks to as In an interview on 1/3 stated her assigned re about the dietary dep following the menus as She stated she freque In an observation of the dining room on 1/3/19 was being followed as from the sampled resi In an interview on 1/3 #24 stated managem resident's disliked of the at the facility was "ter she frequently ordere food on the menu was In an interview on 1/3 stated food was a pro- stated her assigned re the taste and temperation the taste and temperation DDS stated while the Chef and the Adminis daily operations of the the Chef was adequa using the facility's sys be unsuccessful." He order the food while s the Chef was not corr the facility was not ge stated he was not away	DDS came to the facility ssist him. /18 at 11:35 AM, NA #4 esidents often complained artment, cold food, not and the taste of the food. ently had to reheat food. the lunch meal in the main 0 at 12:10 PM, the menu nd no reports of cold food idents. /19 at 1:45 PM, Resident ent was aware of that the the food and stated the food rible." Resident #24 stated d from the AAM because the s not palatable. /19 at 2:45 PM, NA #2 blem at the facility. She esidents were vocal about	F	804			
	stated he was not awa cold food.	are of the complains about					

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				FORM	<i>I</i> APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION	(X3) DATE	
	345177	B. WING			C 04/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREENS AT PINEHURST REHA			205 RATTLESNAKE TRAIL		
	AB & LIVING CENTER		PINEHURST, NC 28374		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 the food. She stated a from the AAM because menu was "so bad". In an interview on 1/4/⁷ Administrator stated it was the food served from the palatable and served a She further stated it was menus be followed. In another interview on DM was unable to provimonitoring completed a which indicated the food proper temperature. She times monitoring begin breakfast and lunch me CFR(s): 483.75(g)(2)(ii §483.75(g)(2) The qua assurance committee r (ii) Develop and implem action to correct identified This REQUIREMENT by: Based on observations interviews and record r Assessment and Assurmaintain implanted prointerventions that the c 	19 at 5:05 PM, NA #5 sidents frequently taste and temperature of lot of the residents ordered a they state the food on the 19 at 10:30 AM, the was her expectation that he dietary department be at the proper temperature. as her expectation that the n 1/4/19 at 10:40 AM, the vide any food temperature after 9/8/18 RC grievance od was not served at the he provided tray delivery nning 12/10/18 of the eals. ent Activities i) seessment and assurance. Mity assessment and must: ment appropriate plans of fied quality deficiencies; is not met as evidenced s, staff and resident review, the facility's Quality rance Committee (QAA) to	F 80			2/1/19

Event ID: PHHC11

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/06/2019 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345177	B. WING _			0.	C 1/04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ENS AT PINEHURST REI			20	05 RATTLESNAKE TRAIL		
				Ρ	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 867	Continued From page	e 59	F	367			
F 867	Resident Rights at F5 grievances of the Res response, Quality of I showers as schedule Services at F804- not temperature. The fir This citation is cross F565- Based on staff record review, the fac resolve Resident Cou (September, October months reviewed for F677- Based on obse interviews and record provide showers as s	deficiencies in the areas of 565-not effectively resolve sident Council with timely Life at F677-not providing d, and Food and Nutrition t serving food at a palatable adings included: referenced to: and resident interviews and cility failed to effectively uncil (RC) grievances for 3 and November 2018) of 3	F	367	cross reference to the following: F 565 The Administrator presented a resolut to the Resident Council President on 1/25/19 for the grievance of answering call lights timely to include monitoring call lights on each unit, each shift 3 tin a week for 4 weeks, to assure call ligh are answered timely. The resolution w accepted by the resident council committee. The Social Service Direct (SSD) provided a written letter of follow to the Resident Council President on 1/25/19 to be shared during the next Resident Council meeting on 1/25/19. The Administrator presented a resolut to the Resident Council President on 1/25/19, for the grievance of cold food include monitoring food temperatures the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during m pass in the dining room and hallways, breakfast, lunch and dinner 5 times a	g of nes its vas or w up ion d to on d eal	
	6 residents reviewed F804- Based on obse and staff interviews a failed to ensure the fo temperature for 5 (Re Resident #21, Reside 5 interviewable reside food. In an interview on 1/4 Administrator was un	ervations, resident interviews nd record review, the facility ood served an appetizing esident #9, Resident #10, ent #22 and Resident #24) of ents reviewed for palatable			week, to assure food temperatures remain within acceptable temperature range of 125 degrees or resident preference. The resolution was accep by the resident council committee. Th SSD provided a written letter of follow to the Resident Council President on 1/25/19, to be shared during the next resident council meeting on 1/251/9. F 677 The facility provided a shower for Resident #9 on1/4/19, following surve exit, and has received showers every _Tuesday and Friday per residents' shower schedule. The Director of Nur	ted le up y	

