DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY
		345177	B. WING			C)3/21/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		JJ/2 1/2019
THE GRE	ENS AT PINEHURST REI	AB & LIVING CENTER		205 RATTLESNAKE TRAIL		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	o		
F 550	conducted on 3/18/19 facility was found in c requirement CFR 483 Preparedness. Even	3.73, Emergency t ID #YQDZ11.	5.65			4/48/46
F 550 SS=D		8	F 55			4/18/19
	self-determination, an access to persons an	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility 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.				
	rights as a resident or or resident of the Uni	right to exercise his or her f the facility and as a citizen ted States.				
	§483.10(b)(1) The fac	cility must ensure that the				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					04/04/2019

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.

	-	D HUMAN SERVICES				FORM	1 APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		CONSTRUCTION	(X3) DATE	0. 0938-0391
-	CORRECTION	IDENTIFICATION NUMBER:					LETED
							c l
		345177	B. WING			03/	21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REH	AB & LIVING CENTER					
				Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	interference, coercion from the facility. §483.10(b)(2) The res free of interference, co reprisal from the facilit rights and to be support exercise of his or her subpart. This REQUIREMENT by: Based on record revir resident and staff inte provide privacy and d urinary catheter drains residents reviewed for #74 & # 53). Findings included: 1. Resident #74 was a 2/14/19 with multiple of retention. The admiss (MDS) assessment da Resident #74 had me problems and she had catheter. Resident #74 did not plan developed for the Resident #74 had a d (2/14/19) for the indwo On 3/19/19 at 9:50 AM #74 was observed in	his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this " is not met as evidenced ew, observation and rview, the facility failed to ignity by not covering the age bag for 2 of 4 sampled r urinary catheter (Residents admitted to the facility on diagnoses including urinary sion Minimum Data Set ated 2/24/19 indicated that mory and decision making d an indwelling urinary have a comprehensive care e use of the urinary catheter. octor's order on admission elling urinary catheter. M and at 4:30 PM, Resident bed. She had a urinary	F	550	Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; The licensed nurse placed Resident #74 s urinary drainage bag in a dignity cover bag on 3/19/19. The licensed nurse placed Resident #53 s urinary drainage bag in a dignity cover bag on 3/19/19. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice The Director of nursing (DON) and Assistant Director of Nursing (ADON) identified 9 current residents with catheters on 3/19/19. All identified residents were observed on 3/19/19, and a dignity bag in place covering the urind drainage bag.	/ er ; nd ary	
		ary catheter bag was facing			ensure that the deficient practice will no recur;	ot	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345177	B. WING		0	C 3/21/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
				205 RATTLESNAKE TRAIL		
INE GREI	INS AT PINEHURST RE	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 550	interviewed. She stat time at the facility and the catheter bag was bag. NA #3 also state Resident #74's cathet bag. On 3/19/19 at 4:35 P interviewed. She stat to report to her that to privacy bag. She ind reported that Reside covered with a privace On 3/21/19 at 8:45 A (DON) was interview expected all catheter privacy bag and NAs the nurse when the o covered. 2. Resident #53 was facility on 12/7/17 and	PM, Nurse Aide (NA) #3 was ted that she just worked part d she didn't not know why s not covered with a privacy ed that she didn't notice that eter bag was not in a privacy PM, Nurse #8 was ated that she expected the NA he catheter bag was not in a dicated that nobody had nt #74's catheter bag was not cy bag. M, the Director of Nursing red. The DON stated that she r bags to be covered with a s were supposed to report to catheter bag was not catheter bag was not cut and the difference of the second s were supposed to report to catheter bag was not catheter bag was not	F 55	 The DON and/or the ADON in service education for the connursing staff on 3/27/19, regardignity bags for residents with catheter bags. Education will for newly hired staff during morth and/or the ADON is physician orders during morth validate that the catheter bag a dignity cover bag. Indicate how the facility plans its performance to make sure solutions are sustained; The DON and/or the ADON is observe 3 catheters a week for then 10 catheters a month for validate that the urinary cathed placed in a dignity cover bag. The DON will review audits/of to identify patterns/trends and plan as necessary for continu compliance. The Administrate the plan during monthly QAPI committee. 	urrent arding use of a urinary be provided w hire s will review ing clinical ek to identify eters and is placed in to monitor that s will or 4 weeks 2 months to eter bag is bservations d will adjust ed or will review and will	
	not have an indwellin Resident #53 had an	ition was intact and she did ng urinary catheter. n order for the urinary (readmission) due to urinary				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345177	B. WING				21/2019
