| DEPART | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | | MAPPROVED |
|--------------------------|--|--|--------------------|-----|---|--------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | <u>). 0938-0391</u> |
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | E CONSTRUCTION | COMF | SURVEY PLETED |
| | | 345370 | B. WING | | | | C /20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | 3 | 300 BLAKE BOULEVARD | | |
| | | | | F | PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 550 SS=G | Resident Rights/Exer CFR(s): 483.10(a)(1)(§483.10(a) Resident I The resident has a rig self-determination, an access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner a promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. | cise of Rights (2)(b)(1)(2) Rights. that to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. Clity must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her if the facility and as a citizen ted States. clity must ensure that the his or her rights without a, discrimination, or reprisal | | 550 | DEFICIENCY) | | 1/25/19 |
| | free of interference, c reprisal from the facili rights and to be suppo | sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATURE | = | | TITLE | | (X6) DATE |

Electronically Signed

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

01/17/2019

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOF | ED: 02/06/201 RM APPROVEI IO. 0938-039 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | TIPLE CONST | | (X3) DAT | TE SURVEY MPLETED |
| | | 345370 | B. WING | | | 1: | C 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | · | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | - | |
| | | | | 300 BLA | KE BOULEVARD | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | PINEHU | RST, 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 550 | Continued From page | e 1 | F | 550 | | | |
| | Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to treat Resident #67 in a dignified manner causing the resident to feel "worthless" and also failed to provide a privacy cover for a urinary catheter drainage bag to promote Resident #135 's dignity for 2 of 4 residents reviewed for dignity and respect. The findings included: 1. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included heart failure, dependence on supplemental oxygen, | | | This nece parti prog cons the a Base resic facili dign "wor priva drair dign | | nued d Medicaid nner alidity of ation, rview, the 7 in a o feel ovide a eter nt #135's | |
| | #67 ' s cognition was assessed with no belicare. Resident #67 r assistance of 2 or moder dressing, toileting, and was dependent on 2 Resident #67 had impler lower extremities wheelchair. An interview was con 12/17/18 at 9:29 AM. during the most recent 12/16/18) she had as out one of the drawer | 75/18 indicated Resident fully intact. She was naviors and no rejection of equired the extensive ore for bed mobility, nd personal hygiene. She or more for transfers. pairment on both sides of | | policNursbagfor reTheresicaffecAn athe IinterSatisandResicathInter | ⁴⁶ was in-serviced and discip cy infractions by the Director sing (DON) on 1/19/2019. A was placed on the foley dra esident #135 on 12/20/2018 facility has determined that dents have the potential to b cted. audit was completed on 01/1 DON and Clinical Superviso rviewable residents using the sfaction Survey form to ensu- respect has been honored t ident and that all residents n reter bag covers had them in rviewable residents stated the n treated with dignity and residents and the | of dignity inage bag all ve 7/2019 by rs on e Resident ure dignity to each needing n place. ney have | |

Event ID: KEWC11

Facility ID: 923403

If continuation sheet Page 2 of 91

| | | MEDICAID SERVICES | | | | <u>IO. 0938-03</u> |
|--------------------------|-------------------------------|---|---------------------|---|-----------------------------------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | · · · | TE SURVEY MPLETED |
| | | | A. BUILDING | <u> </u> | | |
| | | 345370 | B. WING | | | С |
| | | 545570 | | STREET ADDRESS, CITY, STATE, ZIP | | 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | CODE | |
| PINEHUR | ST HEALTHCARE & RE | НАВ | | 300 BLAKE BOULEVARD 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 550 | Continued From pag | e 2 | F 55 | 50 | | |
| | | nt #67 was unable to recall | | no catheter bag covers we | ere missina. | |
| | | member who assisted her. | | Non-interviewable resider | - | |
| | She stated the staff | member removed her drawer | | observed on 01/17/2019 b | by the DON and | |
| | and placed it on her | bed. She indicated that | | Clinical Supervisors to ins | • | |
| | | ed with the drawer she asked | | being treated with dignity | | |
| | | I shift Nursing Assistant (NA), | | had catheter bag covers in | n place if | |
| | | wer back into dresser as she | | needed. | | |
| | | ete this task independently. | | Observations were condu | atad by the | |
| | | that NA #6 told her, "you got ". Resident #67 stated that | | Observations were condu Corporate Director of Clin | | |
| | | ke I was worthless". She | | 1/18/19 5(five) staff memb | | |
| | | ooke to Nurse #6 about the | | and 5 (five) staff members | | |
| | | e permission for Nurse #6 to | | and by the Nurse Manage | | |
| | - | the Director of Nursing | | 3rd shift and weekends. A | | |
| | (DON). | _ | | indicated they were treate | d with dignity | |
| | | | | and respect. | | |
| | | as conducted with Nurse #6 | | | | |
| | | PM. Nurse #6 confirmed that | | In-service education prog | | |
| | | s past weekend at the facility | | conducted with all license | | |
| | | se Supervisor. She stated | | non-licensed staff on all s | - | |
| | that over the past we | reported to her that she | | part-time and weekend sta residents with dignity and | - | |
| | | #67 ask NA #6 to put her | | include providing care for | | |
| | | dresser. She indicated | | an environment that prom | | |
| | | er that NA #6 said something | | protects their rights by the | | |
| | | r you put it back" to Resident | | Director of Clinical Service | | |
| | - | ortedly told the resident she | | Administrator on 01/25/20 | 19. All staff will | |
| | | Nurse #6 reported that | | be in-serviced prior to wor | king the floor. | |
| | | ot able to put the drawer back | | | | |
| | | She indicated that after the | | The social worker will con | | |
| | | d to her by Nurse #7, she | | interviews on 5 potentially | | |
| | | 67. She stated that Resident ng this conversation and that | | residents daily times 5 da | | |
| | | #7 's report of the incident | | potentially affected reside 4 weeks using the facility | - | |
| | | icated that after speaking | | Satisfaction Survey form t | | |
| | | reported the incident to the | | residents are being treate | | |
| | | se #6 stated that she also | | and respect. Observation | | |
| | • • | d provided re-education on | | conducted by the Nurse N | | |
| | assisting residents ti | - | 1 | | ng treated with | 1 |

Facility ID: 923403

If continuation sheet Page 3 of 91

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | PLE CONSTRUCTION | OMB NO. 09 (X3) DATE SURV | |
|--------------------------|--|---|---------------------|--|---|-------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | G | COMPLETE | D |
| | | | | | C | |
| | | 345370 | B. WING | | 12/20/2 | 018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | 300 BLAKE BOULEVARD 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 AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE COU THE APPROPRIATE | (X5) MPLETIO DATE |
| F 550 | with dignity and respensive instructed NA #6 #67 's room during the A phone interview was on 12/18/18 at 4:30 F was working this pass assigned to Resident medication cart was prear Resident #67 's Resident #67 's call she observed NA #6 and the resident asket back into her dresser NA #6 say to Resider made this messI 'n going on break.". NA room and "slammed the indicated she then er and observed the resupset. She stated she Nurse #6 as she was Supervisor. Nurse #1 was not able to put the assistance. A phone interview was 12/18/18 at 4:25 PM. working this past weet to Resident #67. She ready to go on her 30 Resident #67 asked the solution of | ect. She additionally stated not to return to Resident nat shift. As conducted with Nurse #7 PM. Nurse #7 confirmed she t weekend and she was #67. She stated that her positioned in the hallway a door when she observed light go off. She indicated enter Resident #67 ' s room ed her to put her drawer . She stated she overheard ht #67 something like "you m not cleaning it upI ' m A#6 then left Resident #67 ' s the door". Nurse #7 htered Resident #67 ' s room ident crying and visibly the reported the incident to the weekend Nurse 7 reported that Resident #67 he drawer back without as conducted with NA #6 on NA #6 confirmed she was ekend and she was assigned stated she was getting | F 55 | | an audit tool. sing an audit day for 5 staff dnesday and bers on 2nd aturday for 5 shift x 4 weeks. uct audits using ly including all placement of idication of ed has been views and in the DON ations results will uality Assurance plan of ed monthly by mmittee until ubstantial | |
| | bed. NA #6 indicated was clocking out for h putting her back to be denied that Resident drawer away. NA #6 Nurse #6 spoke with | | | | | |

If continuation sheet Page 4 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | E CONSTRUCTION | (X3) DATE | |
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| NAME OF P | ROVIDER OR SUPPLIER | | ł | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 550 | assistance with timely re-enter Resident #67 An interview was con- 12/18/18 at 4:40 PM. phoned her over the p her of the incident wit The DON indicated th of any complaints or of #67 's interaction with her expectation was f with dignity and respect 2) Resident #135 was 12/7/18 with diagnose urine and chronic kidr Review of the hospita 12/7/18 revealed an in was placed secondar obstruction and distal An admission MDS (N progress. The baseline care plat the resident was alert confusion at times. On 12/17/18 at 12:35 made of Resident #13 noted to have an indw the drainage bag atta The urinary catheter of privacy cover and cou- hallway. | y and instructed her not to 7's room that shift. ducted with the DON on She stated that Nurse #6 bast weekend and informed h Resident #67 and NA #6. This was the first instance concerns reported about NA h residents. She stated that for all residents to be treated ect. a admitted to the facility on the state included retention of the y disease Stage 4. I discharge summary dated indwelling urinary catheter y to bladder outlet urethral stricture. Minimum Data Set) was in and cognitively intact with PM, an observation was 35 in his room. He was velling urinary catheter with ched to the side of the bed. drainage bag did not have a | F | 550 | | | |

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | RM APPROVE NO. 0938-039 | |
|--------------------------|---|--|---------------------------------|--|-------------------------------|----------------------------|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | TE SURVEY MPLETED | | |
| | | 345370 | B. WING | | C 12/20/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | • | STR | EET ADDRESS, CITY, STATE, ZIP CO | DE | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | BLAKE BOULEVARD 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE | |
| F 550 F 580 SS=G | was made of Resider urinary catheter drain privacy cover and con hallway. During an interview of Resident #135, he sta that a cover was press drainage bag. An interview was com Nursing (DON) on 12 DON stated it was he staff use a privacy co bags. Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notified (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involver results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue | ht #135 in his room. The hage bag did not have a uld be seen from the in 12/19/18 at 9:30 AM with ated that he felt better now sent on the urinary catheter inpleted with the Director of /20/18 at 10:15 AM, the in expectation that nursing ver for urinary catheter drain jury/Decline/Room, etc.) e)(i)-(iv)(15) cation of Changes. hediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, hial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the | F 550 | | | 1/25/19 | |

Event ID: KEWC11

Facility ID: 923403

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOI | ED: 02/06/2019 RM APPROVED IO. 0938-0391 | |
|--------------------------|---|--|---------------------|---|--|---|--|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | IPLE CONSTRUCTI | | (X3) DATE SURVEY COMPLETED C | | |
| | | 345370 | B. WING | | | 1 | 2/20/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | 1 | STREET ADDRE | SS, CITY, STATE, ZIP CODE | • | | |
| PINEHURS | ST HEALTHCARE & REH | IAB | | 300 BLAKE BO | | | | |
| | | | | PINEHURST, | NC 28374 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EA | PROVIDER'S PLAN OF CORF ACH CORRECTIVE ACTION S SS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 580 | (14)(i) of this section, all pertinent informati is available and provi physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must fu update the address (fi phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must discloss its physical configura locations that compris part, and must specifi room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on observation interviews, the facility of continued unintend loss for 1 (Resident # to nutrition. The findir Resident #10 was ad cumulative diagnoses | fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations T is not met as evidenced ons, staff and Physician failed to notify the Physician ded, significant (27%) weight ethol of 3 residents reviewed ongs included: mitted on 3/15/18 with s of chronic respiratory | F 5 | Based or physician notify the unintende for 1 (resi reviewed Resident | n observations, staff a n interviews, the facility Physician of continue ed, significant (27%) w ident #10) & of 3 resid for nutrition. #10 was re-weighted of | r failed to d reight loss ents on | | |
| | cumulative diagnoses failure, cerebral vasc | | | 1/1/2019 | #10 was re-weighted by Restorative Aide to nange. The resident ha | verify the | | |

Event ID: KEWC11

Facility ID: 923403

If continuation sheet Page 7 of 91

| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | LE CONSTRUCTION | (X3) DAT | IO. 0938-039 TE SURVEY MPLETED |
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| | | 345370 | B. WING | | 1: | C 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 300 BLAKE BOULEVARD | | |
| FINEHUK | ST HEALTHCARE & RE | nad | | 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 | (X5) COMPLETION DATE |
| F 580 | Continued From pag | ie 7 | F 58 | 0 | | |
| | | - | | pound weight increase since h | iis | |
| | Review of Resident | #10's admission orders dated | | re-admission on 12/19/2018. | | |
| | | e feeding was Isosource | | Director was notified of the cu | rrent weight | |
| | | a) 1.5 one can six times daily | | of 131 pounds on 1/2/19 by the | e Clinical | |
| | | meters (ccs) of water with | | Supervisor. | | |
| | each feeding. | | | The facility has determined the | | |
| | Paview of Pasident | #10's care plan dated 3/16/18 | | The facility has determined that residents have the potential to | | |
| | | for dehydration and weight | | affected. All residents were re | | |
| | | is nothing by mouth (NPO) | | to establish a correct weight for | • | |
| | | s include monitoring his labs, | | 2019. | , , , | |
| | weights, tube feeding | gs and a dietician per policy. | | | | |
| | | | | All Resident's were re weighed | | |
| | | note dated 3/23/18 read | | Restorative Aide on 1/17/19. E | | |
| | | ssion weight was 172 | | Manager reviewed weights an | | |
| | • | ad a referral was made to the (RD) and recommendations | | determined 10 Resident's were with significant weight loss. Me | | |
| | - | rse supervisor. The note | | Director and Responsible Part | | |
| | Resident #10 would | continue to be monitored and | | notified on 1/17/19 by the Clin | ical | |
| | | ide to the RD and Physician | | Supervisor. MDS Nurse updat | | |
| | | e was documented by the | | plans of identified Resident's of | on 1/17/19. | |
| | Dietary Manager (DI | VI). | | | | |
| | Review of Resident | #10's electronic medical | | An in-service education progra conducted by the Corporate D | | |
| | record revealed his | | | Clinical Services on 1/23/19 w | | |
| | remained at 172 pou | c | | licensed staff on all shifts inclu | | |
| | | | | weekend and part-time staff a | • | |
| | Review of a dietary r | note dated 5/9/18 read | | circumstances that require not | • | |
| | | ent weight was 172 pounds. | | the resident's physician and re | | |
| | | tinue the current tube | | representative. All licensed st | | |
| | | Resident #10 would continue | | in-serviced prior to working the | | |
| | | referral would be made to | | scheduled shift. The Medical | | |
| | documented by the I | n as needed. This note was אס | | was advised by the Corporate Clinical Services to add reside | | |
| | | | | in his progress notes 1/2/19. | an onanges | |
| | | #10's electronic medical | | The Dietary Manager will conc | | |
| | record revealed his v | | | of five (5) residents weekly for | | |
| | remained at 172 pou | inds. | | weeks using an audit tool. The | ese | |

Facility ID: 923403

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| | - | ID HUMAN SERVICES | | | | FORM | APPROVED |
|---------------|------------------------|--|--------------|-----|--|-----------|--------------------|
| | | MEDICAID SERVICES | (X2) MUIT | | CONSTRUCTION | (X3) DATE | 0. 0938-0391 |
| | CORRECTION | IDENTIFICATION NUMBER: | | | CONSTRUCTION | | LETED |
| | | | | | | (| c |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 30 | 00 BLAKE BOULEVARD | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | Ρ | INEHURST, NC 28374 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | Х | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI | | COMPLETION DATE |
| IAG | REGULATORT ORT | | IAG | | DEFICIENCY) | \. | |
| | | | | | | | |
| F 580 | Continued From page | 28 | E! | 580 | | | |
| | 1.3 | | | | residents will be newly assessed to | | |
| | Review of a dietary ne | ote dated 5/22/18 read | | | ensure that any declines in weight loss | | |
| | | an desired his tube feeding | | | have been identified, properly evaluate | | |
| | | anged from bolus feedings to | | | and communicated to the appropriate | | |
| | - | The note read Resident | | | people. Audits will be kept in the Direc | tor | |
| | 2 | e monitored, and tube | | | of Nursing office. | | |
| | note was documented | usted as necessary. This | | | The Dietary Manager will report her au | dite | |
| | | u by the RD. | | | to the monthly Quality Assurance meet | | |
| | Review of a Physiciar | n order dated 5/22/18 read | | | The plan of correction will be monitore | | |
| | - | eeding was changed from | | | monthly until such time as consistent | | |
| | bolus feedings to con | | | | substantial compliance has been met. | | |
| | | cs per hour with 50 ccs of | | | | | |
| | water per hour due to | abdominal discomfort. | | | Completion Date 01/25/19 | | |
| | Review of Resident # | 10's electronic medical | | | | | |
| | | ocumented weight for the | | | | | |
| | month of June 21018 | | | | | | |
| | | | | | | | |
| | | ote dated 6/7/18 read | | | | | |
| | | ts was stable at 172 pounds | | | | | |
| | orders. The note read | s continuous tube feeding | | | | | |
| | | eding well, his weight would | | | | | |
| | | would be referred to the RD | | | | | |
| | | e was documented by the | | | | | |
| | DM. | | | | | | |
| | | ete end Dhueisis | | | | | |
| | | note and Physician order ecommendation to change | | | | | |
| | | eeding back to bolus of | | | | | |
| | | n every four hours with 200 | | | | | |
| | ccs of water with eacl | | | | | | |
| | | - | | | | | |
| | • | n History and Physical | | | | | |
| | Examination note dat | | | | | | |
| | mention of any weigh | t IOSS. | | | | | |
| | Review of a Physiciar | n History and Physical | | | | | |
| | | - , | | | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | | | (X5) COMPLETION DATE |
| F 580 | Examination note dat of any weight loss. Review of a dietary n late entry for 7/10/18 was stable at 172 por changed to bolus fee | ed 7/3/18 made no mention ote dated 7/18/18 read as a read Resident #10's weight unds. Resident #10's was ding and Resident #10 | F | 580 | | | |
| | related to recent weig Resident #10 would of weights and lab work documented by the R | | | | | | |
| | | nission weight on 7/20/18 | | | | | |
| | Resident #10 readmit tube feeding orders for | an order dated 7/20/18 read ted from the hospital with or Isosource 1.5 one can 200 ccs of water with each | | | | | |
| | Review of a Physician Examination note dat mention of any weigh | | | | | | |
| | Resident #10's weigh read Resident #10 ha hospital since his adm Resident continued h he would be referred related to recent weig documentation that th Resident #10's recen | | | | | | |

Facility ID: 923403

If continuation sheet Page 10 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|---|--|-----|--|----------------------------|---------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | ЗE | (X5) COMPLETION DATE | |
| F 580 | Continued From page | e 10 | F | 580 | | | |
| | Resident #10's weight his weights had rema weeks. The note read of removing his feedin illness. The note read bolus tube feedings. documentation that th Resident #10's recen Resident #10 would of weekly weights. This the DM. | ne Physician was notified of t weight loss. The note read continue to be monitor is note was documented by n History and Physical ed 8/24/18 made no | | | | | |
| | Review of a Physician Examination note dat mention of any weigh Review of Resident # Data Set (MDS) date cognitive impairment, assistance with all of | n History and Physical ed 9/20/18 made no t loss. 10's quarterly Minimum d 9/25/18 indicated severe no behaviors and total his activities of daily living. nown weight loss, a feeding | | | | | |
| | Resident #10's weigh note read Resident # loss since the last die Resident #10 had a r would be referred to t note read Resident # his feeding tube and note read Resident co | ote dated 9/26/18 read t was 134.5 pounds. The 10 had experienced weight tary note. The note read ecent hospitalization and he he RD on his next visit. The 10 had a history of removing recent acute illness. The pontinued his bolus tube ght would continue to be | | | | | |

Facility ID: 923403

If continuation sheet Page 11 of 91

| DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME | | | | | FORM | APPROVED 0. 0938-0391 |
|--|---|--------------------|-----|--|-----------|----------------------------|
| | 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | | | (X3) DATE | |
| | 345370 | B. WING | | | | C 20/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PINEHURST HEALTHCARE & REHAE | 3 | | | 800 BLAKE BOULEVARD PINEHURST, NC 28374 | | |
| PREFIX (EACH DEFICIENCY M | MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| Physician was notified o weight loss. This note w DM. Review of a dietary note Resident #10's weight w 133.8 pounds. New order feeding and begin Isoso hour continuous with 35 The note read this shoul weight goal and Resider was 133-163 pounds. Th #10's tube feeding would tolerance and adjusted a documentation that the R Resident #10's recent w documented by the RD. Review of a dietary note Resident #10's weight w 11/8/18. The note read F remained stable for four change in his tube feedi to continue the plan sinc stable with current interv remain on weekly weigh documentation that the F | o documentation that the of Resident #10's recent vas documented by the e dated 10/12/18 read vas still trending down at ers to stop the bolus ource 1.5 at 60ccs per o ccs of water per hour. Id provide a healthy nt #10's ideal body weight he note read Resident d be monitored for as needed. There was no Physician was notified of veight loss. This note was e dated 11/9/18 read vas 130 pounds on Resident #10's weight to weeks. There was no ing orders. The note read ce Resident #10's weight to weeks. There was no Physician was notified of vertions. He would tts. There was no Physician was notified of veight loss. This note was wentions. He would tts. There was no Physician was notified of veight loss. This note was distory and Physical 11/20/18 made no bss. /18/18 at 11:10 AM, in bed with the head of prees. He was able to | F | 580 | | | |