Facility ID: 923320

ORRECTION	IDENTIFICATION NUMBER: 345177		G	COMPLETED	
	345177				
	1	B. WING	C 01/04/2019		
IS AT PINEHURST RE			STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO	
The Administrator sta ssues in the dietary Manager was on lea he residents in the f	ated there had been some department while the Dietary ve, but she was working with ood committee meetings to	F 86	(DON) discussed the shower scher and resolution with Resident #9 or as a resolution to the grievance documented 11/28/18, showers w offered and given by the certified r assistant (CNA) on the scheduled days and documented on the show sheet. The Licensed nurse will va shower was given and document of Medication administration record (The facility provided a shower for Resident #13 on 1/5/19, following exit, and has received showers ev Wednesday and Saturday per resis shower schedule. The DON discu- the shower schedule and resolution Resident #13 on 1/4/19, as a reso the grievance documented on 11/2 showers will be offered and given CNA on the scheduled shower day documented on the shower sheet. Licensed nurse will validate shower given and document on the MAR. The facility provided a shower for Resident #21 on 1/5/19, following exit, and has received showers ev Saturdays on first shift and Wedne on second shit per residents' show schedule. The DON discussed the shower schedule and resolution w Resident #21 on 1/4/19, as a reso the grievance documented on 12/2 showers will be offered and given CNA on the schedule and resolution w Resident #21 on 1/4/19, as a reso the grievance documented on 12/2 showers will be offered and given CNA on the schedule and resolution w	n 1/4/19, ill be hursing shower wer lidate on the MAR). survey rery idents' issed on with lution to 28/18, by the ys and The er was survey rery esday ver e ith lution to 27/18, by the ys and The issed ith lution to 27/18, by the ys and The ith lution to 27/18, by the ys and The lution to 27/18, by the ys and The lution to 27/18, by the ys and The lution to lution to l	
	The Administrator states in the dietary danager was on leather residents in the find of the find of the dining e	Continued From page 60 The Administrator stated there had been some subside in the dietary department while the Dietary due to the dietary department while the Dietary the residents in the food committee meetings to prove the dining experience:	The Administrator stated there had been some suces in the dietary department while the Dietary Manager was on leave, but she was working with the residents in the food committee meetings to mprove the dining experience.	Continued From page 60 the Administrator stated there had been some issues in the dietary department while the Dietary lanager was on leave, but she was working with the residents in the food committee meetings to mprove the dining experience.	

Event ID: PHHC11

Facility ID: 923320

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 01/04/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 867	Continued From page			867	The Administrator presented a resolut to the Resident Council President on 1/25/19, for the grievance of cold food include monitoring food temperatures of the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks and monitoring food temperature during me pass in the dining room and hallways, breakfast, lunch and dinner 5 times a week, to assure food temperatures remain within acceptable temperature range at the point of service of 125 degrees or resident preference. The resolution was accepted by the residen council. The Administrator and/or the Director of Nursing (DON)and Dietary Manager (I met with Residents # 9, 10, 21,22, and individually on 1/25/19, to present to the the new process for monitoring food temperatures in the dining room and o the hallways. These residents accepted the new process. The Administrator, DON and/or DM will interview Residents 9, 10, 21, 22 and 2 weekly for 4 weeks, to validate that food items were received at an acceptable temperature. Address how the facility will identify oth residents having the potential to be affected by the same deficient practices cross referenced to the following: F 565 Current facility residents have the potential to be affected by the same deficient practice of the facility failure	to
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: PH	нс11	Ear	cility ID: 923320 If contin	uation sheet Page 62 of 75