NAME OF PF	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			95 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	after readmission (2/1 On 3/19/19 at 9:53 Af #53 was observed in catheter and the urina the door and it was no On 3/19/19 at 4:33 Pf interviewed. She state time at the facility and the catheter bag was bag. NA #3 also state Resident #53's cathef bag. On 3/19/19 at 4:35 Pf interviewed. She state to report to her that the privacy bag. She indi- reported that Residen covered with a privace On 3/19/19 at 4:38 Pf interviewed. She state to show your catheter should have covered On 3/21/19 at 8:45 Af (DON) was interviewed expected all catheter privacy bag and NAs	e use of the urinary catheter (8/19). M and at 4:31 PM, Resident bed. She had a urinary ary catheter bag was facing ot covered. M, Nurse Aide (NA) #3 was ed that she just worked part I she didn't not know why not covered with a privacy d that she didn't notice that ter bag was not in a privacy M, Nurse #8 was ted that she expected the NA ie catheter bag was not in a icated that nobody had it #53's catheter bag was not y bag. M, Resident #53 was ted that it was a dignity issue bag in public and staff it. M, the Director of Nursing ed. The DON stated that she bags to be covered with a were supposed to report to	F 5	550			
F 623 SS=C	the nurse when the ca covered. Notice Requirements CFR(s): 483.15(c)(3)-	Before Transfer/Discharge	F 6	523			4/18/19
	§483.15(c)(3) Notice	before transfer.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannee facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ar resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's her allow a more immedia under paragraph (c)(f (D) An immediate tran required by the resider under paragraph (c)(f)	fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or hder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	205 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	TAB & LIVING CENTER		P	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623		ts of the notice. The written	F	623			
	must include the follo (i) The reason for tra	-					
	(iii) The location to wh	nich the resident is					
	transferred or dischar	•					
		e resident's appeal rights,					
	and telephone number	ddress (mailing and email),					
		ts; and information on how					
	to obtain an appeal for						
		and submitting the appeal					
	hearing request;	5					
		s (mailing and email) and					
		the Office of the State					
	Long-Term Care Omb						
	and developmental di	y residents with intellectual					
	-	g and email address and					
		the agency responsible for					
		vocacy of individuals with					
	developmental disabi	lities established under Part					
		tal Disabilities Assistance					
		of 2000 (Pub. L. 106-402,					
	codified at 42 U.S.C.	• *					
		y residents with a mental sabilities, the mailing and					
		lephone number of the					
	agency responsible for	•					
		lls with a mental disorder					
	established under the for Mentally III Individ	Protection and Advocacy uals Act.					
	§483.15(c)(6) Change	es to the notice.					
		ne notice changes prior to					
	effecting the transfer	or discharge, the facility					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/30/2019 APPROVEI 0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345177	B. WING				_ 21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification pritto the State Survey A State Long-Term Carrot the facility, and the resident as the plan for the relocation of the resident as the plan for the relocation of the resident and/or remotification of the react hospital for 2 of 2 resises hospitalization. (Resist The findings included 1) Resident #38 was 9/12/17 with diagnose Sclerosis, muscle we diabetes mellitus, neuthypertension. A medical record revises the resident and/or remotification of the react hospitalization. (Resist 1) Resident #38 was 9/12/17 with diagnose Sclerosis, muscle we diabetes mellitus, neuthypertension.	bients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide for to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at § T is not met as evidenced iews and family, resident the facility failed to provide esident representative written son for transfer to the idents reviewed for ident # 38 and #53). It: admitted to the facility on es that included Multiple akness, seizure disorder, urogenic bladder and ew revealed the resident e hospital on 9/7/18 and on no documentation of a sfer provided to the resident, ponsible party.	F	623	Address how corrective action will be accomplished for those residents foun have been affected by the deficient practice; The Social Service Director (SSD) provided a written letter of discharge/transfer on 4/01/19, to Resid # 38 for hospital transfer dates of 9/7/7 and 10/4/18. The Social Service Director (SSD) provided a written letter of discharge/transfer on 4/01/19, to Resid # 53 for hospital transfer dates of 12/4 1/25/19 and 2/14/19. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice. The Social Service Director (SSD) identified current facility residents that were discharged/transferred to the hospital from March 1, 2019 through A 1, 2019, and a written letter of	dent 18 dent /18, her \$;	