Facility ID: 923403

If continuation sheet Page 12 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE COMF | |
| | | 345370 | B. WING | | | | _ 20/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD | | |
| PINEHUK | SI NEALINCARE & REN | | | | 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 580 | Continued From page answer yes/no questi connected and runnin per hour continuous w hour. In an interview on 12/ stated Resident #10 h off since admission. S home with his wife pri facility in March 2018 #10 frequently remov required frequent hos In an interview on 12/ Dietary Manager (DM Dietician (RD) comes and as needed. She s weekly weights due to associated with his m to illness with multiple feeding tube. The DM discussed at the Paties she contacted the RD Resident #10's weigh RD could make visits consulted with the RD regarding Resident # stated she did not info In a telephone intervie the RD stated Reside at 172 pounds up unt when he hospitalized stated bolus tube feed | a 12 ons. His tube feeding was ag Isosource 1.5 at 60 ccs with 35 ccs of water per 18/18 at 3:10 PM, Nurse #4 had been very sick on and She stated he was living at for to admission to the Nurse #4 stated Resident ed his feeding tube and pitalizations. 18/18 at 3:26 PM, the to the facility once a month stated Resident #10 was on phis known weight loss ultiple hospitalizations due a incidents of removing his I stated Resident #10 was ents at Risk meetings and p for direction about t loss. The DM stated the as needed but that she p for recommendations 10's weight loss. The DM | | 580 | DEFICIENCY) | | |
| | weights continued to changed Resident #1 | eding tube but when his decline, the Physician 0 back to continuous ted he was at the facility | | | | | |

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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 PLETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 00 BLAKE BOULEVARD 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | monthly and as neede contacted him about 1 and he thought the Pl Resident #10's weigh the Physician. Review of a dietary m Resident #10's weigh downward due to mut history of removing hi weight on readmissio continued to trend do to address his weight 12/19/18 for Isosourc continuous with 35 cc was no documentation notified of Resident # This note was docum In an observation on Resident #10 was lyin feeding running contii He was observed to b yes/no questions with observed attempting but rather moving his upward motion. In an interview on 12/ Manager #1 stated th the RD about Residen stated she contacted changing Resident #7 feedings back in June from removing his fee Manager stated Reside in the Patients at Risk | ed. He stated the DM Resident #10's weight loss hysician was aware of t loss but he did not notify ote dated 12/19/18 read t continues to trend tiple hospitalizations and a is feeding tube. His current n was 125 pounds and wnward despite adjustment loss. New orders dated e 1.5 at 65 ccs per hour as of water per hour. There n that the Physician was 10's recent weight loss. ented by the DM. 12/19/18 at 8:20 AM, ng in bed with his tube nuously as the ordered rate. be alert and able to answer nout difficulty. He was not to removing his feeding tube arms in a continuous (19/18 at 11:02 AM, Unit e DM was in contact with nt #10's weight loss. She the Physician about 10's tube feedings to bolus e 2018 to keep Resident #10 eding tube. The Unit dent #10 was being followed a meetings and it was her hysician was aware of | F | 580 | | | |

Facility ID: 923403

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|-------------------------|--|-------------------|----------------------------|
| | CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | SURVEY LETED |
| | | 345370 | B. WING | | | _ 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PINEHUR | ST HEALTHCARE & REH | AB | | 300 BLAKE BOULEVARD 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) | 3E | (X5) COMPLETION DATE |
| F 580 | Continued From page | 9 14 | F 5 | 580 | | |
| F 641 SS=E | Medical Director state nine hospitalizations of facility and multiple in removing his feeding stated some weight loss he was not notified of significant weight loss expectation that the fa- him of Resident #10 of significant weight loss may require a higher prevent further weigh up with the facility RD In an interview on 12/ Director of Nursing st that the Physician of of Unit Manager or the F interventions could hap prevent continued unit loss. Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revit facility failed to code to (MDS) assessment and active diagnoses (Residential to the status) medications (Residential to the status) | a. He stated Resident #10 calorie tube feeding to t loss and he would follow 20/18 at 10:15 AM, the ated it was her expectation continued weight loss by the RD so that other ave been considered to intended, significant weight ents of Assessments. t accurately reflect the is not met as evidenced ew and staff interview, the the Minimum Data Set ccurately in the areas of | F6 | The facility failed to code the Minimur Data Set (MDS) assessment accurate for 8 of 17 residents reviewed in the a of Resident #73 (active diagnosis, bov and bladder incontinence), Resident # (skin conditions), Resident #54 (therapies), Resident #40 (hospice | ly reas vel | 1/31/19 |

Event ID: KEWC11

Facility ID: 923403

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZP CODE PINEHURST HEALTHCARE & REHAB 308 BLAKE BOULEVARD PINEHURST, NC, C 2374 308 BLAKE BOULEVARD PREFIX PROVIDER'S PLAND FOR CORRECTION REACH EXPENDENCIES DE YPULL RECOLLATORY OR LSC DENTIFYING INFORMATION) IP PROVIDER'S PLAND FOR CORRECTION REACH EXPENDENCIES DE YPULL RECOLLATORY OR LSC DENTIFYING INFORMATION) OV PREFIX PREFIX F 641 Continued From page 15 or daily living assistance (Resident #42), skin conditions (Resident #63) and therapies (Resident #67 was admitted to the facility on 11/30/18 with diagnoses that included diabetes melitus type 2. F 641 The quaretry Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67's cogniton was intact. She was noted to have received injections on 6 of 7 days and insulin injections on 6 of 7 days and insulin injections on 6 of 7 days during the MDS look back period. Resident #67 was reassessed on 11/12/019. Resident #73 was reassessed on 11/12/019 io include and bladder incontinence and was transmitted on 11/12/019. Resident #74 was reassessed on 11/12/019. Resident #74 was reassessed on 11/12/019. Resident #74 was reassessed on 11/12/019. Resident #40 was reassessed on 11/12/019. Resident #44 was reassessed on 11/12/019. Resident #47 was reassessed on 11/12/019. Resident #44 was reassessed on 11/12/019. Include back | | | ND HUMAN SERVICES | | | | FOR | ED: 02/06/2019 |
|---|-------------|--|--|---------|---------------------|--|----------------------|----------------------------|
| 346370 B. WNG | STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | · / | | | (X3) DAT | E SURVEY |
| PINEHURST HEALTHCARE & REHAB 309 BLAKE BOULEVARD PINEHURST, NC 28374 (X) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES INCOMPTOR INCOMENSION (EACH ORDERST PLAN OF CORRECTION (EACH ORDERST (RESIDENT) (RESIDENT #83), and INFORMANIC (RESIDENT #83), and INFORMANIC (I) 11/2010 (RESIDENT #83), and INFORMANIC (I) 11/2010 (RESIDENT #1) (I) 10/2010 (RESIDENT #1) (I) 10/201 | | | 345370 | B. WING | | | 12 | C 2/20/2018 |
| PINEHURST HEALTHCARE & REHAB PINEHURST, NC 28374 (rxi)10 TAG ISUMMARY STATEMENT OF DEFICIENCIES (Reconstruction was transmitted construction action should be (Reconstruction was transmitted) ID (Reconstruction was transmitted) | NAME OF P | ROVIDER OR SUPPLIER | • | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHURST, NC 2334 PREFIX SUMMEY STATEMENT OF DEFICENCIES (Resident 754) CERCIENCY MUST BE PRECEDED BY FULL TAG PROVIDERS FLANGE CONCERCTING ACTION (EACH CORRECTIES ACTION SHOULD BE CROBS AFERENCED TO THE APPROPRIATE DEFICIENCY OF CONSTRUCT BE PRECEDED BY FULL (Resident #63), and therapies (Resident #63), and therapies (Resident #63) and therapies (Resident #67) for 8 of 17 residents reviewed. F 641 The findings included: I. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included diabetes mellitus type 2. F 641 The quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67 7 is cognition was indate. She was noted to have received injections on 6 of 7 days and insulin injections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the lo | | | | | 300 BLAKE BOULEVARD | | | |
| Prefix TAG CANCOMPRESENT MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTFINING INFORMATION) PREFIX TAG CANCOMPRESENT BAR ATTON SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CONC THE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CONCENT THE CROSS APPRIATE DEFICIENCY CONCENT THE CROSS APPRIATE DEFICIENCY CONCENT THE CROSS APPRIATE DEFICIENCY CONCENT THE CROSS APPRIATE DEFICIENCY CONCENT THE CROSS APPRIATE DEFICIENCY <thconcent THE THE APPROPRIATE DEFICIENCS DEFICIENCY</thconcent | PINEHUR | SI HEALIHCARE & REP | 146 | | PI | NEHURST, NC 28374 | | |
| of daily living assistance (Resident #42), skin conditions (Resident #54) for 8 of 17 residents reviewed.The findings included:1. Resident #67 was admitted to the facility on 11/30/16 and most recently readmitted on 10/30/18 with diagnoses that included diabetes mellitus type 2.The quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #60 insulin injections on 6 of 7 days and insulin injections on 6 of 7 days and insulin injections on 6 of 7 days and insulin rigections of 6 of 7 days and insulin rigections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period Resident #67 's 11/5/18 MDS that indicated she received insulin rigections on 7 of 7 days was reviewed with MDS Nurse #1. She revealed this cooling was an error and indicated the MDS should have been coded for 7 of 7 injections and 7 of 7 insulin injections.Resident #42 was reassesed on 12/10/19 include facurate ADL indicated the received insulin injections on 7 of 7 days was | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (| (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | (X5) COMPLETION DATE |
| of daily living assistance (Resident #42), skin conditions (Resident #54) for 8 of 17 residents reviewed.The findings included:1. Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included diabetes mellitus type 2.The quartery Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67 's cognition was intact. She was noted to have received injections on 6 of 7 days and insulin injections on 6 of 7 days and insulin finections on 6 of 7 days and insulin finections on 6 of 7 days and insulin injections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period for Resident #67 's 11/5/18 MDS that indicated she received insulin injections on 7 of 7 days was reviewed with MDS Nurse #1. She revealed this coding was an error and indicated the MDS should have been coded for 7 of 7 injections and 7 of 7 insulin injections.prognosis, urinary appliance, Resident #67 (sections and transmitted on 12/20/18, Resident #45Marker Karl StepelonResident #67 (sections Amotions and transmitted on 12/20/2018, Resident #40 was reassessed to 10/11/2019. Res | F 641 | Continued From page | e 15 | F 6 | 41 | | | |
| Resident #67 was admitted to the facility on 11/30/10 and most recently readmitted on 10/30/18 with diagnoses that included diabetes mellitus type 2. The quarterly Minimum Data Set (MDS) assessment dated 11/5/18 indicated Resident #67 's cognition was intact. She was noted to have received injections on 6 of 7 days and insulin injections on 6 of 7 days during the MDS look back period. A review of the Medication Administration Records (MARS) for the look back period of Resident #67 's 11/5/18 MDS (10/30/18 through 11/5/18) indicated Resident #67 was An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The medications section of Resident #67 's 11/5/18 MDS that indicated she received injections on 6 of 7 days and insulin injections on 6 of 7 days and sy was reviewed with MDS Nurse #1 on 12/19/18 at 3:30 PM. The medications section of Resident #67 's 11/5/18 MDS that indicated she received injections on 6 of 7 days and insulin injections on 7 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period of Resident #67 's 11/5/18 MDS that indicated she received insulin injections. | | of daily living assistant conditions (Resident (Resident #54) for 8 d | nce (Resident #42), skin #63), and therapies of 17 residents reviewed. | | | antipsychotic medications), Resident a (diagnosis), Resident #86 (hospice), | # 45 | |
| The quarterly Minimum Data Set (MDS)assessment dated 11/5/18 indicated Resident#67 's cognition was intact. She was noted tohave received injections on 6 of 7 days andinsulin injections on 6 of 7 days during the MDSlook back period.A review of the Medication AdministrationRecords (MARS) for the look back period ofResident #67 's 11/5/18 MDS (10/30/18 through11/5/18) indicated Resident #67 wasadministered Novolog (insulin) injections on 7 of 7days.An interview was conducted with MDS Nurse #1on 12/19/18 at 3:30 PM. The medications sectionof Resident #67 's 11/5/18 MDS that indicatedindicated she received injections on 6 of 7 days andinsulin injections on 6 of 7 days andindicated she received with MDS Nurse #1.indicated she received with MDS Nurse #1. <td></td> <td>1. Resident #67 was 11/30/10 and most re 10/30/18 with diagno</td> <td>admitted to the facility on ecently readmitted on</td> <td></td> <td></td> <td>12/20/18 and injections were correcte include all injections received and transmitted on 12/26/2018. Resident was reassessed on 1/11/2019 to inclu</td> <td>#73</td> <td></td> | | 1. Resident #67 was 11/30/10 and most re 10/30/18 with diagno | admitted to the facility on ecently readmitted on | | | 12/20/18 and injections were correcte include all injections received and transmitted on 12/26/2018. Resident was reassessed on 1/11/2019 to inclu | #73 | |
| A review of the Medication Administration Records (MARS) for the look back period of Resident #67 's 11/5/18 MDS (10/30/18 through 11/5/18) indicated Resident #67 was administered Novolog (insulin) injections on 7 of 7 days. An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The medications section of Resident #67 's 11/5/18 MDS that indicated she had received injections on 6 of 7 days and insulin injections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period of Resident #67 's 11/5/18 MDS that indicated she received insulin injections on 7 of 7 days was reviewed with MDS Nurse #1. She revealed this coding was an error and indicated the MDS should have been coded for 7 of 7 injections and 7 of 7 insulin injections. | | assessment dated 11 #67 ' s cognition was have received injection insulin injections on 6 | 1/5/18 indicated Resident intact. She was noted to ons on 6 of 7 days and | | | bladder incontinence and was transmi on 1/11/2019. Resident #63 was reassessed on 1/11/2019 to include si conditions and was transmitted on 1/11/2019. Resident #54 was reasses on 1/11/2019 to include therapies and | kin ssed | |
| An interview was conducted with MDS Nurse #1 on 12/19/18 at 3:30 PM. The medications section of Resident #67 's 11/5/18 MDS that indicated she had received injections on 6 of 7 days and insulin injections on 6 of 7 days was reviewed with MDS Nurse #1. The MAR for the look back period of Resident #67 's 11/5/18 MDS that indicated she received insulin injections on 7 of 7 days was reviewed with MDS Nurse #1. She revealed this coding was an error and indicated the MDS should have been coded for 7 of 7 injections and 7 of 7 insulin injections.that assessment did not include diagnosis of seizure disorder was reassessed to include active diagnosis of seizure disorder on 1/11/2019 and transmitted on 1/11/2019. Resident #86 was reassessed on 12/20/2018 to include hospice prognosis and transmitted on 12/26/2018. Resident #42 was reassessed on 1/11/2019 to include accurate ADL information and transmitted on 1/11/2019. All MDS corrections and transmission were completed by MDS coordinator. | | Records (MARS) for Resident #67 ' s 11/5 11/5/18) indicated Re administered Novolog | the look back period of /18 MDS (10/30/18 through esident #67 was | | | was reassessed on 1/11/2019 to inclu hospice prognosis, urinary appliances antipsychotic medications and transm on 1/11/2019. Resident #45 does not have seizure disorder diagnosis. However, Resident #31, who's MDS | de and itted | |
| days was reviewed with MDS Nurse #1. She1/11/2019 to include accurate ADLrevealed this coding was an error and indicatedinformation and transmitted on 1/11/2019.the MDS should have been coded for 7 of 7All MDS corrections and transmissioninjections and 7 of 7 insulin injections.were completed by MDS coordinator. | | on 12/19/18 at 3:30 F of Resident #67 's 1 she had received inje insulin injections on 6 with MDS Nurse #1. period of Resident #6 | PM. The medications section 1/5/18 MDS that indicated ections on 6 of 7 days and 6 of 7 days was reviewed The MAR for the look back 67 ' s 11/5/18 MDS that | | | that assessment did not include diagn of seizure disorder was reassessed to include active diagnosis of seizure disorder on 1/11/2019 and transmitted 1/11/2019. Resident #86 was reasses on 12/20/2018 to include hospice prognosis and transmitted on 12/26/20 | osis I on ssed | |
| An interview was conducted with the Director of The facility has determined that all | | revealed this coding the MDS should have | was an error and indicated e been coded for 7 of 7 | | | information and transmitted on 1/11/2 All MDS corrections and transmission | 019. | |
| | | An interview was con | ducted with the Director of | | | The facility has determined that all | | |

Facility ID: 923403

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 02/06/2019 MAPPROVED O. 0938-0391 | |
|--------------------------|--|--|--------------------|-----|---|---|--|--|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345370 | B. WING | | | C 12/20/2018 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PINEHURS | T HEALTHCARE & REF | IAB | | | | | | |
| | | | | Р | INEHURST, NC 28374 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 641 | Continued From page | - 16 | E E | 641 | | | | |
| | Nursing on 12/20/18 | at 10:15 AM. She stated | | 041 | resident have the potential to be affect | cted. | | |
| | she expected the MDS to be coded accurately. 2a. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included periprosthetic fracture around the prosthetic right hip joint. The admission Minimum Data Set (MDS) assessment dated 11/21/18 indicated Resident #73 's cognition was severely impaired. She was noted with an active diagnosis of an "other fracture". The additional diagnoses section indicated Resident #73 had a periprosthetic | | | | Audits were conducted on MDS assessments transmitted on 1/11/18 1/18/18 by clinical Director of Clinical Services. All MDS assessments had correct information coded on MDS. An in-service was conducted by the | | | |
| | | | | | Corporate Director of Clinical Service with the MDS Nurses on 12/20/18 addressing the importance of identify and coding the MDS correctly prior to closing and submission. | ing o | | |
| | An interview was con on 12/19/18 at 3:30 F section of Resident # reviewed with MDS N was not sure why she for "other fracture". S diagnosis for Resider | rosthetic right hip joint. ducted with MDS Nurse #1 PM. The active diagnoses 73 ' s 11/21/18 MDS was lurse #1. She indicated she had coded Resident #73 She reported the active ht #73 ' s fracture was a e around the prosthetic right poted in the additional | | | MDS assessments will be audited by licensed nursing staff using audit tool MDS's completed within a 7-day perio using an audit tool for four (4) weeks ensure proper coding on Activities of Living, Bowel/Bladder continence, sk conditions, medications, health condi therapies and active diagnosis. Audit be kept in Director of Nursing (DON) office. | . 10 od to Daily in tions, | | |
| | diagnoses section. S no other fractures. An interview was con Nursing on 12/20/18 she expected the MD | the stated Resident #73 had ducted with the Director of at 10:15 AM. She stated S to be coded accurately. | | | The Director of Nursing will report to Quality Assurance Committee monthl results of the audits. The plan of correction will be reviewed monthly u such time as consistent substantial compliance has been met. | y the | | |
| | 11/13/18 with diagnos | s admitted to the facility on ses that included e around the prosthetic right | | | Completion Date 01/31/19 | | | |
| | The admission Minim | um Data Set (MDS) | | | | | | |

Facility ID: 923403

If continuation sheet Page 17 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|------|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE | |
| AND I LAN O | CONNECTION | IDENTIFICATION NOMBER. | A. BUILDII | NG _ | | | C |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | | 300 BLAKE BOULEVARD 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 641 | assessment dated 11 #73 's cognition was Resident #73 required of 2 or more for bed in the extensive assistant was not steady on he stabilize with staff assist impairment on one sid and she utilized a walt was noted to always b bowel. A review of the docum and bowel continence following information: An incident report An ursing note data Resident #73 was incomented An interview was control 12/19/18 at 3:30 P section of Resident #7 | /21/18 indicated Resident severely impaired. d the extensive assistance nobility and transfers and nee of 1 for toileting. She r feet and was only able to sistance. Resident #73 had de of her lower extremities ker and a wheelchair. She be continent of bladder and mentation related to bladder e included, in part, the t dated 11/18/18 at 1:27 AM '3 was incontinent. t dated 11/18/18 at 3:19 AM | F | 641 | | | |

Facility ID: 923403

If continuation sheet Page 18 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|----|---|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | PLE CONSTRUCTION | (X3) DATE | |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ST HEALTHCARE & REH | AR | | | 300 BLAKE BOULEVARD | | |
| FINEHOR | | | | | 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 641 | of the Nursing Assista Resident #73 to code MDS. She revealed the nursing notes or in documentation related and bowel continence 11/21/18 MDS. An interview was com Nursing on 12/20/18 a she expected the MD 3. Resident #63 was a 11/8/18 with diagnose dementia. The 11/15/18 admissi (MDS) assessment in cognition was severed ulcer/injury treatments had no applications o or without topical med A review of the treatm Administration Record period of Resident #6 through 11/15/18) ind dated 11/11/18 for ski applied to the skin for barrier) to bilateral he dressing wrap every t was administered to F An interview was com on 12/19/18 at 3:30 P section of Resident #4 indicated she had not | ants (NAs) who worked with this section of her 11/21/18 that she had not reviewed ncident report d to Resident #73 ' s bladder e when she coded the ducted with the Director of at 10:15 AM. She stated S to be coded accurately. admitted to the facility on es that included vascular on Minimum Data Set idicated Resident #63 ' s ly impaired. The skin and s indicated Resident #63 f dressings to the feet (with | F | 64 | | | |

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If continuation sheet Page 19 of 91

| | - | 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 | |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | 3 | 300 BLAKE BOULEVARD | | |
| | | | | F | PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 | physician ' s orders al Resident #63 was adu 11/14/18 that included wrap to her bilateral h MDS Nurse #1. MDS coding was an error a coded the 11/15/18 M application of dressing An interview was com Nursing on 12/20/18 a she expected the MD 4. Resident #54 was a diagnoses that include failure to thrive. The significant chang assessment dated 11. #54 ' s cognition was coded as not receiving during the MDS look I A physician ' s order of ST evaluation order a treat 5 times per weel dysphagia. A review of ST docum #54 received ST from An interview was conform on 12/19/18 at 3:30 P indicated Resident #55 MDS look back perioo Nurse #1. The physic documentation that in | nd TAR that indicated ministered a treatment on d foam protective dressing weels was reviewed with 5 Nurse #1 revealed this and that she should have IDS to indicate the gs to Resident #63 ' s feet. ducted with the Director of at 10:15 AM. She stated S to be coded accurately. admitted to the facility with ed heart disease and adult e Minimum Data Set (MDS) /12/18 indicated Resident severely impaired. She was g Speech Therapy (ST) back period. dated 11/1/18 indicated an s well as an ST order to k for 4 weeks for oral phase mentation indicated Resident 11/1/18 through 11/14/18. ducted with MDS Nurse #1 M. The 11/12/18 MDS that i4 received no ST during the d was reviewed with MDS cian ' s order and the ST | F | 641 | | | |