Event ID: PHHC11

Facility ID: 923320

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	02/06/2019 APPROVED 0.0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345177	B. WING	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER		I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 62	F	867	provide resolution and follow up to grievances voiced during resident cour meetings. The Administrator and/or the SSD reviewed grievances received from the Resident Council group from September 2018 through December 2 to validate that resolutions were initiate or obtained, and the resident council group was given a follow up letter regarding the resolution. F 677 Current facility residents have the potential to be affected by the same deficient practice of not receiving show as scheduled. The DON and ADON's completed an audit on 1/21/19, of shower documentation for current facility residents, to identify residents that had received a shower as scheduled. The were 3 residents identified. Those residents were offered a shower on 1/21/19 and will be offered showers go forward according to shower schedule F 804 Current facility residents that receive no trays have the potential to be affected the same deficient practice.	ee m 018, ed vers vers bing · neal by o o	
	7(02-99) Previous Versions Obs	olete Event ID: PH	1011	- Faa	sility ID: 923320		Page 63 of 75

Event ID: PHHC11

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345177	B. WING		01/04/2019
NAME OF P	ROVIDER OR SUPPLIER	1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		05 RATTLESNAKE TRAIL INEHURST, NC 28374	
				PROVIDER'S PLAN OF CORRECT	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETION
F 867	Continued From page	e 63	F 867	 1/23/19, for the Interdisciplinary Tea (IDT), which consists of the Director Nursing (DON), Assistant Director of Nursing (ADON), Social Service Dir (SSD), Dietary Manager (DM), Activ Director (AD), Rehab Manager (RM Maintenance director (MD), regardi response with resolution to grievand and follow up letter within 5 days of receiving the grievance. The Activities Director will document grievances received during resident council meetings on the approved Grievance form and will forward the grievance form to the SSD to be log onto the Resident Council Grievand The SSD will then forward the griev form to the Administrator, who will ge the appropriate IDT member to inve- and provide resolution to the grievand The Grievance form, along with the investigation information and resolu- will be given to the Administrator to and approve, then the SSD will sub follow up letter to the Resident Council president and/or group within 5 days the receipt of the grievance. A copp follow up letter will be kept with the monthly resident council meeting m F 677 The DON and/or ADON's provided education beginning on 1/22/19, for licensed nurses and CNA's regardir providing showers to residents accouncil sheet, and the licensed nurse will v shower was given and document of residents MAR. When a resident resident for and approxent of the shower schedule, with 	r of of of rector vities (1) and ong (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	B. WING		C 01/04/2019
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE GREENS AT PINEHURST REF		20	05 RATTLESNAKE TRAIL	
THE GREENS AT FINEHORST REP	AB & LIVING CENTER	Р	INEHURST, NC 28374	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 867 Continued From page	e 64	F 867	a shower, the CNA will report to licensed nurse and the licensed follow up with the resident and d refusal or acceptance of the shor the MAR. The education will be provided to hired staff during new hire orient. F 804 The Director of Nursing provided service education on 1/22/19, for nursing staff, regarding passing of trays timely to keep food at the p resident service within the accep temperature range of 125 degree resident preference. This educa be provided to newly hired nursin during new hire orientation. The Dietary Manager completed education for the dietary staff on regarding maintaining acceptable temperatures of 140 degrees or on the tray line. The Dietary Manager orders food for the upcoming weekly menu a always available menu. The DM the cook will validate daily that for are available for the following da and the Always Available menu. is responsible for ordering food if and/or adjusting the menu with alternatives of equal nutritive val necessary to accommodate resid preferences and to meet the nutti guidelines as determined by the The facility provides an Always A Menu or Alternate menu, if the re chooses not to want the food on menu. The DON and/or ADON's will ass	nurse will ocument wer on o newly ation. I in r the of meal ooint of ttable es or tion will ng staff 1/25/19, e food greater d weekly ind the l and/or ood items ys menu The DM tems ue as dent ritional Dietician. available esident the daily