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 04/30/201 DRM APPROVE NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345177	B. WING	B. WING			C 03/21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	Continued From page	e 7	F	623			
F 023	assessment and date cognitively intact. During an interview of Nursing Supervisor # hospital discharge or resident was informe responsible party was stated she was not an notification provided for responsible party. On 3/21/19 at 8:50 an conducted with Resider recall the reason for of and stated she had in notifications from the hospital transfers. The Director of Nursi 3/21/19 at 8:53 am. S informed the resident party when a dischar occurred, but not in w not know the facility wa and/or responsible parts for the transfer or dis 2. Resident #53 was facility on 12/7/17 and	ed 1/24/19 revealed she was on 3/21/19 at 8:20am with 1, she explained when a transfer occurred the d and if applicable, the s notified by phone. She ware of any written to the resident and/or the n an interview was tent #38. She was able to each of the hospital transfers ot received written		023	discharge/transfer was provided to the resident and/or the resident representative by April 4, 2019. The were fifteen residents identified. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will recur; The Regional Director of Clinical Ser provided in service education to the S on April 1, 2019, regarding the regula pertaining to providing written notice transfer/discharge to the resident and the resident representative upon discharge/transfer to the hospital. The SSD and/or the Director of Nurs (DON) will be provided with a list of resident discharges/transfers to the hospital during morning meeting to include prior day and weekend discharge/transfer. The SSD and - DON will provide a written letter of discharge/transfer. Indicate how the facility plans to mor its performance to make sure that solutions are sustained; The Administrator will audit hospital transfer /discharge report weekly for weeks then monthly for 2 months to validate that a written letter was sent/given to the resident and/or the	re nto not vices SSD ation of d/or ing or tified	
	The quarterly Minimu assessment dated 2/ Resident #53's cogni	10/19 indicated that			resident representative following a transfer/discharge to the hospital. The Administrator will review audits t identify patterns/trends and will adjus		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	Сом	E SURVEY PLETED
		345177	B. WING			C / 21/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
THE GREE	ENS AT PINEHURST REP	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 623	Continued From page		F 623		- 1	
	notes revealed that R and was admitted to to shortness of breath her spine and on 2/14 vomiting. The notes	's notes were reviewed. The tesident #53 was transferred the hospital on 12/4/18 due n, on 1/25/19 due to pain on 4/19 due to diarrhea and indicated that the resident Party (RP) were notified of but not in writing.		plan as necessary for continue compliance. The Administrato the plan during monthly QAPI continue audits at the discretio QAPI committee.	or will review and will	
	the nurse when the d out to the hospital but anything in writing pri	ted that she was notified by octor ordered to send her t she had not received or to her discharge. She e facility was sending the				
	was interviewed. He been notifying the res	M, Nursing Supervisor #2 stated that nursing staff had sident and the RP verbally of er/discharge but not in				
	was interviewed and received anything in v	a 3/20/19 at 3:04 PM, the RP of Resident #53 is interviewed and she stated that she had not ceived anything in writing from the facility when sident #53 was discharged/transferred to the spital.				
	(DON) was interviewed nursing staff were sup and the RP when a re discharged/transferre indicated that she did	M, the Director of Nursing ed. The DON stated that oposed to notify the resident esident was ed to the hospital. The DON In't know that facility had to P in writing of the reason for				
	discharge/transfer.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
		345177	B. WING				_ 21/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 636 SS=D	CFR(s): 483.20(b)(1)(§483.20 Resident Ass The facility must cond a comprehensive, acd reproducible assessm functional capacity. §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavid (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritid (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvii) Documentation regarding the additior on the care areas trig the Minimum Data Set (xviii) Documentation	(2)(i)(iii) sessment luct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least lemographic information or patterns. II-being. ing and structural problems. and health conditions. onal status.	F	636			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/201 FORM APPROVE OMB NO. 0938-039	
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345177	B. WING		03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 636	include direct observa- with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When t timeframes prescribe chapter, a facility mus assessment of a resid timeframes specified through (iii) of this se prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record rev interview, and staff in comprehensively ass Minimum Data Set (N areas of cognition an interviewable residen and #62). The findings included 1. Resident #51 was 2/14/18 with diagnose encephalopathy. The annual Minimum	ation and communication well as communication with need direct care staff s. required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility v absence for hospitalization e every 12 months. T is not met as evidenced iew, observation, resident terview, the facility failed to ess residents on the MDS) assessment in the d mood for 2 of 12 ts reviewed (Residents #51 I: admitted to the facility on es that included Wernicke ' s	F 636	Address how corrective action will I accomplished for those residents fo have been affected by the deficient practice; The Social Service Director (SSD) completed a Modified Assessment of 4/02/19 for MDS ARD dated 2/8/19 Resident #51 to reflect sections C0100-C0500 and D0100-D0300, a comprehensively assessed. The Social Service Director (SSD) completed a Modified Assessment of 4/02/19 for MDS ARD dated 2/16/19 Resident #62 to reflect sections C0100-C0500 and D0100-D0300, a comprehensively assessed.	on for as on 9 for	