Facility ID: 923403

If continuation sheet Page 20 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 | |
|--------------------------|---|--|-------------------|-----|---|-------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED | |
| | | 345370 | B. WING | | | | C /20/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | L | I | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | 3374 | | |
| (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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE | |
| F 641 | revealed this MDS wa Resident #54. An interview was con Nursing on 12/20/18 a she expected the MD 5a. Resident #40 was 10/5/18 with multiple retention. The admis (MDS) assessment da Resident #40 had me problems. The asses Resident #40 had a p 10/5/18 for indwelling The Treatment Admin October 2018 reveale provided from 10/5/18 month. On 12/19/18 at 3:50 F interviewed. The MD Resident #40 had an on admission. She st admission MDS asse incorrectly for the indw On 12/20/18 at 10:15 (DON) was interviewed she expected the MD accurately. | lurse #1. MDS Nurse #1 as coded inaccurately for ducted with the Director of at 10:15 AM. She stated S to be coded accurately. a admitted to the facility on diagnoses including urinary sion Minimum Data Set ated 10/12/18 indicated that mory and decision making asment further indicated that have an indwelling urinary hysician's order dated urinary care every shift. histration Record (TAR) for ed that catheter care was 3 through the end of the PM, The MDS Nurse was | F | 641 | | | | |
| | 5b. Resident #40 was 10/5/18 with multiple | - | | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|-------------------|----|--|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | PLE CONSTRUCTION | (X3) DATE | |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ST HEALTHCARE & REH | AR | | | 300 BLAKE BOULEVARD | | |
| TINEITON | | | | | 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 641 | (MDS) assessment da Resident #40 had me problems. The assess Resident #40 was rec did not have a conditi may result in a life ex months under progno Resident #40 had a p 10/5/18 to admit to hot Resident #40 was can receive hospice care. On 12/19/18 at 3:50 F interviewed. The MD Resident #40 was rec admission on 10/5/18 she coded the admiss 10/12/18 incorrectly u indicated that the pro- checked indicating that condition or chronic d expectancy of less that On 12/20/18 at 10:15 (DON) was interviewed she expected the MD accurately. 5c. Resident #40 was 10/5/18 with multiple dementia. The admiss (MDS) assessment da Resident #40 had me problems. The asses | ssion Minimum Data Set ated 10/12/18 indicated that mory and decision making sement further indicated that ceiving hospice care and she on or chronic disease that pectancy of less than 6 sis. hysician's order dated ospice. re planned dated 10/5/18 to PM, the MDS Nurse was S Nurse verified that ceiving hospice care since . She further indicated that sion MDS assessment dated inder the prognosis. She gnosis should have been at the resident had a isease that may result in life an 6 months but it was not. AM, the Director of Nursing ed. The DON stated that S assessments to be coded | F | 64 | | | |

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If continuation sheet Page 22 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----------------|--|------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | | | (X3) DATE COM | E SURVEY PLETED |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | ıx | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 641 | period. The assessme "anti-psychotic medic the review was not co #40 did not receive an On 12/19/18 at 3:50 F interviewed. The MD Resident #40 had rec medication during the further indicated that MDS assessment dat under the anti-psycho On 12/20/18 at 10:15 (DON) was interviewed | e during the assessment ent under the section ation review" indicated that onducted because Resident nti-psychotic medication. PM, the MDS Nurse was S Nurse verified that | F | 64 ⁻ | 1 | | |
| | 11/18/16 with multiple seizures. The quarte assessment dated 10 Resident #45's cognit assessment did not in had a diagnosis of se Resident #45 had a p 4/20/18 for keppra 25 mouth twice a day for Resident #45's Medic Records (MARs) for 0 The MARs revealed t received keppra durin | rly Minimum data Set (MDS) /9/18 indicated that tion was intact. The ndicate that Resident #45 izure disorder. hysician's order dated i0 milligrams (mgs) by seizures. cation Administration October 2018 was reviewed. | | | | | |

Facility ID: 923403

If continuation sheet Page 23 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|-----|--|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | |
| | | 345370 | B. WING _ | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 00 BLAKE BOULEVARD INEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 | assessment period. Scoded the quarterly M 10/9/18 incorrectly, set been checked under of On 12/20/18 at 10:15 (DON) was interviewed she expected the MD accurately. 7) Resident #86 was a 10/25/18 and expired diagnoses included m head of the pancreas A review of the resided dated 10/26/18 reveat Hospice Care The most recent comport of the resided atter and dated 11/1/18 reveat marked with an active prognosis of less than with receiving Hospice During an interview w 12/19/18 at 8:10 AM, aware the resident was and that Hospice was assessment. She state An interview was comported the prognome of the state An with the Director of the prognome of the state An interview was comported the prognome of the state An with the Director of the prognome of the state An interview was comported the prognome of the prognome of the state An with the Director of the prognome of the prognome of the state An with the prognome of the prognome of the state An interview was comported the prognome of the prognome of the prognome of the prognome of the state and that Hospice was assessed to prognome of the prognome | S Nurse verified that every keppra during the She indicated that she IDS assessment dated eizure disorder should have diagnoses but it was not. AM, the Director of Nursing ed. The DON stated that S assessments to be coded admitted to the facility in the facility 11/1/18. His halignant neoplasm of the the resident received prehensive MDS (Minimum n admission assessment vealed the resident was e diagnosis of cancer and a n six months but not coded e care. | F 6 | 541 | | | |

Facility ID: 923403

If continuation sheet Page 24 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-------|--|-------------------------------|----------------------------|
| STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | FIPLE | ECONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG _ | | | C |
| | | 345370 | B. WING | | | | _ 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 00 BLAKE BOULEVARD 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 641 | Continued From page | 24 | F | 641 | | | |
| | 7/17/18 with diagnose (stroke), dysphagia (c aphasia (unable to ex tracheostomy and gas A review a physician in Resident #42 was not simple commands an extremities. During a review of a c dated 7/20/18 it was i was in a vegetative st assistance with all AD Living). A review of a nursing revealed the resident and all needs were an The most recent com Data Set) coded as a and dated 7/24/18 rev impaired memory and self-known or to make as receiving extensive members for all ADL's eating in which she w staff members. She w range of motion to bila extremities. A review of the most r Quarterly assessmen | tifficulty swallowing), press speech), strostomy status. note dated 7/19/18 revealed t able to smile or follow d did not move any care plan conference form indicated that the resident rate and required total DL's (Activities of Daily note dated 7/24/18 was in a vegetative state inticipated by staff. prehensive MDS (Minimum in admission assessment vealed the resident had d was unable to make e decisions. She was coded e assistance of two staff is except for bathing and as dependent on one to two was coded as having limited ateral upper and lower | | | | | |
| | - | had impaired memory and | | | | | |

Facility ID: 923403

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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 COMF | SURVEY LETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 800 BLAKE BOULEVARD 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) | 3E | (X5) COMPLETION DATE |
| F 641 | assistance of two staff except she was dependent members for eating a marked with limited ra- and lower extremities A review of the reside 10/18/18 revealed she her ADL's as well as y repositioning. During an interview w 12/19/18 at 8:45 AM, based on the ADL flow by the aides. She exp through observation a resident was totally de ADL's and felt the pro- education of completi accurately. She stated state whether the ass coded as an accurate based on observation with the ADL flow record An interview was com- 12/19/18 at 2:00 PM. Resident #42 required members for all ADL's eating. She stated that attempts to assist with or legs. An interview was com- AM with the Director of | coded as receiving extensive if members for all ADL's indent on one to two staff ind bathing. She was ange of motion to both upper ent's active care plan dated e was total care regarding with turning and with MDS Nurse #1 on she stated that she coded w record that was completed blained that she was aware and staff interviews that the ependent on staff for all bblem was with training and ing the ADL flow record d that she was unable to essments should have been e reflection of the resident us and staff interviews or ord. ducted with Nurse #3 on She confirmed that | F | 641 | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|--|-------------------------|------------|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | | (X3) DATE COMP | |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | | 00 BLAKE BOULEVARD VINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 655 F 655 SS=D | Baseline Care Plan CFR(s): 483.21(a)(1)- | -(3) | | 655 655 | | | 1/31/19 |
| | Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person that meet professiona The baseline care pla (i) Be developed within admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac | care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information care for a resident ted to- l on admission orders. | | | | | |
| | comprehensive care p care plan if the compre- (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The far resident and their rep | blan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not | | | | | |

Facility ID: 923403

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 02/06/20 MAPPROVE 0.0938-03 |
|--------------------------|-------------------------------|---|--------------------|-----|--|------|--------------------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | | (X3) DATE SURVEY COMPLETED | | |
| | | 345370 | B. WING | | | | C 2/ 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | • | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | НАВ | | | 0 BLAKE BOULEVARD NEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ЗE | (X5) COMPLETIO DATE |
| F 655 | Continued From page | e 27 | F | 655 | | | |
| | | e resident's medications and | | | | | |
| | dietary instructions. | | | | | | |
| | (iii) Any services and | | | | | | |
| | on behalf of the facili | | | | | | |
| | | rmation based on the details | | | | | |
| | | e care plan, as necessary. T is not met as evidenced | | | | | |
| | by: | i is not met as evidenced | | | | | |
| | | views and record reviews, the | | | Based on staff interviews and record | | |
| | | de indwelling urinary catheter | | | reviews, the facility failed to include | | |
| | (Resident #135) and | Dialysis (Resident #235) on | | | Indwelling Urinary Catheter (resident | | |
| | | In for 2 of 2 new admissions | | | #135) and Dialysis (resident #235) on | the | |
| | reviewed. | | | | baseline care plan for 2 of 2 new | | |
| | The findings includes | 4. | | | admissions reviewed. | | |
| | The findings included | 1. | | | Residents #135 and #235 were given | а | |
| | 1) Resident #135 wa | s admitted to the facility on | | | revised summary of their baseline care | | |
| | | es that included retention of | | | plan with the additional information ad | | |
| | | lney disease Stage 4. | | | to the care plan on 12/19/18 by the MI | | |
| | | | | | Nurse. | | |
| | • | ital discharge summary dated | | | | | |
| | | n indwelling urinary catheter | | | Resident #135 and #235 are no longe | | |
| | was placed secondar | | | | residing at the facility. All residents ha | ave | |
| | obstruction and dista | ii urethrai stricture. | | | the potential to be affected. | | |
| | A review of the physi | cian orders dated 12/7/18 | | | All interdisciplinary care plan team | | |
| | revealed catheter car | | | | members responsible for writing basel | line | |
| | | | | | care plans will be in-serviced by the | | |
| | | Minimum Data Set) was in | | | Director of Nursing (DON) and or | | |
| | progress. | | | | Corporate Director of Clinical Services | | |
| | A review of the base | line care plan dated 12/7/18 | | | the procedure for developing baseline | | |
| | | of an indwelling urinary | | | care plans. | | |
| | catheter and had the | | | | An audit was performed on 5 residents | S | |
| | continent of bladder. | | | | admitted between 1/14/2019 to 1/18/2 | | |
| | | | | | to ensure base line care plans accurat | | |
| | | e Tech Information Kardex | | | reflected the resident and care receive | ed | |
| | noted the resident ha | ad an indwelling urinary | | | All care plans accurately reflected eac | :h | |

Facility ID: 923403

If continuation sheet Page 28 of 91

| | - | ID HUMAN SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|---------------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | |
| | | 345370 | B. WING | | | | _ 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | | 00 BLAKE BOULEVARD 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 655 | catheter. During an interview w 12/19/18 at 4:00 PM, resident was marked not marked for an ind the baseline care plan error. An interview was corr Nursing (DON) on 12 stated that it was exp plan to be completed the resident. 2) Resident #235 wa 12/11/18 with end state hemodialysis. An admission MDS (Naprogress. A review of the baseling revealed dialysis was treatment/procedure, outside coordination for During an interview of Nurse #1 confirmed the resident received Herrit it on the baseline care An interview was corr Nursing on 12/20/18 at it was her expectation | with the MDS Nurse #1 on she confirmed that the as continent of bladder and welling urinary catheter on h. She stated that it was an appleted with the Director of /20/18 at 10:15 AM, she ectation for baseline care as an accurate reflection of s admitted to the facility on ge renal disease on Minimum Data Set) was in ne care plan dated 12/11/18 not marked in the other other conditions or in the for Hemodialysis sections. n 12/20/18 at 9:30am, MDS hat she was aware the modialysis and failed to mark | F | 655 | resident audited. These audits were conducted by the DON. The DON, or licensed nursing staff wil complete weekly audits of 5 residents ensure the baseline care plans accura reflect the resident for six (6) consecu weeks using an audit tool. Audits will kept in the Director of Nursing office. The DON will report the findings to the Quality Assurance Committee monthly until such time as consistent substantic compliance has been achieved. Completion Date 01/31/2019 | to htely tive be | |

If continuation sheet Page 29 of 91

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | ECONSTRUCTION | (¥3) DA | TE SURVEY |
|--------------------------|---|--|---------------------|--|---------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | | · · · · | MPLETED |
| | | | | | С | |
| | | 345370 | B. WING | | 1 | 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | Ş | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | 800 BLAKE BOULEVARD 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE |
| F 656 | Continued From page | e 29 | F 656 | | | |
| F 656 SS=D | Develop/Implement C CFR(s): 483.21(b)(1) | Comprehensive Care Plan | F 656 | | | 1/31/19 |
| | implement a compreh care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefri- medical, nursing, and needs that are identifi assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the ru- under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the resided (iv)In consultation witt resident's representa (A) The resident's go desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident' | cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the | | | | |

If continuation sheet Page 30 of 91

| TATEMENT (| OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DA | NO. 0938-039 TE SURVEY MPLETED |
|--------------------------|-------------------------------|---|--|-----|---|-----------------|--------------------------------------|
| | | 345370 | | | | C 12/20/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STI | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 300 F | | 0 BLAKE BOULEVARD | | |
| PINEHUK | ST HEALTHCARE & REH | TAB | | PI | NEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIZ TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 656 | Continued From page | e 30 | F | 356 | | | |
| | entities, for this purpo | | | 550 | | | |
| | | in the comprehensive care | | | | | |
| | | in accordance with the | | | | | |
| | | h in paragraph (c) of this | | | | | |
| | section. | | | | | | |
| | This REQUIREMEN | Γ is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | ons, staff interviews and | | | Based on observations, staff interview | | |
| | | cility failed to develop a care | | | and record review, the facility failed to | | |
| | | Resident #10) and for the | | | develop a care plan for weight loss | | |
| | | tic medication (Resident o failed to implement a care | | | (resident #10) and for the use of an antipsychotic medication (resident #73 | 2) | |
| | | to prevent falls (Resident | | | The facility also failed to implement a | | |
| | | of 17 residents reviewed for | | | planned intervention to prevent falls | care | |
| | | l implementation of care | | | (resident #31). This was for 3 of 17 | | |
| | plan. The findings inc | | | | residents reviewed for the developme and implementation of care plans. | nt | |
| | 1. Resident #10 was | admitted on 3/15/18 with | | | | | |
| | - | s of chronic respiratory | | | Care Plans of residents #10 for weigh | | |
| | | ular accident, dysphagia and | | | loss and #73 for the use of antipsycho | | |
| | a feeding tube. | | | | medication were reviewed and update | | |
| | Deview of Desident f | t10's cleatropic medical | | | indicated on 1/20/19 by the MDS Nurs | | |
| | | #10's electronic medical veights remained stable at | | | The care plan intervention for resident #31's wheelchair for anti-tippers has b | | |
| | | a readmission from the | | | implemented and anti-tippers applied | | |
| | | when his weight was 142 | | | her wheelchair on 12/18/18. | | |
| | pounds on return from | 5 | | | | | |
| | | | | | All residents have the potential to be | | |
| | | 10's care plan dated 3/16/18 | | | affected. | | |
| | | /19 read he was at risk for | | | | | |
| | | ght fluctuations due to his | | | All interdisciplinary care plan team | | |
| | include monitoring hi | PO) status. Interventions | | | members that are responsible for writi care plans will be in-serviced by the | ng | |
| | | ian per policy. Resident #10 | | | Corporate Director of Clinical Services | son | |
| | | plan addressing his 30lb | | | the procedure for developing | 5 011 | |
| | weight loss. | | | | Comprehensive Care Plans and | | |
| | | | | | implementation of the care plans on | | |
| | Resident #10's quart | erly Minimum Data Set | | | 1/23/19. | | |
| | (MDS) dated 9/25/18 | indicated severe cognitive | | | | | |

Facility ID: 923403

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FORI | D: 02/06/2019 MAPPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|---|--|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | COM | SURVEY PLETED |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | · | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | | 00 BLAKE BOULEVARD 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 APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 656 | impairment with total activities of daily livin having a feeding tube coded for weight loss Review of Resident # record revealed his w 134 pounds, 130 pout 131pounds December In an interview on 12. Director of Nursing (I expectation the Resid care planned for the activity joint, disorientation, a withdrawal, and majo The admission Minim assessment dated 11 #73' s cognition was not administered anti the MDS look back po A physician ' s order of #73 indicated Haldol milligram (mg) every for agitation. A review of the Decent Administered PRN Ha | assistance with all of his g. (ADLs). He was coded as e, weight of 135 pounds and s. 410's electronic medical veight in October 2018 was ands November 2018 and er 2018. /20/18 at 10:15 AM, the DON) stated it was her dent #10 would have been actual weight loss. admitted to the facility on ses that included e around prosthetic right hip alcohol dependence with or depressive disorder. | F | 656 | All Resident's were reweighed on 1/1 by the Restorative Aide. Dietary Mana Reviewed weights on 1/17/19 and determined 10 Resident's were identi with significant weight loss. Medical Director and Responsible Party notifie Clinical Supervisor on 1/17/19. Care p updated on identified Resident's on 1/17/19. An audit was conducted on 1/18/2019 on all residents receiving antipsychotic medications to ensure a appropriate Care Plan was in place, w was done by the Clinical Supervisor u the Drug Usage Report. Each residen receiving antipsychotic had an approp care plan in place. An audit on 100% residents was conducted on 1/15/19 k the Quality Assurance team to ensure fall interventions are in place using Fa Interventions Sheet. All interventions were in place. Care Plans will be reviewed weekly in accordance with the care plan schedu by the Clinical Supervisor. All Care P will be updated as indicated. The Director of Nursing (DON), or licensed nursing staff member will complete weekly audits of 5 resident's care plans for six (6) consecutive wee to ensure that the comprehensive car plans are developed for residents. Weekly audits of Care Plans for 5 residents with falls will be completed weekly for six (6) weeks to ensure implementation of Care Plans for residents with falls. All audits will be | ager fied ed by blans un which ising nt oriate of by all all ule lans | |
| | | 2, 12/13, and 12/17 (x3). #73 ' s active care plan was | | | - | dits | |

Facility ID: 923403

If continuation sheet Page 32 of 91

| | S FOR MEDICARE & DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPI | LE CONSTRUCTION | | IO. 0938-039 E SURVEY |
|--------------------------|--|--|---------------------|---|-----------------|---------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | `́сом | IPLETED |
| | | 345370 | B. WING | | 1 | C 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 2/20/2010 |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 300 BLAKE BOULEVARD 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 656 | conducted on 12/18/1 related to the use of a An interview was con on 12/19/18 at 3:30 P responsible for updati psychotropic medicat plan was implemente days when an antipsy initiated for a resident an antipsychotic med physician 's order for #73 was reviewed with active care plan for R addressed the use of was reviewed with MI a care plan related to use should have beer #73 as she had not pl antipsychotic medicat facility. An interview was con Nursing (DON) on 12 stated she expected a adequate clinical india additionally indicated appropriate clinical in Haldol. The DON rep antipsychotic medication effect monitoring was the MAR. 3. Resident #31 was | 18. There was no care plan antipsychotic medication. ducted with MDS Nurse #1 PM. She indicated she was ing care plans related to ions. She stated that a care d within one to two business vchotic medicated was two was not previously on ication. The 12/6/18 PRN Haldol for Resident the MDS Nurse #1. The esident #73 that had not antipsychotic medication DS Nurse #1. She revealed antipsychotic medication implemented for Resident reviously received an tion during her stay at the ducted with the Director of /20/18 at 10:15 AM. She all antipsychotics to have an cation for use. She that agitation was not an dication for the use of PRN borted that all PRN tions were to have behavior ed on the MAR or in the h administration to justify the also to be documented on admitted to the facility on e diagnoses including left | F 65 | 6 will be kept in the DON's office. The Director of Nursing will rep- to the Quality Assurance Comm monthly meetings until such tim consistent substantial complian been achieved. Completion Date 01/31/2019 | nittee le as | |

Facility ID: 923403

If continuation sheet Page 33 of 91

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 656 | was intact. The asse: Resident #31 was ind and she had 2 falls si or prior assessment w Resident #31's care p reviewed. One of the resident was at risk fo The goal was residen injuries related to falls interventions included wheelchair (added 7/2 evaluate for wheelcha Resident #31's nurse were reviewed. The n 1:22 AM revealed that transfer from bed to w rolled and she fell ont to prevent further fall back brake to the whe dated 7/25/18 at 8:03 #31 stated that she w while she was going u tipped backwards cau intervention to preven anti-tipper to the whe dated 12/8/18 at 11:0 #31 stated that she w feeding the birds and backwards ejecting he any injury except sore had requested for a p | Resident #31's cognition ssment further indicated that ependent with locomotion ince admission/entry/reentry with no injury. Dan initiated on 4/11/18 was care plan problems was or injuries related to falls. t would not experience any a through next review. The d anti-tippers to back of 25/18) and therapy to air safety (added 12/8/18). The notes and incident reports note/report dated 7/20/18 at t Resident #31 was trying to wheelchair, the wheelchair o the floor. The intervention was to install an anti-roll eelchair. The note/report AM revealed that Resident as outside the building and up the ramp the wheelchair using her to fall. The t further fall was to install an elchair. The note/report 7 AM revealed that Resident as outside the building her wheelchair flipped over er. Resident #31 had denied eness on her back and she ain medication. PM, Resident #31's ved and there was no I back brake noted. | F | 656 | | | |