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CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	CONTRACTION		A. BUILDIN	IG	C
		345177	B. WING		01/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMPLETION
F 867	Continued From page	2 65	F 8		ng area and mes to assure imely when they n. bw the QAPI planning and ans for bt continue ssure continued entified. of Clinical Services 1/23/19, to the consisting of the of Nursing, rrsing, Social ies Director, enance Director ervisor, regarding dude how to ment a quality plan agoing monitoring e QA coordinator at monthly QAPI update plans that d to assure Members of the nsist of at least the of Nursing, Service Director, tion Control inator, Dietary Director and or. A member of also be invited to lity Plans will be Administrator and ers to validate

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345177	B. WING		01/04/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE GRE	ENS AT PINEHURST REH	IAB & LIVING CENTER		05 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	Continued From page	66	F 867	adjust plans as necessary for continue compliance. Indicate how the facility plans to monit its performance to make sure that solutions are sustained; cross referenced to the following: F 565 The Administrator and/or the Director Nursing will review resident council grievance log 5 x a week for 4 weeks then weekly for 5 months, to validate t grievances received from the resident council group were investigated, a resolution was initiated/completed an follow up letter was provided to the resident council president and/or resid group within 5 days of receiving the grievance. The Administrator and/or the Director Nursing will review the audits to identi patterns/trends and will adjust the plan necessary. The Administrator will revi the plan during the monthly QAPI mee and audits will continue at the discretion the QAPI committee. F 677 The DON and/or the ADON's will audi shower sheets and MARS 5 times a w for 4 weeks then 3 times a week for 5 months to validate that showers are documented as given/refused. The DON and/or the ADON's will inter 10 residents weekly for 4 weeks then residents monthly for 5 months, to validate that showers are given as scheduled. The Director of Nursing will review the audits to identify patterns/trends and v	tor of hat d a lent of fy n as ew eting on of t reek view 20

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/06/2019 MAPPROVED D. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345177	B. WING	B. WING			04/2019
NAME OF P	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			95 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	2 67	F	867	adjust the plan as necessary. The DO will review the plan during the monthly QAPI meeting and audits will continue the discretion of the QAPI committee. F 804 The DM, the cook and/or the Administrator will monitor food temperatures on the tray line for breakfast, lunch and dinner 5 times a week for 4 weeks, then 3 times a week 5 months. Standard of practice is at ea meal, ensuring foods are held at a temperature of above 140 degrees F. The DM, the cook and/or the Administrator will monitor food temperature during meal pass in the dining room and hallways, for breakfast lunch and dinner 5 times a week for 4 weeks then 3 times a week for 5 month to assure food temperatures at point o service remain within acceptable temperature range of 125 degrees or resident preference. The DON and/or the ADON's will monit the dining area and hallways during m times 5 times a week for 4 weeks, ther times a week for 5 months, to validate staff are present in the dining area and hallways and passing trays timely. The Administrator, DON and/or the die manager will interview 5 residents week for 4 weeks then 10 residents monthly 5 months, to validate that food was delivered at an acceptable temperature according to resident preference. The Administrator, Dietary Manager and/or the Director of Nursing will review	at c for ach st, hs, f tor eal a 3 that f that f for e	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/20 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345177	B. WING		C 01/04/2019	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.00	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION	
F 867	Continued From page	≥ 68	F 867	audits/monitors and interviews to ide patterns and trends and will adjust th plan as necessary. The Administrator/Dietary manager/E will review the plan during monthly Q meeting and will continue the plan at discretion of the QAPI committee. Indicate dates when corrective action be completed;	DON DAPI the	
F 925 SS=D	CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain program so that the fa rodents.	est Control Program n an effective pest control acility is free of pests and	F 925	February 1, 2019	2/1/19	
	maintain an effective of two halls observed The findings included An interview was con AM with Resident #11 the facility indicated F oriented. During the stated his room was F resident also reported with roaches." The re cockroach last night of room. He also recalled	d review, the facility failed to pest control program on one (100 Hall).		F 925 Address how corrective action will be accomplished for those residents four have been affected by the deficient practice; Resident #11's room 113 was treated 12/12/18, 12/27/18 and 1/15/19. Room 111 was treated on 12/12/18, and 1/15/19. Room 124 was treated on 12/12/18, 12/27/18 and 1/15/19. Room 127 was treated on 12/27/18. Visitors bathroom near lobby was tre 12/12/18, 12/27/18 and 1/15/19. Address how the facility will identify of	and to d on 12/27 ated	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 01/04/2019
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP (CODE
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 925	bed. He stated it was if he had told anyone roaches, he stated he admitted to the facility did not say anything it cockroaches last wee staff was already awa previous reports. Ad- stated the nursing sta cockroaches being a rooms as well. A review of Resident revealed the resident on 9/4/18 from a hos #11 's most recent qu (MDS) assessment d resident was assesse impaired cognitive sta making. An interview was con with the facility 's Ass (ADON) for the Long included Resident #1 ADON reported Resident questions appropriate An interview with Ho of the interview, Hous Resident #11 's hall. she worked full time of the housekeeper stat cockroach on anothe reported the roaches so the only ones she	s a cockroach. When asked about the problem with a did when he was first y. However, he reported he to anyone about the ek or last night because the are of this problem from his ditionally, Resident #11 aff has talked about concern in other residents ' #11 's medical record : was admitted to the facility pital. A review of Resident uarterly Minimum Data Set ated 12/12/18 revealed the ed to have moderately atus for daily decision ducted on 1/2/19 at 3:35 PM sistant Director of Nursing Term Care unit, which 1 's hall. Upon inquiry, the dent #11 was alert and Resident #11 could answer ely and reliably. ducted on 1/2/19 at 11:30 pusekeeper #2. At the time sekeeper #2 was working on Housekeeper #2 reported on 1st shift. Upon inquiry, red she last saw a dead	F 92	25 residents having the poten affected by the same defic The Maintenance director 100% audit of the facility o identify areas of pest infes areas identified are Kitcher Long term care (LTC) med nursing station, LTC locker main hallway, rooms 113, Address what measures w place or systemic changes ensure that the deficient purecur; The Maintenance director, and/or the Director of Nurs completed education on 1/ staff, all days, all shifts incl and prn staff, regarding pro- reporting when pest is obs include a Pest Control log each nurse's station. Staff on the log, where the pest and type of pest. The Maintenance director, supervisor and/or manage monitor the logs daily and appropriate treatments or n control company. The facility obtained a con pest control company on 1 company will treat facility and the following dates: 12/12/ and 1/15/19. The facility has provided w current residents and/or re representatives to store for	ient practice ; completed a n 1/4/19, to tation. Focus n, service hall, room, LTC r room, LTC 123 and 124. iill be put into a made to ractice will not Administrator sing (DON) 25/19 for all luding weekend bocess for erved, to book located at f will document were observed Housekeeping r on duty will provide hotify pest tract with a new 2/12/18. The at least twice a The company focus areas on 18, 12/27/18