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F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) D	ATE SURVEY
CORRECTION	IDENTIFICATION NUMBER:	· ,			OMPLETED
					С
	345177	B. WING			03/21/2019
ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
			205 RATTLESNAKE TRAIL		
INS AT FINEHORST REP	AB & LIVING CENTER		PINEHURST, NC 28374		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
Continued From page	e 11	F 6	36		
				mbursement	
•			provided in service educati	on on 4/2/19,	
			sections B, C, and D of the	MDS.	
			Address how the facility wil	l identify other	
•					
				•	
				•	
				MDS	
•				mbursement	
			· · ·		
· ·			March 31, 2019, to identify	MDS	
			-		
-	-				
•	U				
				the SSD	
and appropriate answ	vers.		completed modified assess	ments on	
.			4/02/19 for those residents	identified.	
				Il bo put into	
			recur;		
				mbursement	
			-		
	-				
				-	
			C, and D of the MDS.	r sections B,	
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page had clear speech, wa others, and usually u C, the Cognitive Path comprehensively ass Question C0100 was Interview for Mental S conducted with Reside interview, questions C coded as not assesse section, was not com Resident #51. Quest indicate a resident me conducted with Reside interview, questions C coded as not assesse Resident #51. Quest indicate a resident me conducted with Reside interview, questions C coded as not assesse Resident #51. Quest indicate a resident me conducted with Reside interview, questions C coded as not assesse Resident #51 was lying bed sheet fully covern initially declined an im provided with pleasar he removed the bed s head and he completed and appropriate answ An interview was com 3/20/19 at 5:00 PM. completed Section C annual MDS assesses Resident #51 refused 2/8/19 MDS. She stat had coded the BIMS interview as not asses	345177	At BUILDIN ALLIAN ALLIAN ALLIAN B. WING COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 had clear speech, was usually understood by others, and usually understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #51. Question C0100 was coded to indicate a Brief Interview for Mental Status (BIMS) was to be conducted with Resident #51. The BIMS interview, questions C0200 through C0500, was coded as not assessed. Section D, the Mood section, was not comprehensively assessed for Resident #51. Question DD100 was coded to indicate a resident mood interview was to be conducted with Resident #51. The resident mood interview, questions D0200 through D0300, was coded as not assessed. Section C and D of Resident #57 's 8/31/18 MDS was completed by the Social Worker (SW). An observation and interview were conducted with Resident #51 on 3/18/19 at 11:50 AM. Resident #51 was lying in bed in his room with a bed sheet fully covering his head. Resident #51 initially declined an interview, but after being provided with pleasantries and encouragement he removed the bed sheet that was covering his head and he completed an interview with logical and appropriate answers. An interview was conducted with the SW on 3/20/19 at 5:00 PM. The SW indicated she completed Section C and D of Resident #51 's annual MDS assessment dated 2/8/19. Section C and D of the 2/8/19 MDS for Resident #51 was reviewed with the SW. She reported that Resident #51 refused to be interviewed for this 2/8/19 MDS. She stated that this wa	345177 B. WING INSTREET ADDRESS, CITY, STATE, ZIP C STREET ADDRESS, CITY, STATE, ZIP C INS AT PINEHURST REHAB & LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP C SUMMARY STATEMENT OF DEFICIENCIES (REQUATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDER CALL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PEERX (REGULATORY OR LSC IDENTIFYING INFORMATION) PEERX (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 had clear speech, was usually understood by others, and usually understood to indicate a Brief Interview (rouestions CO200 through CO500, was conducted with Resident #51. The BIMS interview, questions CO200 through CO500, was conducted with Resident #51. The BIMS interview, questions D0200 through CO500, was conducted with Resident #51. The BIMS interview, questions D0200 through CO500, was conducted with Resident #51. The BIMS interview, questions D0200 through D0300, was conducted with Resident #51. The resident mood interview, questions D0200 through D0300, was conducted with Resident #51. The Bims interview, questions D0200 through D0300, was coded as not assessed. Section C and D of Resident #51 was lying in bed in his room with a bed sheet fully covering his head. Resident #51 initially declined an interview, but after being provided with pleasantries and encouragement he removed the bed sheet that was covering his head and he completed an interview with logical and appropriate answers. Address what measures wi place or systemic changes ansure MDS assessment steat 2/8/19 MDS for Resident #51 was reviewed with thes SW. She reported that Resident #51 refused to be intervieweed for this 2/8/19 MDS. She stated that this was w	NUMM 345177 B. WING INS AT PINEHURST REHAB & LIVING CENTER STREET ADDRESS. CITY, STATE, ZIP CODE 205 MARKY STATEMENT OF DEFICIENCIES (EACH CORRECTACK MARY STATEMENT OF DEFICIENCIES) (EACH CORRECTACK MARY STATEMENT OF DEFICIENCIES) (EACH CORRECTAC ACTION SINCULD BE CONSIDERT AND THE PRECEDED IN FULL RECOLLATIONY ON LISC DENTIFYING INFORMATION) ID (EACH CORRECTAC ACTION SINCULD BE CONSIDERT ACTION SINCULD ACTION SINCULD ACTION CONSIDERT ACTION SINCULD ACTION SINCULD ACTION SINCULD ACTION S