If continuation sheet Page 34 of 91

| | DF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|---|-----------------------|
| | | 345370 | B. WING | | C 12/20/201 | 18 |
| | ROVIDER OR SUPPLIER | IAB | | STREET ADDRESS, CITY, STATE, ZIP COE 300 BLAKE BOULEVARD PINEHURST, NC 28374 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE COMPL E APPROPRIATE DA | X5) PLETIOI ATE |
| F 656 | wheelchair was obse anti-roll back brake. resident's wheelchair anti-tippers due to he On 12/20/18 at 10:15 (DON) was interview | rved with Nurse #2. The rved with no anti-tipper nor Nurse #2 stated that the was supposed to have | F 65 | 56 | | |
| F 686 SS=D | CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indi- demonstrates that the (ii) A resident with pro- necessary treatment with professional stand promote healing, pre- new ulcers from dever This REQUIREMENT by: Based on record rev- interview, the facility promote healing of pr the alternating pressi according to the resident | grity are ulcers. ehensive assessment of a nust ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent | F 68 | Based on record review, obs staff interview, the facility fail care to promote healing of a ulcer by not setting the altern pressure reducing air mattres to the resident's weight for 1 residents reviewed for pressu | ed to provide pressure hating ss according of 3 sampled | |

Event ID: KEWC11

Facility ID: 923403

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 02/06/2019 M APPROVED D. 0938-0391 |
|--------------------------|--|---|---------------------|-----|--|-----------------|---|
| STATEMENT C | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | СОМ | E SURVEY PLETED |
| | | 345370 | B. WING | | | C 12/20/2018 | |
| NAME OF PF | ROVIDER OR SUPPLIER | • | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 30 | 00 BLAKE BOULEVARD | | |
| PINEHURS | ST HEALTHCARE & REH | IAB | | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | Continued From page | e 35 | F 6 | 686 | The setting on the alternating pressur | e | |
| | on 2/14/18 with multip Alzheimer's disease. | ginally admitted to the facility ple diagnoses including The significant change in Set (MDS) assessment | | | reducing mattress for resident #45 was corrected on 12/20/2018 per the resid correct weight by the Treatment Nurse | lent's | |
| | severe cognitive impa stage 3 and two stage | ated that Residents #45 had airment and she had one e IV pressure ulcers. The ndicated that Resident #45 | | | All residents who have been identified having tan alternating pressure mattre are at risk. | | |
| | needed extensive as | loctor's order dated 8/14/18 | | | The Corporate Director of Clinical Services reviewed with the Wound No on 12/20/2018 how to set the weight | urse | |
| | Resident #45's care p | re reducing mattress to bed. blan dated 9/19/18 was e care plan problems was | | | setting on the alternating pressure reducing air mattress. All residents o alternating pressure reducing air | n | |
| | resident was at risk for and deterioration of c | or further skin breakdown urrent areas due to limited right and left hip and stage 3 | | | mattresses were evaluated by the Wo Nurse on 12/20/2018 to ensure all mattresses were set correctly for each | | |
| | on sacrum. The goal ulcer would have mea | was resident's pressure asurable healing through the | | | resident's individual weight. The pres on each alternating pressure mattress | sure | |
| | alternating mattress t | | | | was set on correct settings for each resident with one in use. The Wound Nurse educated all wound care nurse | S | |
| | Resident #45's weigh was 143 lbs. | It on 10/10/18 and 11/12/18 | | | including part time, weekend and all s on 1/18/2019 on how to set the weigh settings on the alternating pressure | | |
| | observed in bed on h | AM, Resident #45 was is back. The alternating attress machine was set at | | | mattress. All staff was educated prior working scheduled shift. | r to | |
| | | he machine had settings nd indicated to set according er lbs. | | | The Wound Nurse will do audits with audit tool five (5) days a week for four weeks of all alternating pressure redu air mattresses to ensure mattresses a | r (4) icing | |
| | observed in bed on h alternating pressure r | AM, Resident #45 was is back. Resident #45's reducing mattress was again chine was set at 300 lbs. | | | set for the correct weight for each resident, then two (2) times weekly fo months. All audits will be kept in the Director of Nusing office. | r 3 | |
| | On 12/20/18 at 9:22 / | AM, the Treatment Nurse | | | The Wound Nurse will report the resu | Its of | |

Event ID: KEWC11

Facility ID: 923403

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| OLITICI | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-039 |
|--------------------------|---|---|---------------------|--|-------------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345370 | B. WING | | C 12/20/2018 |
| | ROVIDER OR SUPPLIER | HAB | 30 | IREET ADDRESS, CITY, STATE, ZIP CODE 00 BLAKE BOULEVARD | · |
| - | | | I | INEHURST, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETIO |
| F 689 SS=D | was interviewed. Sh responsible for settin machine according to indicated that she wa air mattress machine time she checked th was 6 days ago (Frid indicated that Reside have been set at 144 143 lbs. She further who had changed th because the machin On 12/20/18 at 10:14 (DON) was interview she expected the air to the resident's weig pressure ulcer to pro- Free of Accident Hat CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must ensis §483.25(d)(2)Each r supervision and assis accidents. This REQUIREMEN by: Based on record rev resident and staff int install the anti-tipper care planned to prev | he stated that she was ing up the air mattress to the resident's weight. She as checking the setting of the te twice a week and the last te machine of Resident #45 day). The Treatment Nurse ent #45's machine should 5 lbs. because his weight was te stated that she didn't know te setting on the machine te was locked. 5 AM, the Director of Nursing yed. The DON stated that mattress to be set according ght for residents with bmote healing. zards/Supervision/Devices)(2) s. | F 686 | Based on record review, observation resident and staff interviews, the facilit failed to install the anti-tipper or anti-re back brake as care planned to prever repeated falls for 1 of 2 sampled resident reside | ty bll t |

Event ID: KEWC11

Facility ID: 923403

If continuation sheet Page 37 of 91

| F DEFICIENCIES | | | | | | |
|-----------------------|--|--|--|---|---|---|
| CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | A. BOILDING | ° | | | С |
| | 345370 | B. WING | | | . | 12/20/2018 |
| OVIDER OR SUPPLIER | I | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 30 | 00 BLAKE BOULEVARD | | |
| I HEALIHCARE & REH | IAB | | PI | INEHURST, NC 28374 | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | | | | (X5) COMPLETION DATE |
| Continued From page | 37 | Eeg | 00 | | | |
| | 5 57 | F UC | 69 | The entitioners were installed on resis | lont | |
| rindings included. | | | | | | |
| Resident #31 was ad | mitted to the facility on | | | - | • | |
| | | | | | | |
| | | | The nursing management team review | ed | | |
| | | | | all residents identified through | | |
| | C C | | | - . | | |
| | | | | | | |
| | | | | currently in place and appropriate. | | |
| | | | | | | |
| or prior assessment v | with no injury. | | | | ifts, | |
| Desident #21's sere r | lon initiated on 1/11/19 was | | | • | .t | |
| | | | | · · | Л | |
| | | | | | | |
| | | | | d | | |
| | | | | - | | |
| | | | | | | |
| wheelchair (added 7/2 | 25/18) and therapy to | | | | | |
| evaluate for wheelcha | air safety (added 12/8/18). | | | Morning Clinical Meeting to ensure | | |
| | | | | appropriate implementation of safety | | |
| Resident #31's nurse | 's notes and incident reports | | | interventions including the updating of | the | |
| | - | | | care plan. | | |
| | | | | | | |
| | - | | | | | |
| | | | | | all | |
| • | | | | | in | |
| | - | | | | | |
| | | | | | | |
| | - | | | The nursing management team will rev | /iew | |
| | | | | | | |
| | • | | | ensure appropriate interventions are | | |
| | - | | | implemented and the care plan is | | |
| | | | | | N), | |
| | - | | | or nursing management member will | | |
| | | | | | | |
| | | | | | | |
| | THEALTHCARE & REF SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Findings included: Resident #31 was ad 11/18/16 with multiple above the knee ampu Minimum Data Set (M 10/9/18 indicated that was intact. The asse Resident #31 was ind and she had 2 falls si or prior assessment w Resident #31's care p reviewed. One of the resident was at risk fo The goal was resident injuries related to falls interventions included wheelchair (added 7// evaluate for wheelchait Resident #31's nurse were reviewed. The 1:22 AM revealed that transfer from bed to v rolled and she fell ont to prevent further fall back brake to the who dated 7/25/18 at 8:03 #31 stated that she w while she was going to tipped backwards can intervention to prever anti-tipper to the who dated 12/8/18 at 11:0 #31 stated that she w feeding the birds and backwards ejecting h | OVIDER OR SUPPLIER T HEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 | OVIDER OR SUPPLIER T HEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 37 F 6 Findings included: Resident #31 was admitted to the facility on 11/18/16 with multiple diagnoses including left above the knee amputation. (AKA). The quarterly Minimum Data Set (MDS) assessment dated 10/9/18 indicated that Resident #31's cognition was intact. The assessment further indicated that Resident #31 was independent with locomotion and she had 2 falls since admission/entry/reentry or prior assessment with no injury. Resident #31's care plan initiated on 4/11/18 was reviewed. One of the care plan problems was resident was at risk for injuries related to falls. The goal was resident would not experience any injuries related to falls through next review. The interventions included anti-tippers to back of wheelchair (added 7/25/18) and therapy to evaluate for wheelchair safety (added 12/8/18). Resident #31's nurse's notes and incident reports were reviewed. The note/report dated 7/20/18 at 1:22 AM revealed that Resident #31 was trying to transfer from bed to wheelchair. The note/report dated 7/25/18 at 8:03 AM revealed that Resident #31 stated that she was outside the building and while she was going up the ramp the wheelchair tipped backwards causing her to fall. The intervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/8/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building feeding the birds and her wheelchair flipped backwards ejecting her. Resident #31 had denied | OVIDER OR SUPPLIER S T HEALTHCARE & REHAB ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 37 F 689 Findings included: Resident #31 was admitted to the facility on 11/18/16 with multiple diagnoses including left above the knee amputation. (AKA). The quarterly Minimum Data Set (MDS) assessment dated 10/9/18 indicated that Resident #31's cognition was intact. The assessment further indicated that Resident #31 was independent with locomotion and she had 2 falls since admission/entry/reentry or prior assessment with no injury. Resident #31's care plan initiated on 4/11/18 was reviewed. One of the care plan problems was resident was at risk for injuries related to falls. The goal was resident would not experience any injuries related to falls through next review. The interventions included anti-tippers to back of wheelchair (added 7/25/18) and therapy to evaluate for wheelchair, the wheelchair rolled and she fell onto the floor. The intervention to prevent further fall was to install an anti-roll back brake to the wheelchair. The note/report dated 7/25/18 at 8:03 AM revealed that Resident #31 stated that she was outside the building and while she was going up the ramp the wheelchair tipped backwards causing her to fall. The intervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/8/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building feeding the birds and her wheelchair flipped backwards ejecting her. Resident #31 had denied | OWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLACE BOULEVARD PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX TAG Continued From page 37 Findings included: F 689 Findings included: The anti-lippers were installed on resic #31's wheelchair on 12/18/2018 by the Facility Maintenance Director. Minimum Data Set (MDS) assessment dutted 10/9/18 indicated that Resident #31's cognition and she had 2 falls since admission/entry/reentry or prior assessment with no injury. F 689 Resident #31's care plan initiated on 4/11/18 was resident #31's care plan problems was resident #31's care plan initiated on 4/11/18 was resident #31's nurse's notes and incident reports were reviewed. The note/report dated 7/25/18 at 81:03 AM revealed that Resident #31 stadet that she was outside the building and while she was going up the ramp the wheelchair rolated 12/2/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building ant threper to the wheelchair. The note/report dated 72/2/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building mitervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/2/18 at 11:07 AM revealed that Resident #31 stated that she was outside the building feeding the birds and her wheelchair tipper to tack that she was outside the building feeding the birds and her wheelchair that he weis using the to fall. The intervention to prevent further fall was to install an anti-tipper to the wheelchair. The note/report dated 12/2/18 at 11:07 AM revealed that Resident #31 stated that she was outs | OWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 308 BLAKE BOULEVARD 308 BLAKE BOULEVARD BLAKE BOULEVARD PINEHURST, NC 28374 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 37 Findings included: F 689 Resident #31 was admitted to the facility on 11/18/16 with multiple diagnoses including left above the knee amputation. (KAK). The quarterly Minimum Data Set (MDS) assessment dated 10/9/18 indicated that Resident #31's cognition was intact. The assessment further indicated that Resident #31's care plan initiated on 4/11/18 was reviewed. One of the care plan problems was reviewed. One of the care plan initiated on 4/11/18 was reviewed. One of the care plan problems was reviewed. One of the care plan problems was reviewed. The notifreport dated 7/20/18 at 1:22 AM revealed that Resident #31's unse's notes and incident reports where reviewed. The note/report dated 7/20/18 at 1:22 AM revealed that Resident #31 was trying to transfer from bet to wheelchair. The note/report dated 12/8/18 at 8:03 AM revealed that Resident #31 stated that she was outside the building and while she was going up the ramp the wheelchair tipper to the wheelchair. The note/report dated 12/8/18 at 8:1:07 AM revealed that Resident #31 stated that she was outside the building redering the bricks and her wheelchair tipper to the wheelchair. The note/report dated 12/8/18 at 1:07 AM revealed that Resident #31 stated that she was outside the building redering the bricks and her wheelchair tipper to the wheelchair. The note/report dated 12/8/18 at 1:07 AM revealed that Resident #31 stated that she was outside the building redering the bricks and her wheelchair |

Facility ID: 923403

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 02/06/2019 MAPPROVED D. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | PLETED |
| | | 345370 | B. WING | | | | C /20/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 00 BLAKE BOULEVARD INEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | was feeding the birds. flipped backward. Rest therapy department has had been ordered for #31's wheelchair was anti-tipper or anti-roll II On 12/18/18 at 2:11 P Resident #31, was int Resident #31 was sup on her wheelchair dua #31's wheelchair was of or anti-roll back brake On 12/18/18 at 2:35 P (PT) was interviewed. was informed of Resid ago and she had scree recommended anti-tip wheelchair to prevent stated that the mainte responsible for installi wheelchair and she has maintenance departm On 12/18/18 at 2:53 P staff members were in indicated that they we nor therapy staff that I anti-tippers to her whe they had not received for Resident #31's anti- | PM, Resident #31 was ted that she had a fall ouple of days ago while she. Her wheelchair had sident #31 stated that the ad told her that anti-tippers her wheelchair. Resident observed and there was no back brake noted. PM, Nurse #2, assigned to terviewed. She stated that opposed to have anti-tippers to her recent fall. Resident observed with Nurse #2. PM, the Physical Therapist. The PT stated that she dent #31's fall about a week tened the resident. She had opers to Resident #31's is ther from falling. The PT enance department was ing the anti-tippers to ad informed the nent to install them. PM, the two maintenance herviewed. They both ere not informed by nursing Resident #31 needed eelchair. They indicated that a work order request form ti-tippers. | F | 689 | that appropriate interventions have be put in place to reduce the risk of falls of accidents. This information will be ke the DON's office. The DON will report the findings of the audit to the Quality Assurance commi- monthly meeting until such time as consistent substantial compliance has been achieved. Completion Date 01/31/2019 | or ot in e tee | |
| | On 12/19/18 at 8:40 A | M, Nurse #3 was | | | | | |

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-------------------|----------------------------|
| - | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 800 BLAKE BOULEVARD 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 689 F 690 SS=E | interviewed. Nurse # Resident #31 on 7/25 after the fall, she com maintenance to instal #31's wheelchair. Nu not able to check if th she was assigned to stated that the facility members. These new members were not he On 12/20/18 at 10:15 (DON) was interviewe she didn't know what anti-tippers but she et should have been ins wheelchair as care pl falls. The DON furthe maintenance departm installing the anti-tipp should be informed by form and this did not Bowel/Bladder Incont CFR(s): 483.25(e)(1). §483.25(e)(1) The fac resident who is contir admission receives se maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re incontinence, based of comprehensive assess ensure that- | 3 was the nurse assigned to /18. The nurse stated that ipleted a work order for the I anti-tippers on Resident irse #3 added that she was ey were installed because different halls. She also had new maintenance staff we maintenance staff ere in July 2018. AM, the Director of Nursing ed. The DON stated that happened to Resident #31's xpected that anti-tippers talled on Resident #31's anned to prevent further r indicated that the nent was responsible for ers or anti-roll back and they y completing a work order happened for Resident #31. inence, Catheter, UTI -(3) mce. cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. | | 689 | | | 1/31/19 |

Facility ID: 923403

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| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOR | ED: 02/06/20 MAPPROVE <u>O. 0938-039</u> | |
|--------------------------|--|---|--------------------|--|--|-----------------|--|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 345370 | B. WING | | | C 12/20/2018 | | |
| | | | | | TREET ADDRESS, CITY, STATE, ZIP CODE 00 BLAKE BOULEVARD | | | |
| PINEHUR | ST HEALTHCARE & REH | ТАВ | | PINEHURST, NC 28374 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 690 | Continued From pag | e 40 | F | 690 | | | | |
| | | not catheterized unless the not catheterized unless the | | | | | | |
| | catheterization was r | necessary; hters the facility with an | | | | | | |
| | | r subsequently receives one | | | | | | |
| | | val of the catheter as soon | | | | | | |
| | • | e resident's clinical condition atheterization is necessary; | | | | | | |
| | and | - | | | | | | |
| | | incontinent of bladder | | | | | | |
| | | treatment and services to infections and to restore | | | | | | |
| | continence to the ext | | | | | | | |
| | §483.25(e)(3) For a r incontinence, based | | | | | | | |
| | | ssment, the facility must | | | | | | |
| | | nt who is incontinent of bowel | | | | | | |
| | | treatment and services to | | | | | | |
| | restore as much norr possible. | mal bowel function as | | | | | | |
| | 1 | Γ is not met as evidenced | | | | | | |
| | - | on, record review and staff | | | Based on observation, record revie | ew, and | | |
| | - | failed to provide catheter | | | staff interview, the facility failed to p | orovide | | |
| | | and anchoring the catheter tension and to facilitate flow | | | catheter care by not securing and anchoring the catheter to prevent | | | |
| | - | npled residents reviewed for | | | excessive tension and to facilitate f | low of | | |
| | • • | theter (Residents # 40, # 45 | | | urine for 3 of 3 sampled residents | | | |
| | and #135). | | | | reviewed for indwelling urinary cath | neter | | |
| | Findings included: | | | | (residents #40, #45, and #135). | - | | |
| | 1. Resident #40 was | admitted to the facility on | | | On 12/18/2018 catheter straps wer placed on residents #40, #45, and | | | |
| | 10/5/18 with multiple | diagnoses including urinary | | | prevent excessive tension and to fa | | | |
| | | ssion Minimum Data Set | | | flow of urine by the Charge Nurse. | | | |
| | | lated 10/12/18 indicated that emory and decision making | | | All residents with indwelling cathete | ers | | |
| | | ssment further indicated that | | | were checked for placement of cath | | | |

Facility ID: 923403

If continuation sheet Page 41 of 91

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|---|---|---------------------|---|---|----------------------------|--|
| | | 345370 | B. WING | | | 0/2018 | |
| | ROVIDER OR SUPPLIER ST HEALTHCARE & REF | IAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PINEHURST, NC 28374 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 690 | catheter. Resident #40 had a p 10/5/18 for indwelling Resident #40 had a c 10/5/18 for potential f of indwelling urinary of urinary retention. The to receive no injury se manipulation through approaches included thigh to prevent pullin On 12/18/18 at 10:48 observed during the i care. The catheter w anchored to the resid On 12/18/18 at 3:53 F observed in bed. The secured or anchored On 12/18/18 at 3:54 F Resident #40, was in that there was no req anchor the catheter. S #40 was care planned that was only when th On 12/20/18 at 10:15 (DON) was interviewed | have an indwelling urinary hysician 's order dated urinary care every shift. are plan problem dated for injury related to presence catheter with diagnosis of e goal was for Resident #40 econdary to catheter next review. The to secure the catheter to ag on tubing. AM, Resident #40 was ncontinent care and catheter as observed not secured or ent 's thigh. PM, Resident #40 was e catheter was observed not | F 69 | 0 straps, each resident had a cal in place on 12/18/18 by the Tre Nurse. Licensed and unlicensed nursi including all shifts, weekend, a time were in-serviced on the pl catheter straps for residents to excessive tension and to facilit of urine 1/23/19 by Corporate I Clinical Services and Nurse Ma Team. All staff was in-serviced working scheduled shift. The Treatment Nurse or memb Nurse Management Team will twice per week using an audit weeks including all shifts to en catheter straps are in place. Al be kept in the DON's office. The DON will report the finding audits to the Quality Assurance Committee monthly meeting un time as substantial compliance Completion Date 01/31/2019 | eatment ng staff nd part lacement of prevent tate the flow Director of anagement d prior to per of the do audits tool for four sure I audits will ps of the entil such | | |

If continuation sheet Page 42 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM APPROVED OMB NO. 0938-0391 | | |
|--------------------------|---|---|--------------------|-----|---|------------------------------------|----------------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | | |
| | | 345370 | B. WING | | | | C 20/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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) | BE | (X5) COMPLETION DATE | |
| F 690 | facility on 2/14/18 with including urinary reter change in status Mini assessment dated 10 Resident #45 had sev and had an indwelling Resident #45 had a p 5/10/18 for suprapubi Resident #45 had a c risk for complications catheter. The goal wa experience infections use through next revia included monitor tubir and to provide cathete plan did not include si On 12/18/18 at 3:55 F observed up in wheel #45 ' s catheter was observe On 12/18/18 at 3:54 F Resident #45, was int that there was no req anchor the catheter. S #45 was not care plar doctor ' s order to sec On 12/20/18 at 10:15 (DON) was interviewe she expected cathete at all times. 3) Resident #135 was | n multiple diagnoses ntion. The significant mum Data Set (MDS) //25/18 indicated that /ere cognitive impairment g urinary catheter. hysician 's order dated c catheter care daily. are plan dated 10/25/18 for due to use of suprapubic as Resident #45 would not /complications from catheter ew. The approaches ng for kinks or twist in tubing er care per order. The care ecurement of the catheter, PM, Resident #45 was chair in his room. Resident observed with NA #1. The d not anchored or secured. PM, Nurse #2, assigned to terviewed. Nurse #2 stated uirement to secure or She added that Resident need and did not have a cure the catheter. AM, the Director of Nursing ed. The DON stated that rs to be secured/anchored | F | 690 | | | | |