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) D	NO. 0938-039 DATE SURVEY OMPLETED	
				i		С	
		345177	B. WING			01/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
THE GREI	ENS AT PINEHURST REF	AB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 925	Continued From page	e 70	F 92	5			
	problem with cockroa than it had previously An observation was n of a small (approxima black bug in the corner the common hallway Housekeeper #1 was near the bathroom at Upon request, House dead insect and state At that time, she repo cockroaches in the fa An interview was control inquiry, the Director reported Maintenance to control inquiry, the Director reported fro binging in outside foo items in sealed contai the facility has been to type of container to st residents ' rooms. Th insect spray and deep due in Room #111 du been reported in that #11 ' s hallway). An interview was comp PM with the facility ' s The Director reported October, 2018. Wher	ches might be a little better been. nade on 1/3/19 at 8:35 AM tely 1/2 inch long), dead er of a restroom adjacent to near the facility 's lobby. observed to be working the time of the observation. keeper #1 observed the d it was a dead cockroach. rted there have been cility. ducted on 1/3/19 at 11:35 Director of Housekeeping. he worked with ol pests in the facility. Upon eported there has been a ches in the facility but noted, ths we have been really " He stated a lot of the m the residents ' families od without placing the food iners. The Director reported alking about buying some		 closed containers. The facility containers as needed. Facility storage of food items in reside will be provided and reviewed admissions in the new admiss Indicate how the facility plans its performance to make sure solutions are sustained; Director of Maintenance will m areas at least 5 times a week it then 3 x week for 4 weeks. Director of Maintenance will m other areas of the facility week weeks then q 2 weeks for 2 m Director of Maintenance will reaudits/logs monthly to identify patterns/trends and will adjust necessary The plan will be reviewed durin QAPI and will continue at the othe completed; February 1, 2019 	y protocol for ents' rooms with new ion packet. to monitor that nonitor focus for 8 weeks nonitor the kly for 4 onths. eview plan as ng monthly discretion of		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED	
		345177	B. WING			C 01/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GREE	ENS AT PINEHURST REH	AB & LIVING CENTER		205 RATTLESNAKE TRAIL			
					PINEHURST, NC 28374		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 925	asked staff to keep hi problems and to keep crumbs. The Director continued to receive of cockroaches from sta control service to com new pest control company #111 and to re-treat th main hall, and a servi Director of Maintenan developed a Quality A Improvement (QAPI) monthly meetings. A review of the facility from the past 3 month On 9/6/18, a monthl was provided; no spe on the invoice. On 10/4/18, a servic provided; no special if the invoice. On 11/1/18, a month was provided; no spe on the invoice. On 12/12/18, an invi- control company indic was provided.	The Director stated he has m informed of any pest of the rooms cleaned from r reported when he complaints about ff, he asked a new pest he out to the facility. The pany came out to do a 12/18. On 12/27/18, the new come back to target Room he dining room, kitchen, ce hall. To date, the loce stated the facility had not Assurance and Performance plan to present at the QAPI	F	92			
	respray was done and An interview was con- with Nursing Assistan 2nd shift and reported	cated a general pest control d included Room #111. ducted on 1/3/19 at 2:55 PM t (NA) #7. NA #7 worked on d she was frequently Resident #11. During the					