If continuation sheet Page 43 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 690 | Continued From page | 9 43 | F | 690 | | | |
| | 12/7/18 revealed an in was placed secondar obstruction and distal | - | | | | | |
| | | n dated 12/7/18, specified and cognitively intact with | | | | | |
| | | Tech Information Kardex had an indwelling urinary | | | | | |
| | stated that he did not | ent #135 in his room. He have any type of strap on catheter tubing and moved | | | | | |
| | | ith NA #1 on 12/18/18 at hat a strap should be in rinary catheters. | | | | | |
| | urinary catheter tubin | PM, Nurse #2 stated that g straps were not required ered or on the baseline care theter tubing. | | | | | |
| | Nursing (DON) on 12 stated that it was exp | pleted with the Director of /20/18 at 10:15 AM, she ectation for indwelling e secured or anchored nt's thigh to prevent | | | | | |

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| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 02/06/2019 MAPPROVED D. 0938-0391 | |
|--------------------------|--|---|-------------------|-----|--|-----------------|--|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>'</i> | | CONSTRUCTION | | PLETED | |
| | | 345370 | B. WING | | | C 12/20/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | | 00 BLAKE BOULEVARD INEHURST, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| F 692 | Continued From page | e 44 | Í F | 692 | | | | |
| F 692 SS=G | Nutrition/Hydration S CFR(s): 483.25(g)(1) | tatus Maintenance | | 692 | | | 1/25/19 | |
| | (Includes naso-gastri both percutaneous en percutaneous endoso enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Mainta of nutritional status, s desirable body weigh balance, unless the r demonstrates that thi preferences indicate §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a the | ssment, the facility must it- ins acceptable parameters such as usual body weight or it range and electrolyte esident's clinical condition s is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. | | | | | | |
| | by: Based on observatio interviews, the facility address continued un weight loss and imple | nintended, significant (27%) ement effective interventions moval of a feeding tube for 1 esidents reviewed to | | | Based on observations, staff and Physician interviews, the facility failed adequately address continued unintended, significant weight loss (27 and implement effective interventions prevent the self-removal of a feeding t for 1 (resident #10) of 3 residents reviewed for nutrition. | '%) to | | |
| | cumulative diagnoses failure, cerebral vasc | mitted on 3/15/18 with s of chronic respiratory ular accident and dysphagia. 410's admission orders dated | | | Resident #10 on 1/7/2019 is presently pounds for an increase of 6 pounds sin his readmission on 12/17/2018. | | | |

Facility ID: 923403

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOR | ED: 02/06/201 RM APPROVEI O. 0938-039 | |
|--------------------------|------------------------------|---|---------------------|---|-------------------------------|---|--|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345370 | B. WING | | C 12/20/2018 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| | | | | 300 BLAKE BOULEVARD | E BOULEVARD | | |
| PINEHURS | ST HEALTHCARE & REH | IAB | | 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 692 | Continued From page | e 45 | F 69 | 2 | | | |
| 1 002 | | e feeding was Isosource | F 09 | All residents with G-tubes have | the | | |
| | (tube feeding formula | a) 1.5 one can six times daily neters (ccs) of water with | | potential of self-removing their (| | | |
| | each feeding. | | | Dietician made recommendation | ns to | | |
| | - | | | increase resident's tube feeding |) on | | |
| | | 10's care plan dated 3/16/18 | | 12/19/2018, Medical Director ar | | | |
| | | or dehydration and weight | | responsible party was notified a | | | |
| | | s nothing by mouth (NPO) | | carried out on same date. Facil | | | |
| | | include monitoring his labs, as and a dietician per policy. | | obtained a Physician's order to abdominal binder on the resider | • | | |
| | weights, tube leeding | js and a dietician per policy. | | decrease his pulling out his G-tu | | | |
| | Review of a Physicia | n order dated 5/22/18 read | | poor safety awareness seconda | | | |
| | - | feeding was changed from | | cerebral vascular accident. The | - | | |
| | bolus feedings to cor | ntinuous feedings of | | Responsible Party (RP) was no | tified on | | |
| | | cs per hour with 50 ccs of | | 1/14/2019 by the Clinical Coord | | | |
| | water per hour due to | o abdominal discomfort. | | regarding the medical reason for placement of the binder. Reside | | | |
| | | note dated 5/22/18 read | | Care Plan was updated to reflect | | | |
| | | nected his tube feeding and | | of the abdominal binder on 1/14 | | | |
| | - | draining into his bed. The | | the MDS Coordinator. Skin Ass | | | |
| | tubing was reconnect | led. | | will be conducted every 2 hours nurse with release of binder. | by charge | | |
| | Review of a nursing r | note dated 5/24/18 read | | | | | |
| | | ed his feeding tube and was | | All Resident's with G-tubes were | e | | |
| | | ue to bleeding from the | | reweighed on 1/17/19 by the Re | | | |
| | feeding tube site. | - | | Aide. Dietary Manager reviewed | | | |
| | | | | on 1/17/19 and determined no o | | | |
| | | note dated 6/8/18 read | | Resident' with g-tubes experien | ced weight | | |
| | | ed his feeding tube and | | loss. | | | |
| | | place the feeding tube. The | | Lipping and unlighted at f | oludina c'' | | |
| | reeding tube was rep | laced without difficulty. | | Licensed and unlicensed staff ir shifts part time and weekend sta | | | |
| | Review of a nursing r | note and Physician order | | been in-serviced by the MDS nu | | | |
| | | ecommendation to change | | 1/14/2019 for the use of the abo | dominal | | |
| | | feeding back to bolus of | | binder and how to release and r | | | |
| | | n every four hours with 200 | | All staff was in-serviced prior to | working | | |
| | ccs of water with eac | h feeding. | | the floor. | | | |
| | Review of a nursing r | note dated 6/13/18 read | | The Director of Nursing (DON), | or | | |

Facility ID: 923403

If continuation sheet Page 46 of 91

| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | OMB NO. 0938 (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|---|---|----------------------|
| | | | A. BUILDING | 3 | C | |
| | | 345370 | B. WING | | 12/20/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 300 BLAKE BOULEVARD 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) | ULD BE COMPL | (5) LETION ATE |
| F 692 | Resident #10 removes sent to the hospital a replace it at the facilit urinary tract infection bacterial infection of the infection). Resident # facility 6/15/18. Review of a nursing m Resident #10 was set increased respiratory oxygen saturation lew facility on 6/29/18. Review of a nursing m Resident #10 was set suspected sepsis. He facility on 7/20/18 wit Isosource 1.5 one ca ccs of water with eac Review of Resident # stable at 172 pounds April and May 2018 a of a weight obtained readmission from the his weight was 142 p hospital. Review of a nursing m Resident #10 removes to the hospital after fa the facility. He was ac urinary tract infection on 8/10/18. There wa feeding orders. | ed his feeding tube and was fter failed attempts to ty. He was hospitalized for , Clostridium difficile (c-diff-a the colon) and sepsis (blood 210 was readmitted to the note dated 6/26/18 read nt to the hospital due to secretions and a drop in his vel. He was readmitted to the hote dated 7/16/18 read nt to the hospital for e was readmitted to the h tube feeding orders for n every four hours with 200 h feeding. 210's weights remained for the month of March, at 172 with no documentation in June 2018. On hospital on 7/20/18 when ounds on return from the hote dated 8/5/18 read ed his feeding and was sent ailed attempts to replace it at dmitted to the hospital for a and returned to the facility as no change in his tube | F 69 | licensed nursing staff will do audit an audit tool five (5) times weekly (4) weeks including all shifts, ther for four (4) weeks including all shift ensure the placement of the abdot binder to prevent self-removal of the G-tube. The audits will be kept in DON's office. The DON will report the findings of audit to the Quality Assurance Comonthly until substantial compliant ben achieved. Completion Date 01/25/2019 | for four weekly fts, to minal the the of the mmittee | |
| | | note dated 8/28/18 read ed his feeding tube and | | | | |

Facility ID: 923403

If continuation sheet Page 47 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-----------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | E SURVEY PLETED |
| | | 345370 | B. WING | | | | C /20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD 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 692 | feeding tube was repl Review of a nursing r Resident #10 was set increased respiratory oxygen saturation lev facility on 9/18/18 with feeding orders. Review of a nursing r Resident #10 remove orders received to rep larger size. The tube difficulty. Review of Resident # Data Set (MDS) date cognitive impairment, assistance with all of He was coded with kr tube and weight of 13 Review of a dietary m Resident #10 had a h feeding tube and rece repeat hospitalization pounds and there was feeding orders. Review of a dietary m Resident #10's weigh | blace the feeding tube. The laced without difficulty. note dated 9/5/18 read int to the hospital for secretions and a drop in his el. He was readmitted to the in no change in his tube note dated 9/23/18 read do his feeding tube with blace the feeding tube with blace the feeding tube with a was replaced without 10's quarterly Minimum d 9/25/18 indicated severe no behaviors and total his activities of daily living. nown weight loss, a feeding 05 pounds. ote dated 9/26/18 read istory of removing his ent acute illnesses with s. His weight was 135 s no change in his tube ote dated 10/12/18 read t was still trending down at lers to stop the bolus feeding 1.5 at 60ccs per hour | F | 692 | | | |
| | Resident #10 remove | note dated 10/30/18 read d his feeding tube with s to reinsert the tube. He | | | | | |

Facility ID: 923403

If continuation sheet Page 48 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | l | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, 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 APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 692 | was sent to the hospi reinserted. Review of a dietary n Resident #10's weigh was no change in his Review of a nursing n Resident #10 remove orders were received feeding tube was repl Review of a nursing n Resident #10 was sent blood in his stool. He 12/17/18 with no char orders. In an observation on Resident #10 was lyin his bed elevated 30 d move his arms and leanswer yes/no questi connected and runnin per hour continuous w hour. In an interview on 12/ stated Resident #10 f off since admission. S home with his wife pr facility in March 2018 | tal to have his feeding tube ote dated 11/9/18 read it was 130 pounds. There tube feeding orders. note dated 11/14/18 read ed his feeding tube and to replace the tube. The laced without difficulty. note dated 12/11/18 read int to the hospital due to returned to the facility on nge in his tube feeding 12/18/18 at 11:10 AM, ng in bed with the head of legrees. He was able to ons. His tube feeding was ng Isosource 1.5 at 60 ccs with 35 ccs of water per (18/18 at 3:10 PM, Nurse #4 had been very sick on and She stated he was living at ior to admission to the . Nurse #4 stated Resident icult time adjusting to the | F | 692 | | | |
| | frequently removed h frequent hospitalization facility tried using an | he stated Resident #10 is feeding tube and required ons. Nurse #4 stated the abdominal binder to prevent his feeding tube, but he | | | | | |

Facility ID: 923403

If continuation sheet Page 49 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 02/06/2019 APPROVED). 0938-0391 |
|--------------------------|---------------------------------------|---|-------------------|-----|--|---|-------------------|---|
| STATEMENT C | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345370 | B. WING | | | | | C 20/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE | E, ZIP CODE | | |
| PINEHURS | ST HEALTHCARE & REH | AB | | | 00 BLAKE BOULEVARD INEHURST, NC 28374 | | | |
| | | | | F | - | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTI) CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| F 692 | Continued From page | 9 49 | F | 692 | | | | |
| | | n issues, so it had to be | | | | | | |
| | | 4 stated the only other | | | | | | |
| | | d to prevent Resident #10 ding tube was to change his | | | | | | |
| | - | ous to bolus. She stated | | | | | | |
| | | at preventing him from | | | | | | |
| | • • | tube. She stated psychiatric | | | | | | |
| | services were involve | d in Resident #10's care. | | | | | | |
| | In an interview on 12/ | 18/18 at 3:26 PM, the | | | | | | |
| | |) stated the Registered | | | | | | |
| | | to the facility once a month | | | | | | |
| | | stated Resident #10 was on his known weight loss | | | | | | |
| | | ultiple hospitalizations due | | | | | | |
| | to illness and multiple feeding tube. | incidents of removing his | | | | | | |
| | | ew on 12/18/18 at 5:15 PM, nt #10's weights were stable | | | | | | |
| | | il sometime in July 2018 | | | | | | |
| | | several times for sepsis, | | | | | | |
| | | issues. The RD stated eiving plenty of calories to | | | | | | |
| | | The RD stated bolus tube | | | | | | |
| | | nented at one time because | | | | | | |
| | it was felt he would be | e less likely to remove his | | | | | | |
| | • | his weights continued to | | | | | | |
| | back to continuous fe | n changed Resident #10 edings | | | | | | |
| | back to continuous ici | cungs. | | | | | | |
| | - | ote dated 12/19/18 read | | | | | | |
| | Resident #10's weight | | | | | | | |
| | | tiple hospitalizations and a sfeeding tube. His current | | | | | | |
| | | n was 125 pounds. New | | | | | | |
| | | B for Isosource 1.5 at 65 ccs | | | | | | |
| | | vith 35 ccs of water per | | | | | | |
| | hour. | | | | | | | |

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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: | · / | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 00 BLAKE BOULEVARD 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 692 | Continued From page | \$ 50 | F | 692 | | | |
| | feeding running contin He was observed to be yes/no questions with observed attempting is but rather moving his upward motion. In an interview on 12/ stated Resident #10 v feeding tube and requine hospitalizations. She after visits from his fa In an interview on 12/ Medical Director state nine hospitalizations as facility and multiple in removing his feeding stated some weight loss tried an abdominal bin started to develop skit discontinued. He state feedings from continue instances in hopes th #10 from removing his attempts other interver #10 from removing his Resident #10 may reference | ng in bed with his tube nuously as the ordered rate. be alert and able to answer out difficulty. He was not to removing his feeding tube arms in a continuous 20/18 at 9:00 AM, Nurse #3 vas known to remove his uired frequent stated he often acted out mily. 20/18 at 9:10 AM, the ed he was aware of at least since being admitted to the cidences of Resident #10 tube. The Medical Director bas was to be expected but the continued unintended, but the AD stated the facility inder at one time, but he n issues, so it was ed he also changed his ious to bolus on few at it would deter Resident is feeding tube. The MD expectation that the facility entions to prevent Resident is feeding tube. He stated quire a higher calorie tube ther weight loss and he | | | | | |
| | | 20/18 at 10:15 AM, the ated it was her expectation | | | | | |

Facility ID: 923403

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| TATEMENT (| OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | OMB NO. 0938-0 (X3) DATE SURVEY | |
|--------------------------|--|--|---------------------|---|------------------------------------|--|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| | | | 5.14/11/0 | | С | |
| | | 345370 | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REI | AB | | 00 BLAKE BOULEVARD PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLET | |
| F 692 | Continued From pag | e 51 | F 692 | | | |
| | that facility staff woul of continued weight I | d have notified the Physician oss so that other | | | | |
| | | ave been considered to intended, significant weight | | | | |
| F 756 SS=D | Drug Regimen Revie CFR(s): 483.45(c)(1) | w, Report Irregular, Act On (2)(4)(5) | F 756 | | 1/31/19 | |
| | | jimen Review. ug regimen of each resident least once a month by a | | | | |
| | §483.45(c)(2) This re of the resident's med | eview must include a review lical chart. | | | | |
| | irregularities to the a facility's medical dire and these reports mu (i) Irregularities inclu drug that meets the o (d) of this section for | narmacist must report any ttending physician and the ctor and director of nursing, ust be acted upon. Ide, but are not limited to, any criteria set forth in paragraph an unnecessary drug. noted by the pharmacist | | | | |
| | separate, written rep attending physician a director and director minimum, the reside | ust be documented on a ort that is sent to the and the facility's medical of nursing and lists, at a nt's name, the relevant drug, ne pharmacist identified. | | | | |
| | (iii) The attending ph resident's medical re irregularity has been action has been take | ysician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to | | | | |
| | _ | medication, the attending sument his or her rationale in al record | | | | |

Event ID: KEWC11

Facility ID: 923403

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOF | ED: 02/06/201 RM APPROVE IO. 0938-039 |
|--------------------------|---|---|--------------------|--|---|--|---|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | TE SURVEY MPLETED |
| | | 345370 | B. WING | | | C 12/20/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | | 00 BLAKE BOULEVARD 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 756 | maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by: Based on record rev interview, the facility f irregularities reported pharmacist (Resident failed to identify and t anti-psychotic medica specific diagnosis (Re sampled residents re- medications. Findings included: 1. Resident #40 was 10/5/18 with multiple dementia. The admis (MDS) assessment d Resident #40 had me problems. The asses Resident #40 had rec medication for 7 days period. Resident #40 had a p 10/5/18 for Risperdal milligrams (mgs) by m anxiety. | cility must develop and procedures for the monthly that include, but are not s for the different steps in s the pharmacist must take ifies an irregularity that n to protect the resident. " is not met as evidenced iew and pharmacist and staff failed to act upon the and identified by the attent of protect the use of atton prescribed without a esident #73) for 2 of 5 viewed for unnecessary admitted to the facility on diagnoses including ssion Minimum Data Set ated 10/12/18 indicated that errory and decision making ssment further indicated that ceived an anti-psychotic a during the assessment | F | 756 | Based on record review and pharm and staff interviews, the facility faile act upon the irregularities reported a identified by the Pharmacist (resider and the pharmacist failed to identify report the use of anti-psychotic medication prescribed without a spe diagnosis (resident #73) for 2 of 5 sampled residents reviewed for unnecessary medications. The Dyskinesia Identification Syster Condensed User Scale (DISCUS) for resident #40 was completed, signed closed on 12/18/2018 by the Assista Director of Nursing. The psychotic disorder diagnosis wa added to the Medication Administrat Record (MAR) and diagnosis list for resident #40 per Medical Director's for on 12/20/2018 by Medical Records. The medication regimen for residen was reviewed by the physician on 12/18/2018. The antipsychotic press as needed for agitation was discont on 12/18/2018. | d to and nt #40) and to ecific n or l and ant as cion orders t #73 cribed | |
| | | d. The DRR dated 10/11/18 Director of Nursing (DON). | | | The facility has determined that all | | |

Facility ID: 923403

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 02/06/20 FORM APPROVI OMB NO. 0938-03 |
|--------------------------|--|---|---------------------|--|--|
| STATEMENT C | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345370 | B. WING | | C 12/20/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | 3 | 300 BLAKE BOULEVARD | |
| PINEHURS | ST HEALTHCARE & REF | IAB | F | 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETIO |
| F 756 | Dyskinesia Identificat User Scale (DISCUS for the use of Risperd was addressed to the requested a second t and to add diagnosis Risperdal on the Med Record (MAR). The addressed to the DOU requested a third time to add diagnosis (psy Risperdal on the MAR Review of Resident # including electronic re DISCUS was not com Review of Resident # December 2018 MAR diagnosis of psychoti the MARs. On 12/18/18 at 11:20 was interviewed. UM responsible for ensur recommendations bu DISCUS was comple and she failed to add disorder on the Nove indicated that starting was responsible for ensur | requested to complete ion System Condensed) and to have a justification lal. The DRR dated 11/1/18 a DON. The pharmacist had ime to complete DISCUS (psychotic disorder) for lication Administration DRR dated 12/14/18 was N. The pharmacist had a to complete DISCUS and rchotic disorder) for the R. 40's medical records ecords revealed that hpleted as of 12/18/18. 40's November and Rs revealed that the c disorder was not added on AM, Unit Manager (UM) #1 I #1 stated that she was ing that the pharmacist ere acted upon. She verified e October 2018 t failed to ensure that ted by the admitting nurse the diagnosis of psychotic mber MAR. UM #1 also I November 2018, UM #2 insuring the pharmacist ere acted upon on residents | F 756 | residents have the potential to be affected. All Resident's charts were audited to ensure that current DISC in place on 1/18/19 by Clinical Nurs Resident's have current DISCUS in A review of all as needed medicatio orders and indications for use was completed on 1/15/2019 by the Clin Nurse Supervisor. All medications indication for use. The Pharmacy Consultant was in-s on 1/12/2019 by the Corporate Dire Clinical Services about addressing use of an antipsychotic medication prescribed without an adequate clin indication for use. Licensed Nursing staff including all part time and weekend were in-ser on 1/23/2019 by the Corporate Dire Clinical Services on how to comple DISCUS, sign and close the asses All staff was in serviced prior to wo their shift. The Director of Nursing (DON), or licensed nursing staff, will complete weekly audits using an audit tool for (6) weeks for new anti psychotic medication orders to ensure that appropriate indications for use of a antipsychotic drugs are clearly documented in the medical record that a DISCUS has been complete DON, or licensed nursing staff, will complete weekly audits using an an | CUS is se. All n place. on hical had an serviced ector of the nical shifts, viced ector of ete a sment. rking e or six ny and d. The |
| | | AM, UM #2 was interviewed. e started working at the | | for six (6) weeks on all new admiss and current Resident's to ensure th | |