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					OMB NO. 0938-039		
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			С	
		345177	B. WING		0	1/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		110-112010	
				205 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 925	Continued From page	o 72	E 02	5			
1 325	Continued From page 72 interview, the NA reported the resident was alert, oriented and reliable. When asked if she had seen any cockroaches in his room, the NA stated,		F 92	.5			
	"They are all over the place, but it 's gotten better						
		ne NA reported about 2-3					
		e went into a drawer to					
	retrieve something fo						
	-	ach ran up her arm. The NA					
	stated she did report	the incident.					
	An interview was conducted on 1/3/19 at 3:00 PM						
		eported she worked on 1st					
		he NA stated she saw three					
		bing on the privacy curtain					
		orning. Upon request, the					
		veyor to Room #124. The					
		she hit the corner guard on een Bed #1 ' s privacy					
		oom. At that time, a live,					
		beared before crawling back					
		rd. The NA confirmed this					
	-	. When asked if she had					
	told anyone about the	e roach, the NA stated she					
		usekeeper and the Director					
		e days ago when she saw					
		The NA stated she did not kroaches today because					
		in told about the problem.					
	An interview was cor	nducted on 1/3/19 at 3:10 PM					
		laintenance. During the					
		r was asked if he had been					
	-	rns of cockroaches in Room					
		nad not. Upon request, the m #124. At that time, a live					
		rved to be climbing on the					
		of the bathroom door in the					
		e Director confirmed this					
		hen asked, the Director of		1		1	

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DEPART CENTER		FORM APPROVED OMB NO. 0938-0391						
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345177	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE				
THE GREENS AT PINEHURST REHAB & LIVING CENTER				205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 925	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	925	5			

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	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: (FORM A OMB NO. (PPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345177		B. WING		_	C 01/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 925	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 contract with the new pest control company at this time. An interview was conducted on 1/4/19 at 12:30 PM with the Assistant Housekeeper. Upon inquiry, the housekeeper stated no staff members had reported a concern to him about cockroaches within the last two weeks. He reported if he had been told about a problem, he would have notified his supervisor. An interview was conducted on 1/3/19 at 3:17 PM with the facility 's Administrator. During the interview, the concerns regarding cockroaches in the facility were discussed. The Administrator stated the facility was currently on a 2-week cycle with a new pest control company. When asked if a plan of correction had been formulated to address the problem (including QAPI involvement), the Administration stated, "We have not done a QAPI plan." Upon inquiry, the Administrator stated her expectation would be for staff to notify either the Director of Maintenance or herself if cockroaches were seen in a resident 's room.		F 92		JEFICIENCY)		

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