Facility ID: 923403

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 02/06/2019 M APPROVED O. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-----------|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , , | | CONSTRUCTION | (X3) DATI | E SURVEY PLETED |
| | | 345370 | B. WING | | | 12 | C / 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ST HEALTHCARE & REH | | | 30 | 00 BLAKE BOULEVARD | | |
| FINEHOR | | | | Ρ | 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | facility in October and | d was in training until | F | 756 | DISCUS was completed. All audits v | vill be | |
| | the November 2018. She | e stated that she signed off | | | kept in the DON's office. | | |
| | recommendations too added that she had c | day, 12/19/18. She also completed DISCUS also ad not added the diagnosis | | | The DON will report the findings of a to the Quality Assurance Committee monthly until such time as consistent substantial compliance has been achieved. | | |
| | (DON) was interview she had delegated th address/act upon the recommendations to them to act upon the | | | | Completion Date 01/31/2019 | | |
| | 11/13/18 with diagnos | admitted to the facility on ses that included, cohol dependence with | | | | | |
| | #73' s cognition was other behavioral sym on 1 to 3 days. Resid falls with no injury sin administered antianx | 1/21/18 indicated Resident severely impaired. She had ptoms and rejection of care dent #73 had two or more nce admission. She was iety medication on 5 of 7 chotic medication during the | | | | | |
| | outbursts, crying, and noted with delusions physician was contac needed (PRN) Ativan | 12/6/18 at 9:29 AM 73 continued with behavioral d screaming out. She was and hallucinations. The cted and informed that as n (antianxiety medication) 2 ineffective. A new order was | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345370 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 800 BLAKE BOULEVARD 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | received to start Hald mg every 6 hours PR A physician ' s order of | ol (antipsychotic medication) | F | 756 | | | |
| | hours PRN for agitation December 2018 MAR monitoring and/or sid been added to the Me | on. A review of the | | | | | |
| | administered Haldol | 18 to 12/15/18 she was I mg PRN on the following 12/08/18 (x2), 12/11/18, | | | | | |
| | 12/15/18 completed b indicated Resident #7 for agitation. This DF was to be made for a PRN Haldol as well a monitoring added to t indication the Pharma the need for a diagno | men Review (DRR) dated by the Pharmacy Consultant 73 was receiving PRN Haldol RR noted a recommendation 14 day stop date for the s the need for behavior he MAR. There was no acy Consultant addressed sis related to the PRN e was an adequate clinical | | | | | |
| | conducted on 12/18/1 related to the use of a An interview was con (UM) #2 on 12/19/18 Resident #73 was ad rehabilitation following | #73 's active care plan was 18. There was no care plan antipsychotic medication. ducted with Unit Manager at 2:25 PM. She reported mitted to the facility for g a hospitalization related to ted Resident #73 had | | | | | |

Facility ID: 923403

If continuation sheet Page 56 of 91

| | OF DEFICIENCIES | MEDICAID SERVICES | | LE CONSTRUCTION | | IO. 0938-03 |
|--------------------------|------------------------|---|---------------------|---|------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | | | · · · · | IPLETED |
| | | | | | | С |
| | | 345370 | B. WING | | 12/20/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ST HEALTHCARE & REI | HAR | | 300 BLAKE BOULEVARD | | |
| I INEIION | | | | 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETIO DATE |
| F 756 | Continued From pag | e 56 | F 75 | 6 | | |
| | | ss, and rejection of care | 1.70 | | | |
| | | her rehabilitation. She | | | | |
| | explained that Reside | ent #73 would not stay still | | | | |
| | | UM #2 stated that the PRN | | | | |
| | Haldol was prescribe | - | | | | |
| | | Ativan had previously been on, but it was not consistently | | | | |
| | | led the PRN Haldol had | | | | |
| | | lent #73 and also resulted in | | | | |
| | | ore cooperative. She stated | | | | |
| | that according to her | primary care physician, | | | | |
| | - | psychiatric diagnosis prior to | | | | |
| | her admission to the | facility was depression. | | | | |
| | An interview was cor | nducted with Resident #73 ' s | | | | |
| | | 8 at 9:15 AM. He stated he | | | | |
| | | ector at the facility as well as | | | | |
| | | an for Resident #73. The gave the order for PRN | | | | |
| | | ned him and said the PRN | | | | |
| | - | ng and they had not known | | | | |
| | | ained that the PRN Ativan | | | | |
| | | cribed for Resident #73 to | | | | |
| | | of hollering out and being | | | | |
| | physically combative | with staff. | | | | |
| | An interview was cor | nducted with the Pharmacy | | | | |
| | | on 12/19/18 at 4:00 PM. | | | | |
| | The monthly drug reg | gimen review for Resident | | | | |
| | | laldol prescribed for agitation | | | | |
| | | e Pharmacy Consultant. He | | | | |
| | | ot requested for the physician g diagnosis on this initial | | | | |
| | | aldol as he expected it to be | | | | |
| | | on a short-term basis related | | | | |
| | - | djustment to the facility. He | | | | |
| | | #73 was still on the Haldol at | | | | |
| | | eview he would have asked | | | | |
| | for a specific diagnos | sis as there may have been | 1 | | | |

If continuation sheet Page 57 of 91

| | - | D HUMAN SERVICES | | | | FORM | M APPROVED |
|--------------------------|---|---|--------------------|-------|---|-----------|----------------------------|
| | S FOR MEDICARE & I | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TIPLE | E CONSTRUCTION | (X3) DATE | D. 0938-0391 SURVEY |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
| | | 345370 | B. WING | | | | C /20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 800 BLAKE BOULEVARD 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 756 F 758 SS=E | an underlying reason Pharmacy Consultant requested behavior m MAR for the use of the An interview was come Nursing (DON) on 12, stated she expected a adequate clinical indic additionally indicated appropriate clinical indi- Haldol. The DON sta Pharmacy Consultant use of an antipsychot without an adequate of Free from Unnec Psy CFR(s): 483.45(c)(3)(§483.45(c)(3) A psych affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe- resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication | for her agitation. The stated that he had ponitoring be added to the e PRN Haldol. ducted with the Director of (20/18 at 10:15 AM. She all antipsychotics to have an cation for use. She that agitation was not an dication for the use of PRN ted that she expected the to identify and address the ic medication prescribed clinical indication for use. chotropic Meds/PRN Use e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following | | 756 | | | 1/31/19 |

Event ID: KEWC11

Facility ID: 923403

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| | | | | PRINTED: 02/06/20 FORM APPROV OMB NO. 0938-03 |
|--|--|--|--|---|
| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | (X3) DATE SURVEY COMPLETED |
| | 345370 | B. WING _ | | C 12/20/2018 |
| ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF | P CODE |
| | | | 300 BLAKE BOULEVARD | |
| ST HEALTHCARE & REF | 148 | | PINEHURST, NC 28374 | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE COMPLETIC O THE APPROPRIATE DATE |
| §483.45(e)(2) Reside drugs receive gradua behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medication diagnosed specific co in the clinical record; §483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PF beyond 14 days, he of rationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev interviews with the pf consultant, and staff, adequate clinical india antipsychotic (Reside assess a resident wh medication for extrap | ents who use psychotropic I dose reductions, and ons, unless clinically h effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a ondition that is documented and rders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced iew, observations, and hysician, pharmacy the facility failed to have an cation for the use of an tion and to monitor the verse consequences of the ent #73) and also failed to o was on an antipsychotic yramidal symptoms (EPS), a | F7 | Based on record review, and interviews with the p pharmacy consultant, an failed to have an adequa indication for the use of a medication and to monito effectiveness and advers of the antipsychotic (resid also failed to assess resi | , observations, hysician, d staff, the facility te clinical an antipsychotic or the se consequences dent #73) and dent who was on |
| | S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ST HEALTHCARE & REF SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page §483.45(e)(2) Reside drugs receive gradua behavioral interventic contraindicated, in ar drugs; §483.45(e)(3) Reside psychotropic drugs p unless that medicatic diagnosed specific cc in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he c rationale in the reside indicate the duration §483.45(e)(5) PRN o drugs are limited to 1 renewed unless the a prescribing practition the appropriateness o This REQUIREMENT by: Based on record rev interviews with the pf consultant, and staff, adequate clinical indi antipsychotic (Reside assess a resident wh medication for extrap | FORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345370 ROVIDER OR SUPPLIER ST HEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced | SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A . BUILDI 345370 ROVIDER OR SUPPLIER 345370 B. WING_ ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIC TAG Continued From page 58 \$483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; F 1 2 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and F 1 2 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. \$483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the physician, pharmacy consultant, and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication and to monitor the effectiveness and adverse consequences of the antipsychotic medication for | SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZII 300 BLAKE BOULEVARD PINEHURST, NC 28374 STREET ADDRESS, CITY, STATE, ZII 300 BLAKE BOULEVARD PINEHURST, NC 28374 ST HEALTHCARE & REHAB STREET ADDRESS, CITY, STATE, ZII 300 BLAKE BOULEVARD PINEHURST, NC 28374 Continued From page 58 \$483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; F 758 \$483.45(e)(2) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and F 758 \$483.45(e)(2) Residents do not receive psychotropic drugs and cannot be renewed unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beycond 14 days, he or she should document their rationale in the resident for the PRN order. \$483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by; Based on record review, and interviews with the physician, pharmacy consultant, and staff, the facility failed to have an andequate clinical indication for the use of an antepsychotic (Resident #73) and also failed to assess a resident who was on an antipsychotic ef |

Facility ID: 923403

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| | | ND HUMAN SERVICES | | | PRINTED: 02/06/2 FORM APPRO OMB NO. 0938-03 | |
|--------------------------|--|---|---------------------|---|---|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345370 | B. WING | | C 12/20/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | 300 BLAKE BOULEVARD 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETI | |
| F 758 | Continued From page | e 59 | F 758 | 3 | | |
| | medications. | | | induced movement disorder (#40) for 2 of 5 residents revie | | |
| | The findings included | i: | | unnecessary medications. | | |
| | 1. Resident #73 was admitted to the facility on 11/13/18 with diagnoses that included, disorientation, and alcohol dependence with withdrawal. | | | The medication regimen for R was reviewed by the physicial 12/18/2018. The antipsychotic prescribed as needed for agit discontinued on 12/18/2018. | n on ic medication | |
| | 11/14/18, included, in areas: - The risk for side efference medication use. This 11/14/18 and the interence and observe resident - Impaired thought pro- crying out. This prob- 11/14/18 and the interence 11/14/18 and the | s problem was initiated on reventions included, in part, esident 's target behaviors for adverse side effects. occesses with episodes of lem was initiated on reventions included, in part, | | The Dyskinesia Identification Condensed User Scale (DISC Resident #40 completed, sign closed on 12/18/2018 by the 7 Director of Nursing. The facility has determined th residents receiving medication admissions are at risk. | CUS) for hed and Assistant hat all ns and new | |
| | manner and monitor behaviors with any ch reported to the physic | | | All Medication Administration (MAR) were reviewed for psyc medications to ensure that be monitoring was being complet resident receiving psychotrop | chotropic havior ted for any ic | |
| | #73 ' s cognition was other behavioral sym on 1 to 3 days. Resid | In Data Set (MDS) I/21/18 indicated Resident severely impaired. She had ptoms and rejection of care dent #73 had two or more nce admission. She was | | medications on 1/17/2019 by Supervisor. All resident's recomposition psychotropic medications hav monitoring in place on Medica Administration Records. Care all residents on antipsychotic | eiving re behavior ation e Plans for | |
| | administered antianx days and no antipsyc MDS look back perio | iety medication on 5 of 7 shotic medication during the d. | | were reviewed to ensure that appropriate care plan was in p 1/18/2019 by the Nursing Mar Team. All residents receiving | an place on nagement | |
| | 11/21/18 MDS indica | elated to Resident #73 ' s ted she had problems with | | psychotropic medication had appropriate care plan in place | 3. | |
| | delirium as noted in h | nospital notes and nursing | | All Resident's charts were aud | | |

Facility ID: 923403

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| | | MEDICAID SERVICES | | | | NO. 0938-039 |
|--------------------------|--|---|---------------------|--|---|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | IPLE CONSTRUCTION | · · · | TE SURVEY MPLETED |
| | | 345370 | B. WING | | | C 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | 2/20/2010 |
| | | | | 300 BLAKE BOULEVARD | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | PINEHURST, 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 O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 758 | Continued From page | e 60 | F 7 | 758 | | |
| | 1.0 | She was indicated to be | | ensure that current DISCI 1/18/19 by the clinical nur Resident's had current DI | se. All | |
| | 11/21/18 MDS indica confusion and agitati as unable to understa facility and she wante packed up her belong out of the wall. She evaluation and return day. The nursing not refused to have vital as some exercises in A nursing note dated indicated Resident # outbursts, crying, and noted with delusions physician was contao needed (PRN) Ativar milligrams (mg) was received to start Halo mg every 6 hours PR | signs taken at times as well therapy. 12/6/18 at 9:29 AM 73 continued with behavioral d screaming out. She was and hallucinations. The cted and informed that as n (antianxiety medication) 2 ineffective. A new order was dol (antipsychotic medication) RN. | | The Pharmacy Consultan by the Corporate Director Services on 1/12/2019 ab the use of an antipsychoti prescribed without an ade indication for use. All licensed nurses includ time and weekend were in completing DISCUS on ac quarterly by the Corporate Clinical Services on 1/23/ in-serviced prior to workin The Director of Nursing (I licensed staff member, wi audits with an audit tool o psychotropic medications behavior monitoring is att MAR and DISCUS are co new admissions during da | t was in-serviced of Clinical out addressing ic medication equate clinical ing all shifts, part n-serviced on dmission and e Director of 2019. All were ng the floor. DON), or ill complete f all new to ensure that ached to the impleted for all aily clinical | |
| | #73 indicated Haldol hours PRN for agitati December 2018 MAF monitoring had not be Administration Recor PRN Haldol order. Review of Resident # revealed from 12/06/ administered Haldol dates: 12/07/18 (x3), 12/12/18, 12/13/18 a | | | meeting 5x (five) times we weeks. Care plans for real antipsychotic medication 5x (five) weekly for six (6) ensure that appropriate care place. All audits will be ke office. The DON will report the fi audits to the Quality Assu Committee monthly until s consistent substantial core been met. | sidents on will be reviewed o weeks to are plan is in ept in the DON's ndings of the rance such time as | |

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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: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345370 | B. WING | | C 12/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | |
| PINEHUR | ST HEALTHCARE & REF | IAB | | 300 BLAKE BOULEVARD 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BECOMPLETIONIE APPROPRIATEDATE |
| F 758 | Continued From page | e 61 | F 75 | 8 | |
| | | and monthly pharmacy drug ding the administration of | | Completion Date 01/31/2019 | 9 |
| | administered PRN Ha Ativan 2 mg IM. A nu 3:03 AM, written by N #73, "had multiple be Began to hit at staff w called staff names f | AM Resident #73 was aldol 1 mg PO and PRN rsing note dated 12/7/18 at lurse #8, indicated Resident havioral issues this shift. while being helped to stand for no apparent reason. make her happy or please | | | |
| | administered PRN Ha | AM Resident #73 was aldol 1 mg PO. There was entation to indicate the dol was administered. | | | |
| | by Nurse #9, specifie administered PRN Ha agitation with effectiv | PM a nursing note, written d Resident #73 was aldol 1 mg PO for increased e results. Resident #73 was bed with her eyes closed. | | | |
| | administered PRN Hand the second s | PM Resident #73 was aldol 1 mg PO. There was entation to indicate the dol was administered. | | | |
| | was administered PR 12/8/18 at 8:16 PM. 1 | PM Resident #73 ' s medical N Haldol 1 mg PO on There was no behavioral icate the reason this PRN ered. | | | |
| | administered PRN Ha | PM Resident #73 was aldol 1 mg PO and PRN rsing note dated 12/12/18 at | | | |

Facility ID: 923403

If continuation sheet Page 62 of 91

| | - | 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 |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 758 | 2:56 AM, written by N #73 was agitated, cry to be consoled. She and she walked herse Resident #73 was not anxiety and was put t On 12/12/18 at 4:22 F administered PRN Ha Ativan 2 mg IM. A nu 6:33 PM, written by N #73 had intermittent of day. She was noted fo of time and then without of very tearful, agitated, care. Redirection wa administered PRN Ha medication pass with with agitation and war rooms and trying to g take their chairs. Res medicated with PRN / effective within the ho On 12/13/18 at 3:30 F administered PRN Ha note dated 12/13/18 at #2, indicated Resider tearfulness and she w Haldol. She was noted for a gitation. This DF was to be made for a PRN Haldol as well a | urse #8, indicated Resident ing loudly, and was unable was noted to be restless elf into her bathroom. ted to be medicated for o bed. PM Resident #73 was addol 1 mg PO and PRN rsing note dated 12/12/18 at urse #2, indicated Resident confusion throughout the to be cooperative for periods out provocation becoming yelling out, and resistant to s ineffective. She was addol during the afternoon little effect. She continued s going into other resident ive them her wheelchair and sident #73 was then Ativan 2 mg IM which was our. PM Resident #73 was addol 1 mg PO. A nursing at 8:14 PM, written by Nurse it #73 had one episode of vas medicated with PRN | F | 758 | | | |

Facility ID: 923403

If continuation sheet Page 63 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | <u>.</u> | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD PINEHURST, 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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 758 | indication the Pharma addressing the need PRN Haldol to ensure clinical indication for to On 12/17/18 at 12:48 Resident #73 was ad PO. There was no be indicate the reason the were administered. A 12/17/18 at 7:39 PM, indicated Resident #7 cooperative and appri- have one short period able to regain her cor A review of Resident conducted on 12/18/1 related to the use of a Resident #73 was ob PM. She was lying in book. There were no An interview was con 12/20/18 at 9:40 AM. with Resident #73 an admission to the facil received orders for P well as PRN Haldol P PRN Ativan was utiliz episodes of agitation, and resistance to car PRN Haldol was adm She stated it was use by psychotic symptor these psychotic symptor | acy Consultant was for a diagnosis related to the e there was an adequate use. AM, 3:08 PM and 8:34 PM ministered PRN Haldol 1mg ehavioral documentation to bese doses of PRN Haldol A nursing note dated written by Nurse #2, 73 was much more opriate. She was noted to d of tearfulness and she was mposure. #73 's active care plan was 18. There was no care plan antipsychotic medication. served on 12/19/18 at 3:00 bed her room reading a behavioral issues noted. ducted with Nurse #2 on She stated she was familiar d was aware that since her ity Resident #73 had RN Ativan PO and IM as PO. She reported that the ted for Resident #73 's tearfulness, exit seeing, e. Nurse #2 was asked why inistered to Resident #73. ed for agitation accompanied ns. She explained that borms included the false | F | 758 | | | |
| | by psychotic symptor these psychotic symp beliefs that she was g | ns. She explained that | | | | | |

Facility ID: 923403

If continuation sheet Page 64 of 91

| - | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 2: 02/06/2019 APPROVED 0: 0938-0391 |
|---|--|---|---------------------|---------------------------------|---|-------------------|---|
| STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION | ES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345370 | B. WING | | | (12/2 | ; 20/2018 |
| NAME OF PROVIDER OR S | UPPLIER | | | STREET ADDRESS, CITY, STAT | E, ZIP CODE | | |
| | | | | 300 BLAKE BOULEVARD | | | |
| PINEHURST HEALTHO | CARE & REH | AB | 1 | PINEHURST, NC 28374 | | | |
| PREFIX (EAC | CH DEFICIENC | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| Resident # symptoms therapy as several fail of bed una calmed Re She was a implement Haldol for intervention consoling, a glass of Nurse #2 w behavior m related to f PRN Haldo documente She was u included b monitoring An interviet (UM) #2 of Resident # rehabilitati a fracture. agitation, r which was explained and let her Haldol was explained effective. helped to of the resident # | were impa s well as car is due to re- assisted. Si esident #73 isked what red prior to Resident #7 ins included increased wine as orco- was asked wine increased wine as orco- was asked wine as local ed on the M inable to re- ehavior mo- related to related to set was con- n 12/19/18 #73 was add on following She indica restlessness affecting h that Reside rself rest. Us prescribed that PRN A I for agitatic She revealed calm Reside that being mo- ding to her #73 's only | 64 tion and psychotic cting her participation in using the resident to have peated attempts to get out he revealed the PRN Haldol and made her less restless. type of interventions were the administration of PRN 73. She indicated the redirection, verbal monitoring, and offering her lered by the physician. where documentation of nd side effect monitoring tration of Resident #73 's ted. She indicated it was AR or in the nursing notes. call if Resident #73 's MAR nitoring and side effect the PRN Haldol. ducted with Unit Manager at 2:25 PM. She reported mitted to the facility for g a hospitalization related to ted Resident #73 had a, and rejection of care er rehabilitation. She nt #73 would not stay still JM #2 stated that the PRN d for agitation. She nt #73 and also resulted in re cooperative. She stated primary care physician, psychiatric diagnosis prior to acility was depression. | F 758 | | | | |

Facility ID: 923403

If continuation sheet Page 65 of 91

| | - | 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 | |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 300 BLAKE BOULEVARD | | |
| PINEHUK | ST HEALTHCARE & REH | AB | | F | PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 758 | Continued From page | e 65 ducted with Resident #73 ' s | F | 758 | | | |
| | was the Medical Direct the attending physicial | 3 at 9:15 AM. He stated he ctor at the facility as well as an for Resident #73. The ave the order for PRN | | | | | |
| | | ned him and said the PRN | | | | | |
| | what to do. He expla was previously presci | ig and they had not known ined that the PRN Ativan ribed for Resident #73 to f hollering out and being with staff. | | | | | |
| | Consultant by phone The monthly drug reg #73 related to PRN H was reviewed with the | ducted with the Pharmacy on 12/19/18 at 4:00 PM. imen review for Resident aldol prescribed for agitation e Pharmacy Consultant. He t requested for the physician | | | | | |
| | to provide a qualifying review of the PRN Ha | g diagnosis on this initial Idol as he expected it to be n a short-term basis related | | | | | |
| | to Resident #73 's ac indicated if Resident a the time of his next re | ljustment to the facility. He #73 was still on the Haldol at wiew he would have asked | | | | | |
| | an underlying reason Pharmacy Consultant | nonitoring be added to the | | | | | |
| | Nursing (DON) on 12 stated she expected a adequate clinical india additionally indicated | ducted with the Director of /20/18 at 10:15 AM. She all antipsychotics to have an cation for use. She that agitation was not an dication for the use of PRN | | | | | |
| | | admitted to the facility on | | | | | |

Facility ID: 923403

If continuation sheet Page 66 of 91

| | - | 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 |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u>.</u> | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 758 | 10/5/18 with multiple dementia. The admiss (MDS) assessment di Resident #40 had me problems. The assess Resident #40 had recomedication for 7 days period. Resident #40 had a p 10/5/18 for Risperdal milligrams (mgs) by m Resident #40's care p reviewed. One of the Resident #40 was at anti-anxiety and anti- The goal was Reside effects from medication review. The approact (dyskinesia identificat scale) per policy. Review of Resident # including electronic re DISCUS was not com admission. On 12/18/18 at 11:20 was interviewed. UM policy for completing admission and then q she was responsible on anti-psychotic medic completed by the admit that DISCUS was not #40. She indicated th | diagnoses including ssion Minimum Data Set ated 10/12/18 indicated that mory and decision making ssment further indicated that reived an anti-psychotic during the assessment hysician's order dated (an anti-psychotic drug) 1 nouth twice a day. blan dated 10/5/18 was care plan problems was risk for negative effects from psychotic medications use. Int #40 will have no negative ons use through the next hes included DISCUS ion system condensed user 40's medical records ecords revealed that spleted to assess for EPS on AM, Unit Manager (UM) #1 #1 stated that the facility's the DISCUS was on uarterly. She indicated that for ensuring that residents | F | 758 | 3 | | |

If continuation sheet Page 67 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|--|---------------------|------|---|-------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | DNSTRUCTION | (X3) DATE COMP | |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | BLAKE BOULEVARD 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 758 | Continued From page | 9 67 | F 7 | 758 | | | |
| | | | | | | | |
| | (DON) was interviewe she expected residen | ISCUS completed within 3 | | | | | |
| F 761 SS=D | Label/Store Drugs an CFR(s): 483.45(g)(h)(| | F 7 | '61 | | | 1/31/19 |
| | Drugs and biologicals | y and cautionary | | | | | |
| | §483.45(h) Storage o | f Drugs and Biologicals | | | | | |
| | Federal laws, the faci biologicals in locked of | rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. | | | | | |
| | locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut | cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can | | | | | |

Facility ID: 923403

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOF | ED: 02/06/2019 RM APPROVED O. 0938-0391 |
|--------------------------|--|--|---------------------|---|---|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | E SURVEY IPLETED |
| | | 345370 | B. WING | | 1: | C 2/20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 300 BLAKE BOULEVARD 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 761 | by: Based on observation facility failed to discar and failed to date whe (400 even/600 hall ca carts reviewed for me The findings included A review of the facility Medication Administr and dated January 20 opened insulin pens of date opened. Once of be used within the nut the product stability in for that product. On 12/19/18 at 4:30 f medication cart for 40 conducted with Nurse included: *Humalog Kwik I was opened and und *Basaglar Kwik I was opened and und *Humalog Kwik I was opened and und *Novolog Insulin | ⁷ is not met as evidenced Ins and staff interviews, the rd two expired insulin pensen opened three insulin pensen opened three insulin pensent) for 1 of 2 medication edication storage. I: y policy titled Injectable ation: Insulin Pen Delivery 017, read in part that all should be labeled with the pened the insulin pen must unber of days specified in information of manufacturer PM, an observation of the 20 even/600 halls was e #1. Items discovered nsulin Pen for Resident #236 ated. nsulin Pen for Resident #8 ated. nsulin Pen for Resident #135 | F 761 | | discard two to date pens edication storage. bired and 2/19/18 by ens were of the date Carts were 2/19/18 by cal Services rts were d dated at all e the Services g all shifts, ssing the medication | |
| | Pen. *Humalog Kwik I dated opened on 11/ ⁷ | ter 28 days on the Insulin nsulin Pen for Resident #55 15/18. /19/18 at 4:30 PM, Nurse #1 | | Clinical Supervisors will inspect medication carts daily using ar for two (2) weeks then weekly month for medication containe appropriate dating on an on-go The Director of Nursing will pre- | n audit tool for one (1) rs to ensure bing basis. | |

Event ID: KEWC11

Facility ID: 923403

If continuation sheet Page 69 of 91

| ATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | NO. 0938-03 TE SURVEY MPLETED |
|--------------------------|---|--|---------------------|---|----------|-------------------------------------|
| | | 345370 | B. WING | | 1 | C 2/20/2018 |
| IAME OF PI | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP CODE | · · · | |
| | | | | 300 BLAKE BOULEVARD | | |
| INERUK | ST HEALTHCARE & RE | | | PINEHURST, NC 28374 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIC DATE |
| F 761 | Continued From pa | | F 76 | | | |
| | were expired and o | 't noticed the medications r not dated. He was unable to ns had not been dated when | | findings of the audits to the QAA Committee monthly until consis substantial compliance is met. | | |
| | opened. | AM, an interview was | | Completion Date 01/31/2019 | | |
| | conducted with Nur Clinical Coordinator weekly for expired a | se #2 who stated that the checked the medication carts and undated medications, but uld also be checking for | | | | |
| | Director of Nursing expectation for all in | on 12/20/18 at 8:00 AM, the stated that it was her isulins to be dated when insulins to be discarded by them. | | | | |
| | Pharmacist stated t medication carts in just completed an a he lets the facility ke expired medications He stated that the of Humalog, Basaglar days after they were stated that it was hi insulin to be discard | 2/20/18 at 9:10 AM, the hat he audits all the the facility quarterly and had udit 10/30/18. He stated that now of his findings to include and undated medications. liscard recommendations for and Novolog insulins was 28 e opened. The Pharmacist s expectation for expired led and replaced when found be dated when opened. | | | | |
| F 791 SS=G | Routine/Emergency CFR(s): 483.55(b)(| v Dental Srvcs in NFs 1)-(5) | F 79 [.] | 1 | | 1/25/19 |
| | - | vices sist residents in obtaining · emergency dental care. | | | | |
| | §483.55(b) Nursing | | | | | |

Facility ID: 923403

If continuation sheet Page 70 of 91

| CENTERS FOR I | | ND HUMAN SERVICES MEDICAID SERVICES | | | FC | TED: 02/06/2019 DRM APPROVED NO. 0938-0391 |
|---|---|---|---------------------|--|------------------------------|--|
| STATEMENT OF DEFICIE AND PLAN OF CORRECT | NCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION G | (X3) D. | ATE SURVEY DMPLETED |
| | | 345370 | B. WING | | | C 12/20/2018 |
| NAME OF PROVIDER (| OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | |
| PINEHURST HEAL | THCARE & REH | ΙΔB | | 300 BLAKE BOULEVARD | | |
| TINEHONOTTIERE | | | | PINEHURST, NC 28374 | | |
| | EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 791 Continu The fac | ued From page sility- | e 70 | F 7 | 91 | | |
| outside of this j the nee (i) Rou under t (ii) Eme §483.5 assist t (i) In m (ii) By a dental §483.5 resider dental 3 days what th and dri service led to t §483.5 circums denture charge denture policy t §483.5 | resource, in a bart, the follow eds of each res- tine dental ser he State plan) ergency dental 5(b)(2) Must, in he resident- aking appointra- arranging for tr services location 5(b)(3) Must p its with lost or services. If a re- the facility mu- ey did to ensu- nk adequately s and the exter- ne delay; 5(b)(4) Must h stances when es is the facility a resident for es determined o be the facility 5(b)(5) Must a and wish to p rsement of der l expense und EQUIREMENT | vices (to the extent covered ; and I services; f necessary or if requested, ments; and ransportation to and from the ons; romptly, within 3 days, refer damaged dentures for eferral does not occur within ust provide documentation of ure the resident could still eat while awaiting dental enuating circumstances that ave a policy identifying those the loss or damage of y's responsibility and may not the loss or damage of in accordance with facility y's responsibility; and ssist residents who are articipate to apply for ntal services as an incurred ler the State plan. T is not met as evidenced | | | | |
| | on observatio | ns, staff and Physician | | Based on observations, staf | fand | |

Facility ID: 923403

If continuation sheet Page 71 of 91

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | <u>10. 0938-03</u> |
|--------------------------|------------------------|---|---------------------|--|--------------------------------|---------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | PLE CONSTRUCTION | · · · | TE SURVEY MPLETED |
| | | 0.45050 | | | | С |
| | | 345370 | B. WING | | | 2/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CC | DDE | |
| PINEHUR | ST HEALTHCARE & RE | HAB | | 300 BLAKE BOULEVARD 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETIO DATE |
| F 791 | Continued From pag | e 71 | F 79 | 91 | | |
| | | y failed to provide dental | | Physician interviews, the fac | cility failed to | |
| | | nt with expressed tooth pain | | provide dental services for a | | |
| | | of 1 residents reviewed to | | expressed tooth pain for 1 (| | |
| | dental care. The find | | | of 1 residents reviewed for c | , | |
| | | dmitted on 3/15/18 with | | Resident #10 was seen by t | | |
| | - | s of chronic respiratory | | Dentist on 1/8/2019 who ma | | |
| | failure, cerebral vasc | cular accident and dysphagia. | | to an Oral Surgeon which w 1/29/19 by the Social Worke | | |
| | Review of a nursing | note dated 5/1/18 read | | - | | |
| | Resident #10 was e> | periencing tooth pain. He | | The facility has determined | that most | |
| | was seen by the Mee | dical Director with new orders | | residents have the potential | to be | |
| | • | al topical pain reliever), and | | affected. The in-house Den | | |
| | | sident #10 to see the dentist | | visits to residents on 1/8/20 | | |
| | | the antibiotics. The note read | | residents were seen on this | | |
| | #10 to see the in-hou | ty (RP) preferred Resident | | is a list of the residents seer Director of Nursing (DON)'s | | |
| | | ise dentist. | | 26 residents seen on this da | | |
| | Review of a History | and Physical Examination | | residents were noted toned | • | |
| | | edical Director dated 5/1/18 | | referrals to the oral Surgeon | | |
| | read Resident #10 w | | | referrals were made on 1/29 | | |
| | toothache to the righ | | | Social Worker. | | |
| | | ibed for 10 days for a | | | | |
| | - | abscess, the application of | | The Social Worker and Lice | nsed Nurses | |
| | | and for him to be put on the | | on all shifts including weeke | ends and part | |
| | | dentist as soon as possible. | | time staff were in-serviced of | | |
| | | | | importance of assisting resid | dents in | |
| | | al record revealed Physician | | obtaining routine and 24-ho | | |
| | | that read as follows: Anbesol | | dental care by the Corporate | | |
| | | Sel-Apply to painful tooth | | Clinical Services on 01/23/1 | | |
| | three times a day, Pe | | | in-serviced prior to working | their | |
| | | ing tube every 6 hours for 10 | | scheduled shift. | | |
| | | /18 for painful tooth, Next | | The Social Merker will cond | luct a monthly | |
| | | gency Dental Clinic for an | | The Social Worker will cond | • | |
| | Appointment due to | | | audit using an audit tool of a referrals for 1 year to ensure | | |
| | Review of a care pla | n dated 5/2/18 read Resident | | being seen by the dentist as | | |
| | - | g tooth pain. Interventions | | Audits will be kept in the DC | | |
| | | s as ordered, antibiotics as | | | | |

Event ID: KEWC11

Facility ID: 923403

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| ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER: | | () - | CONSTRUCTION | (X3) DATE SURVEY | | |
|---|--|---|--|--|--|--|
| | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | | |
| | 345370 | B. WING | | C | | |
| IDER OR SUPPLIER | 545570 | | TREET ADDRESS, CITY, STATE, ZIP CODE | 12/20/2018 | | |
| | AB | 3 | 00 BLAKE BOULEVARD | | | |
| (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLET | | |
| dered, dental service oplication of an ice p an was documented to was in the hospita 14/18. Review of the vealed the facility D 14/18. Resident#10 sidents to be seen the e Dental Notes-Sun eview of the Dental e facility Dental Hyg 4/18. Resident#10 v sidents to be seen the e Dental Notes-Sun as not in the hospita ygienist visit. eview of the medica 10 was in the hospita 29/18. Review of the vealed the facility D 27/18. Resident#10 sidents to be seen the e Dental Notes-Sun ould have been una ospitalization. | tes as ordered and for the back as ordered. The care d as resolved on 11/28/18. I record revealed Resident al from 5/9/18 through e Dental Notes-Summary entist visited the facility on was not of the list of by the in-house Dentist on mary dated 5/14/18. Notes-Summary revealed gienist visited the facility on was not of the list of by the Dental Hygienist on mary dated 6/4/18 and he al at the time of the Dental I record revealed Resident al from 6/26/18 through e Dental Notes-Summary entist visited the facility on was not of the list of by the in-house Dentist on mary dated 6/27/18 but vailable due to note dated 7/13/18 read es to have dental pain. An | F 791 | The Social Worker will report the f of the audit to the Quality Assuran Committee monthly meetings until consistent substantial compliance been achieved. Completion Date 01/25/2019 | ce | | |
| | SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Dentinued From page dered, dental service oplication of an ice p an was documented eview of the medica 0 was in the hospit 14/18. Review of the vealed the facility D 14/18. Resident#10 sidents to be seen the e Dental Notes-Sun eview of the Dental e facility Dental Hyg 4/18. Resident#10 v sidents to be seen the e Dental Notes-Sun as not in the hospital ygienist visit. eview of the medica 0 was in the hospital 29/18. Review of the vealed the facility D 27/18. Resident#10 sidents to be seen the e Dental Notes-Sun as not in the hospital 29/18. Review of the vealed the facility D 27/18. Resident#10 sidents to be seen the e Dental Notes-Sun build have been una ospitalization. | IDER OR SUPPLIER TEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dontinued From page 72 dered, dental services as ordered and for the oplication of an ice pack as ordered. The care an was documented as resolved on 11/28/18. Eview of the medical record revealed Resident 0 was in the hospital from 5/9/18 through 14/18. Review of the Dental Notes-Summary vealed the facility Dentist visited the facility on 14/18. Resident#10 was not of the list of sidents to be seen by the in-house Dentist on the Dental Notes-Summary revealed the facility Dental Hygienist visited the facility on 4/18. Resident#10 was not of the list of sidents to be seen by the Dental Hygienist on the Dental Notes-Summary dated 6/4/18 and he as not in the hospital at the time of the Dental vgienist visit. Eview of the medical record revealed Resident 0 was in the hospital from 6/26/18 through 29/18. Review of the Dental Notes-Summary vealed the facility Dentist visited the facility on 27/18. Resident#10 was not of the list of sidents to be seen by the in-house Dentist on the Dental Notes-Summary dated 6/27/18 but but but have been unavailable due to | IDER OR SUPPLIER IDER OR SUPPLIER #EALTHCARE & REHAB ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID pontinued From page 72 F 791 dered, dental services as ordered and for the oplication of an ice pack as ordered. The care an was documented as resolved on 11/28/18. F 791 eview of the medical record revealed Resident 0 was in the hospital from 5/9/18 through 14/18. Review of the Dental Notes-Summary vealed the facility Dentist visited the facility on 14/18. Resident#10 was not of the list of sidents to be seen by the in-house Dentist on e Dental Notes-Summary dated 5/14/18. eview of the Dental Notes-Summary revealed e facility Dental Hygienist visited the facility on 4/18. Resident#10 was not of the list of sidents to be seen by the Dental Hygienist on e Dental Notes-Summary dated 6/4/18 and he as not in the hospital at the time of the Dental vigenist visit. eview of the medical record revealed Resident 0 was in the hospital from 6/26/18 through 29/18. Review of the Dental Notes-Summary vealed the facility Dentist visited the facility on 27/18. Resident#10 was not of the list of sidents to be seen by the in-house Dentist on e Dental Notes-Summary dated 6/27/18 but ould have been unavailable due to sepitalization. eview of a nursing note dated 7/13/18 read esident #10 continues to have dental pain. An der already in place for Anbesol. New order for a packs as needed. | IDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IEALTHCARE & REHAB ID ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ICAL OF THE STATE ST | | |

Facility ID: 923403

If continuation sheet Page 73 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 02/06/2019 APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|--|--|-------------------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 345370 | B. WING | | _ | | C 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | ATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | 300 BLAKE BOULEVARD 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 CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 791 | Continued From page minutes. | 273 | F 79 | 1 | | | |
| | Review of the medica documentation related to present. | l record revealed no d to tooth pain after 7/13/18 | | | | | |
| | the facility Dentist visit Resident#10 was not seen by the in-house Notes-Summary date | Notes-Summary revealed ted the facility on 8/20/18. of the list of residents to be Dentist on the Dental d 8/20/18 and he was not in e of the in-house Dentist | | | | | |
| | the facility Dentist visit Resident#10 was not seen by the in-house Notes-Summary date | Notes-Summary revealed ted the facility on 9/5/18. of the list of residents to be Dentist on the Dental d 9/5/18 and he was not in e of the in-house Dentist | | | | | |
| | Data Set (MDS) dated cognitive impairment, assistance with all of | 10's quarterly Minimum d 9/25/18 indicated severe no behaviors and total his activities of daily living. r experiencing mouth pain. | | | | | |
| | the facility Dental Hyg 10/22/18. Resident#1 residents to be seen b Hygienist on the Dent 10/22/18 and he was | Notes-Summary revealed gienist visited the facility on 0 was not of the list of by the in-house Dental al Notes-Summary dated not in the hospital at the Dental Hygienist visited the | | | | | |
| | | Notes-Summary revealed ted the facility on 11/19/18. | | | | | |

If continuation sheet Page 74 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMF | E SURVEY PLETED |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | | 300 BLAKE BOULEVARD 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 APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 791 | Resident#10 was not seen by the in-house Notes-Summary date in the hospital at the to visited the facility. Review of the Dental the facility Dentist visi Resident#10 was not seen by the in-house Notes-Summary date in the hospital at the to visited the facility. In an interview on 12/ stated Resident #10 f ache that she could re facility had in-house of In an interview on 12/ Worker (SW) stated if the in-house dentist of months and there had providers. The SW co responsible to updatin seen by the in-house facility. She stated Re hospital when the der May. The SW stated se informing her to place be seen by the in-house facility when she was r #10 was experiencing that time, she contact Responsible Party (R | of the list of residents to be Dentist on the Dental d 11/19/18 and he was not ime of the in-house Dentist Notes-Summary revealed ited the facility on 11/30/18. of the list of residents to be Dentist on the Dental d 11/30/18 and he was not ime of the in-house Dentist 18/18 at 3:10 PM, Nurse #4 had expressed any tooth ecall. She confirmed the dental services. (19/18 at 8:25 AM, the Social t was her understanding that ame to the facility every 6 d been a change in dental onfirmed she was ng the list of residents to be dentist on each visit to the esident #10 was likely in the hist came to the facility in she did not recall anyone e Resident #10 on the list to use Dentist. (19/18 at 11:02 AM, Unit he wrote the orders in May made aware that Resident g tooth pain. She stated at | F | 791 | | | |

Facility ID: 923403

If continuation sheet Page 75 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD 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 791 | out of the facility. The Resident #10 out to the rather opted to have P next scheduled visit of Manager #1 stated it she spoke with the SV Resident #10 to the d next scheduled visit in the hospital at the time 2018, he would have Dental visit in June 20 In an observation on Resident #10 was lyin was not experiencing but refused visualizat mouth odor detected. In an interview on 12/ Assistant (NA) #4 state always cooperative w In an interview on 12/ stated she was not ave experiencing tooth par report it to Unit Manage In an interview on 12/ Nurse stated she reserved plan on 11/28/18 beca any recent complaints Anbesol order was dis stated she spoke to F 2018 and he expression not required the use of 2018. In an interview on 12/ | RP refused to send ne emergency Dentist but Resident #10 seem on the of the in-house Dentist. Unit was at the time, she thought <i>N</i> and asked her to add ental list to be seen at the n May 2018 and if he was in e of the Dentist visit in May been added to the next 018. 12/19/18 at 8:20 AM, ng in bed. He confirmed he any tooth pain at present ion. There was no noted (19/18 at 3:00 PM, Nursing ted Resident #10 was not ith his oral care. (20/18 at 9:00 AM, Nurse #3 ware that Resident #10 was in but if he was, she would | F | 791 | | | |

If continuation sheet Page 76 of 91

| | OF DEFICIENCIES | MEDICAID SERVICES | | | OMB NO. 0938-03 (X3) DATE SURVEY | |
|------------------------------|--|---|---------------------|---|-------------------------------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | · , | | COMPLETED | |
| | | | | | С | |
| | | 345370 | B. WING | | 12/20/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | | |
| | | | 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | DATE | |
| F 791 | Continued From page | e 76 | F 791 | | | |
| | | pain would have been | | | | |
| | | s possible and he was not | | | | |
| | | for Dental Consult was not | | | | |
| | | ted he would follow up with | | | | |
| | the facility to expedia | ite a Dental Consult. | | | | |
| | In an interview on 12 | /20/18 at 10:15 AM, the | | | | |
| Dir the Ev Re wa | | tated it was her expectation | | | | |
| | the Resident #10 rec | | | | | |
| | | ed tooth pain. She stated if | | | | |
| | | the hospital in May 2018, it that he would have been | | | | |
| | | eduled in-house Dentist visit | | | | |
| | in June 2018. | | | | | |
| F 804 | | ar, Palatable/Prefer Temp | F 804 | | 1/31/19 | |
| SS=E | CFR(s): 483.60(d)(1) | (2) | | | | |
| | §483.60(d) Food and | drink | | | | |
| | | es and the facility provides- | | | | |
| | 8483 60(d)(1) Food r | prepared by methods that | | | | |
| | | lue, flavor, and appearance; | | | | |
| | | | | | | |
| | | and drink that is palatable, | | | | |
| | attractive, and at a sate temperature. | are and appelizing | | | | |
| | | is not met as evidenced | | | | |
| | by: | | | | | |
| | | on, record review, and | | Based on observation, record review, a | | |
| | | interviews with residents, family, and staff, the facility failed to ensure food was served at an | | interviews with residents, family, and sta | att, | |
| | | re for 8 of 14 interviewable | | the facility failed to ensure food was served at an appetizing temperature for | 8 | |
| | | or palatable food (Residents | | or 14 interviewable residents reviewed f | | |
| | | 27, #30, #43, and #67). | | palatable food (residents #9, #19, #20, #22, #27, #30, #43, and #67). | | |
| | The findings included | l: | | $\pi_{22}, \pi_{21}, \pi_{30}, \pi_{33}, \text{ and } \pi_{01}$ | | |
| | _ | | | No residents were harmed as a result | | |
| | | admitted to the facility on | | from this alleged deficiency. The facility | | |

Event ID: KEWC11

Facility ID: 923403

If continuation sheet Page 77 of 91

| | | MEDICAID SERVICES | | | | <u> </u> |
|--------------------------|--------------------------------|---|-----------------------------|---|--------------------|----------------------------|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | COM | E SURVEY PLETED | |
| | | 345370 | B. WING | | C 12/20/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | ST HEALTHCARE & REH | | | 300 BLAKE BOULEVARD | | |
| FINEHOR | ST HEALTHCARE & REP | had | | 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 804 | Continued From page | e 77 | F 804 | 1 | | |
| | - | ly Minimum Data Set (MDS) | 1 00- | has purchased new Heat Keeper | | |
| | assessment dated 10 | | | Insulating Base and Dome System | ns to | |
| | cognition was fully in | | | extend the temperature holding tir | | |
| | | | | twenty (20) minutes or more. 3 do | | |
| | The Resident Counci | il minutes and concern follow | | were ordered on 01/02/19 and 3 c | lozen | |
| | | 18 indicated Resident #30 | | were ordered on 01/22/19. This so | | |
| | • | were cold. This form was | | maintains meals at safe temperate | ures | |
| | | tary Manager and indicated | | during short distance deliveries. | | |
| | the cooks were spoke concerns. | en to related to food | | The facility has determined that al | ı | |
| | concerns. | | | residents receiving meals have th | | |
| | An observation and i | nterview were conducted | | potential to be affected. | 6 | |
| | | n 12/19/18 at 8:09 AM. | | · · · · · · · · · · · · · · · · · · · | | |
| | Resident #30 had be | en served breakfast in her | | Audit was conducted on 1/17/201 | 9 by the | |
| | room and she was ea | ating independently. She | | Nursing Management team using | the | |
| | | and grits on her tray. She | | audit tool on all residents lunch m | eal to | |
| | | was not warm enough | | ensure food is at an appetizing | | |
| | - | e her french toast, but she | | temperature and food is palatable | | |
| | | e remaining items as they | | Resident's liking. All residents we | | |
| | | n appetizing temperature. er food was consistently | | satisfied with temperature and pal of food. | atability | |
| | | tizing temperature when she | | | | |
| | ate in her room. | | | An in-service was provided by Die | tarv | |
| | | | | Manager on 1/23/2019 to the nurs | - | |
| | An interview was con | nducted with the Activities | | assistants including all shifts, part | - | |
| | | at 2:45 PM. She stated she | | and weekends. Focusing on the | | |
| | | ent Council meetings. She | | proper/timely way to handle the m | | |
| | | vare that the temperature of | | delivery system and the important | | |
| | | alls had been a concern | | getting the meal trays to the reside | ents as | |
| | past. She stated that | ident council meetings in the the residents were | | quickly as possible. All were in-serviced prior to workir | na | |
| | | eeting that they could ask for | | scheduled shifts. | '9 | |
| | - | tray if it the food was not | | | | |
| | warm enough. | , | | The Dietary Manager will conduct resident tray audits using an audit | • • | |
| | An interview was con | nducted with the | | weekly across all three meals incl | | |
| | | 18/18 at 2:50 PM. He | | weekends for six (6) weeks to ens | - | |
| | | are that "cold food" was an | | compliance. All audits will be kep | | |
| | issue since he began | n working at the facility in | | Director of Nursing's office. | | |

Facility ID: 923403

If continuation sheet Page 78 of 91

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOF | ED: 02/06/2019 RM APPROVED IO. 0938-0391 |
|--------------------------|--|--|---------------------|--|-----------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 345370 | B. WING | | 1 | C 2/20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 300 BLAKE BOULEVARD | | |
| | 1 | | | 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 804 | was primarily concern halls. He indicated to looking into a new me would help sustain the so it was served at a temperature. He rew tray delivery system was tray delivery system was the Administrator state new system was goin An interview was cont Manager (DM) on 12 stated that she had bo 1 ½ years and reveal food" was an ongoing this issue was primar on the halls. She state been told that they cont their tray or to receive food was not warm e Administrators intervit looking into purchasing system that would here | He reported that this issue hing food served on the hat the facility had been eal tray delivery system that e temperature of the food, | F 80 | The Dietary Manager will repo findings of the audits to the Q Assurance Committee until su consistent substantial complia been achieved. Completion Date 01/31/2019 | uality uch time as | |
| | 11/30/10 and most re 10/30/18. Her quarte | rly Minimum Data Set ated 11/5/18 indicated her | | | | |
| | with Resident #67 on Resident #67 had be room and she was ea | nterview were conducted 12/19/18 at 8:05 AM. en served breakfast in her ating independently. She as and sausage on her plate. | | Facility ID: 022402 | | |

Facility ID: 923403

If continuation sheet Page 79 of 91

| | MENT OF HEALTH AN S FOR MEDICARE & | PRINTED: 02/06/201 FORM APPROVEI OMB NO. 0938-039 | | | |
|--------------------------|---|---|---------------------|--|---|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345370 | B. WING _ | | C 12/20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, | • |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 300 BLAKE BOULEVARD 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 PLA ((EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE DIENCY) |
| F 804 | She stated that her for She further stated that her room and that he served at an unapped indicated this was co- not reported it to any everyone was aware changed. She stated have her food heated taken too long. An interview was com Administrator on 12/1 revealed he was awa issue since he began September of 2018. was primarily concern halls. He indicated t looking into a new me would help sustain th so it was served at a temperature. He rev tray delivery system of The Administrator sta new system was goin An interview was com Manager (DM) on 12 stated that she had b 1 ½ years and reveal food" was an ongoing this issue was primar on the halls. She sta been told that they co their tray or to receive food was not warm e Administrators intervi looking into purchasin | bod was not warm enough. at she ate all her meals in r food was consistently tizing temperature. She nsistent issue and she had one recently as she believed of it and nothing had I that she had not asked to I up because it would have nducted with the 18/18 at 2:50 PM. He are that "cold food" was an a working at the facility in He reported that this issue ning food served on the hat the facility had been eal tray delivery system that ie temperature of the food, | F 8 | 304 | |

If continuation sheet Page 80 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FC | TED: 02/06/2019 DRM APPROVED NO. 0938-0391 |
|--------------------------|--|--|---------------------|---|--------------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | CONSTRUCTION | (X3) D/ | ATE SURVEY DMPLETED |
| | | 345370 | B. WING | | | C 12/20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | L | ST | REET ADDRESS, CITY, STATE, ZIP CO | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | 0 BLAKE BOULEVARD 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 804 | temperature. 3. Resident #43 was a quarterly Minimum Da dated 10/18/18 indica An interview was con 12/18/18 at 1:30 PM of meeting. She reporter served at meals contri- facility. She stated the issue for food served that staff had told her her food heated up, b always having to ask An interview was con Director on 12/18/18 af facilitated the Resider indicated she was awa food served on the har mentioned in the resider past. She stated that reminded at every me staff to heat up their the warm enough. An interview was con Administrator on 12/11 revealed he was awa issue since he began September of 2018. was primarily concerning was primarily concerning An interview concerning and a served on the har and a served on the har and a served on the har and a served on the har mentioned in the resider staff to heat up their the staff to heat up the staff to h | admitted on 7/18/18. Her ata Set (MDS) assessment ated her cognition was intact. ducted with Resident #43 on during the Resident Council ed that "cold food" being nued to be an issue at the at this was primarily an on the halls. She indicated that she could ask to have but that she got tired of them to do this. ducted with the Activities at 2:45 PM. She stated she nt Council meetings. She trare that the temperature of alls had been a concern dent council meetings in the the residents were betting that they could ask for ray if it the food was not ducted with the 8/18 at 2:50 PM. He re that "cold food" was an working at the facility in He reported that this issue ning food served on the | F 804 | | | |
| | looking into a new me | hat the facility had been eal tray delivery system that e temperature of the food, more appetizing | | | | |

Facility ID: 923403

If continuation sheet Page 81 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|------|---|-----------|----------------------------|
| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 345370 | B. WING | NG _ | | | C |
| | ROVIDER OR SUPPLIER | 040010 | | ç | STREET ADDRESS, CITY, STATE, ZIP CODE | 12 | /20/2018 |
| | | | | | 300 BLAKE BOULEVARD | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 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 APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 804 | tray delivery system w The Administrator stanew system was goin An interview was con Manager (DM) on 12/ stated that she had bu 1 ½ years and reveal food" was an ongoing this issue was primarion the halls. She state been told that they con their tray or to receive food was not warm er Administrators intervie looking into purchasir system that would he the food, so it was se temperature. 4. Resident #20 was to the facility on 7/2/18. Data Set (MDS) asset indicated her cognition An interview was con 12/18/18 at 1:30 PM of meeting. She reported served at meals contif facility. She stated the issue for food served that staff had told her | ealed that the current meal was not working well enough. ted he was unsure when a g to be implemented. ducted with the Dietary (20/18 at 8:30 AM. She een working at the facility for ed she was aware that "cold g issue. She reported that ily concerning food served ated that the residents have build ask for staff to heat up e an entirely new tray if their hough. She confirmed the ew that the facility was ng a new meal tray delivery lp sustain the temperature of rved at a more appetizing most recently readmitted to Her quarterly Minimum ssment dated 10/5/18 n was fully intact. ducted with Resident #20 on during the Resident Council ed that "cold food" being nued to be an issue at the tat this was primarily an on the halls. She indicated that she could ask to have built that she got tired of | F | 804 | | | |
| | | ducted with the Activities at 2:45 PM. She stated she | | | | | |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FC | TED: 02/06/2019 DRM APPROVED NO. 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|--------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) D | ATE SURVEY OMPLETED |
| | | 345370 | B. WING | | | | C 12/20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | | 800 BLAKE BOULEVARD 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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 804 | indicated she was aw food served on the har mentioned in the reside past. She stated that reminded at every me staff to heat up their to warm enough. An interview was come Administrator on 12/1 revealed he was awar issue since he began September of 2018. It was primarily concern halls. He indicated th looking into a new me would help sustain the so it was served at a temperature. He rev tray delivery system v The Administrator stat new system was goin An interview was come Manager (DM) on 12/ stated that she had be 1 ½ years and reveale food" was an ongoing this issue was primari on the halls. She stat been told that they co their tray or to receive food was not warm er Administrators intervie looking into purchasin system that would help | At Council meetings. She are that the temperature of alls had been a concern dent council meetings in the the residents were betting that they could ask for ray if it the food was not ducted with the 8/18 at 2:50 PM. He re that "cold food" was an working at the facility in He reported that this issue ing food served on the hat the facility had been that the facility ha | F | 804 | | | |
| | - | rved at a more appetizing | | | | | |

Facility ID: 923403

If continuation sheet Page 83 of 91

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | |
| | | 345370 | B. WING | | | | 20/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | ST HEALTHCARE & REH | AB | | : | 300 BLAKE BOULEVARD | | |
| FINEHOR | | | | | 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 APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 804 | Continued From page | 83 | F | 804 | 4 | | |
| | the facility on 7/24/17 Set (MDS) assessme her cognition was full An interview was con 12/18/18 at 1:30 PM of meeting. She reporte served at meals conti facility. She stated th issue for food served that staff had told her her food heated up, b always having to ask An interview was con Director on 12/18/18 facilitated the Resider indicated she was aw food served on the har | ducted with Resident #22 on during the Resident Council ed that "cold food" being nued to be an issue at the lat this was primarily an on the halls. She indicated that she could ask to have but that she got tired of them to do this. ducted with the Activities at 2:45 PM. She stated she nt Council meetings. She vare that the temperature of alls had been a concern dent council meetings in the | | | | | |
| | reminded at every me staff to heat up their t warm enough. An interview was con Administrator on 12/1 revealed he was awa issue since he began September of 2018. was primarily concerr halls. He indicated th looking into a new me | eeting that they could ask for ray if it the food was not ducted with the | | | | | |
| | so it was served at a temperature. He rev | more appetizing ealed that the current meal | | | | | |

Facility ID: 923403

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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</i> | | E CONSTRUCTION | (X3) DATE | |
| | | 345370 | B. WING | | | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| PINEHUR | ST HEALTHCARE & REH | АВ | | | 000 BLAKE BOULEVARD 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 | The Administrator stanew system was goin An interview was com Manager (DM) on 12/ stated that she had be 1 ½ years and reveale food" was an ongoing this issue was primario on the halls. She state been told that they contheir tray or to receive food was not warm er Administrators intervie looking into purchasin system that would hel the food, so it was set temperature. 6. Resident #19 was of the facility on 3/12/18 Data Set (MDS) asse indicated her cognitio An interview was con- 12/18/18 at 1:30 PM of meeting. She reported served at meals conti- facility. She stated the issue for food served that staff had told her her food heated up, b always having to ask An interview was com- Director on 12/18/18 af facilitated the Resider | vas not working well enough. ted he was unsure when a g to be implemented. ducted with the Dietary 20/18 at 8:30 AM. She een working at the facility for ed she was aware that "cold i issue. She reported that ly concerning food served ted that the residents have uid ask for staff to heat up e an entirely new tray if their hough. She confirmed the ew that the facility was ing a new meal tray delivery lp sustain the temperature of rved at a more appetizing most recently readmitted to . Her quarterly Minimum ssment dated 10/3/18 n was intact. ducted with Resident #19 on during the Resident Council ed that "cold food" being nued to be an issue at the at this was primarily an on the halls. She indicated that she could ask to have ut that she got tired of | F | 804 | | | |

Facility ID: 923403

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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 COMP | SURVEY LETED |
| | | 345370 | B. WING | | _ | | C 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | AB | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | L | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 804 | mentioned in the resid past. She stated that reminded at every me staff to heat up their to warm enough. An interview was com Administrator on 12/1 revealed he was awa issue since he began September of 2018. It was primarily concern halls. He indicated th looking into a new me would help sustain the so it was served at a temperature. He rev tray delivery system v The Administrator sta new system was goin An interview was com Manager (DM) on 12/ stated that she had be 1 ½ years and reveale food" was an ongoing this issue was primari on the halls. She sta been told that they co their tray or to receive food was not warm er Administrators intervie looking into purchasin system that would he | alls had been a concern dent council meetings in the the residents were beting that they could ask for ray if it the food was not ducted with the 8/18 at 2:50 PM. He re that "cold food" was an working at the facility in He reported that this issue hing food served on the hat the facility had been eal tray delivery system that e temperature of the food, more appetizing ealed that the current meal was not working well enough. ted he was unsure when a | F 804 | 4 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345370 | B. WING | | | | C 2 0/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 300 BLAKE BOULEVARD 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 | 7. Resident #9 was m the facility on 9/25/17 Data Set (MDS) asse indicated her cognitio An interview was con 12/18/18 at 1:30 PM of meeting. She reported served at meals contif facility. She stated the issue for food served that staff had told her her food heated up, b always having to ask An interview was con Director on 12/18/18 af facilitated the Resider indicated she was aw food served on the har mentioned in the resider past. She stated that reminded at every me staff to heat up their t warm enough. An interview was con Administrator on 12/1 revealed he was awa issue since he began September of 2018. I was primarily concern halls. He indicated the looking into a new me would help sustain the so it was served at a temperature. He rev tray delivery system v | A construction of the second s | F | 804 | | | |

If continuation sheet Page 87 of 91

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345370 | B. WING | | | | C / 20/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| PINEHUR | ST HEALTHCARE & REH | IAB | | | 800 BLAKE BOULEVARD PINEHURST, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 804 | new system was goin An interview was con Manager (DM) on 12/ stated that she had but 1 ½ years and reveal food" was an ongoing this issue was primari on the halls. She state been told that they con their tray or to receive food was not warm en Administrators intervit looking into purchasin system that would he the food, so it was se temperature. 8. Resident #27 was 11/21/17. Her annual assessment dated 10 cognition was modera An interview was con 12/18/18 at 1:30 PM of meeting. She reporte served at meals contif facility. She stated the issue for food served that staff had told her her food heated up, b always having to ask An interview was con Director on 12/18/18 af facilitated the Resider indicated she was aw food served on the har | Ig to be implemented. ducted with the Dietary (20/18 at 8:30 AM. She een working at the facility for ed she was aware that "cold g issue. She reported that ily concerning food served ated that the residents have build ask for staff to heat up e an entirely new tray if their hough. She confirmed the ew that the facility was ng a new meal tray delivery lp sustain the temperature of rved at a more appetizing admitted to the facility on I Minimum Data Set (MDS) (/17/18 indicated her ately impaired. ducted with Resident #27 on during the Resident Council ed that "cold food" being nued to be an issue at the tat this was primarily an on the halls. She indicated that she could ask to have but that she got tired of | F | 804 | | | |

Facility ID: 923403

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 02/06/2019 // APPROVED). 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|--|------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | | | LETED |
| | | 345370 | B. WING | | | _ | | C 20/2018 |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | - | |
| PINEHURS | ST HEALTHCARE & REH | AB | | | 300 BLAKE BOULEVARD PINEHURST, NC 28374 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 804 | staff to heat up their to warm enough. An interview was com Administrator on 12/1 revealed he was away issue since he began September of 2018. If was primarily concerr halls. He indicated th looking into a new me would help sustain the so it was served at a temperature. He rev tray delivery system v The Administrator sta new system was goin An interview was com Manager (DM) on 12/ stated that she had be 1 ½ years and reveale food" was an ongoing this issue was primari on the halls. She sta been told that they co their tray or to receive food was not warm er Administrators intervia looking into purchasir system that would hel the food, so it was set temperature. | the residents were being that they could ask for ray if it the food was not ducted with the 8/18 at 2:50 PM. He re that "cold food" was an working at the facility in He reported that this issue hing food served on the nat the facility had been eal tray delivery system that e temperature of the food, more appetizing ealed that the current meal vas not working well enough. ted he was unsure when a g to be implemented. ducted with the Dietary 20/18 at 8:30 AM. She een working at the facility for ed she was aware that "cold i issue. She reported that ly concerning food served ited that the residents have uld ask for staff to heat up e an entirely new tray if their hough. She confirmed the ew that the facility was ing a new meal tray delivery lp sustain the temperature of rved at a more appetizing | | 804 | | | | 1/21/10 |
| F 867 SS=E | QAPI/QAA Improvem CFR(s): 483.75(g)(2)(| | | 867 | | | | 1/31/19 |

Event ID: KEWC11

Facility ID: 923403

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| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | FO | ED: 02/06/20 RM APPROVE IO. 0938-039 |
|--|---|---|--------------------------------------|---|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | | |
| | | 345370 | B. WING | | 1 | 2/20/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | DE | | |
| PINEHURST HEALTHCARE & REHAB | | | | 300 BLAKE BOULEVARD 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETIO DATE |
| F 867 | Continued From page §483.75(g) Quality as | e 89 ssessment and assurance. | F 86 | 67 | | |
| | assurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by: Based on observation record review, the fact and Assurance Commit implanted procedures that the committee put annual recertification was for two recited du Accuracy of Assessmic coding the Minimum medications, hospice cited on 11/16/17 and Incontinence, Cathete a urinary catheter pre- findings included: This citation is cross | ement appropriate plans of tified quality deficiencies; Γ is not met as evidenced ons, staff interviews and cility's Quality Assessment mittee (QAA) to maintain s and monitor interventions ut into to place following the survey dated 11/16/17. This eficiencies in the areas of nents at F641-not accurately Data Set in the areas of and prognosis previously d Bowel/Bladder er/UTI at F690-not securing eviously cited 11/16/17. The | | Based on observations, staff and record review, the facility Assurance and Performance Improvement Committee (QA Committee) failed to maintain procedures and monitor inter the committee put into place annual recertification survey 11/16/17. This was for two re deficiencies in the areas of Ar Assessments at F641- not ac coding the Minimum Data Se of medications, hospice and p previously cited on 11/16/17 a Bowel/Bladder Incontinence, UTI at F690- not securing a u catheter previously cited 11/1 | r's Quality PI n implanted ventions that following the dated ecited ccuracy of ecurately t in the areas prognosis and Catheter/ urinary | |
| | the facility failed to co (MDS) assessment a active diagnoses (Re bladder and bowel (F medications (Resider (Resident #40), hosp of daily living (Resider (Resident #63), and t 8 of 17 residents revi F690-Based on obse staff interview, the far catheter care by not s | bde the Minimum Data Set accurately in the areas of esidents #31 and #73), Residents #40 and #73), nts #67 and #40), prognosis ice (Resident #86), activities ent #42), skin conditions therapies (Resident #54) for ewed. | | Members of the QAPI Comm 1/16/2019 to discuss repeat of at F641 and F690 to modify t QAPI plan. The Corporate D Clinical Services was present meeting and completed an in 01/16/2019 on the purpose o Committee in insuring perform improvements are completed plan was made and implement members of the QAPI Committee(consisting of Adm Staff Development Coordinat | ittee met on deficiencies he facility's irector of t at the service on f the QAPI nance . An action nted by the ninistrator, | |

Facility ID: 923403

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| TATEMENT | OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ί, γ | E CONSTRUCTION | OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED C |
|--------------------------|---|---|---------------------|--|--|
| | | 345370 | B. WING | | 12/20/2018 |
| | ROVIDER OR SUPPLIER | IAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLET |
| F 867 | facilitate flow of urine reviewed for indwellir (Residents #40, #45 In an interview on12/ Administrator stated Administrator at the f was in the process of process. He stated h | e for 3 of 3 sampled residents ng urinary catheter and #135). 20/18 at 11:12 AM, the he had only been the facility for 3 months and he f revamping the QAA e was uncertain why there and it could possibly be a | F 867 | Supervisor, Social Worker, Director Nursing, Medical Records Director, Dietary Manager, Housekeeping Supervisor). The next meeting was scheduled for 1/30/2019 to review outcomes. The facility has determined that all residents have a potential to be affee The Corporate Director of Clinical Services did an in-service with the licensed and unlicensed staff incluo part time and weekend staff regardit facility's QAPI (Quality Assurance & Performance Improvement) plan or 01/24/2019. The Administrator will with all new hires during orientation educate them on the facility's QAPI program. The QAPI Committee will monthly to discuss action plans rela- the repeat deficiencies at F641 and and all items on the QAPI agenda. Medical Director will be physically p no less than quarterly at the meetin Results of these meetings will be kee- the Administrator's office. This plan of correction will be contir evaluated by the Administrator and QAPI committee until such time as consistent substantial compliance is achieved. Completion Date 01/31/2019 | ected. ling ing the a meet to I meet ated to F690 The present gs. ept in huously the |

Facility ID: 923403

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