Facility ID: 923320

		MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		0.45477			С
	ROVIDER OR SUPPLIER	345177		STREET ADDRESS, CITY, STATE, ZIP CODE	03/21/2019
NAME OF P	ROVIDER OR SUPPLIER			205 RATTLESNAKE TRAIL	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLE
F 636	Continued From page	e 12	F 63	6	
F 030	specified in the Resid (RAI) manual for the o interviews in Sections An interview was con Nursing (DON) on 3/2 indicated her expecta be comprehensively a MDS. 2) Resident #62 was 11/13/18 with diagnos anxiety disorder, major restless leg syndrome The quarterly Minimu assessment dated 2/7 #62 had clear speech self-understood at tim others. Section C, the was not comprehensi #62. Question C0100 Resident #62 was rar the Brief Interview for questions C0200-C06 Section D, the Mood comprehensively ass Question D0100 was #62 was rarely/never interview (questions I not conducted. On 3/20/19 at 5:00pm the Social Worker. S Sections C and D on MDS assessment dat Resident #62 wasn't i	lent Assessment Instrument completion of the resident s C and D. ducted with the Director of 21/19 at 10:21 AM. She tion was for all residents to assessed in all areas of the admitted to the facility on ses that included dementia, or depressive disorder, e and polyarthritis. m Data Set (MDS) 16/19 indicated Resident a, was able to make hes and rarely understood c Cognitive Patterns section, vely assessed for Resident 0 was coded to indicate rely/never understood and Mental Status (BIMS- 500) was not conducted.	F 63	6 The MDS coordinator and the SS follow the MDS RAI guidelines for and assessing residents for secti and D and will provide documenta the residents □ medical record to coding documentation. Indicate how the facility plans to r its performance to make sure that solutions are sustained; The MDS coordinator will audit 5 MDS assessments Sections B,C weekly for 4 weeks then 10 reside assessments Sections B, C and D monthly for 2 months, to validate residents were assessed and Se C and D are coded accurately. The MDS coordinator will review identify patterns/trends and will ac plan as necessary for continued compliance. The MDS coordinator review the plan during monthly Q. will continue audits at the discreti- QAPI committee.	r coding ons B, C ation in support nonitor t resident and D ent MDS D that the ctions B, audits to djust or will API and

Facility ID: 923320

If continuation sheet Page 13 of 89

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/ FORM APPRC OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345177	B. WING		03/21/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
THE GREI	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
F 636	the Resident Assessr manual for the compl interviews in Sections On 3/21/19 at 10:25a stated it was her expe be comprehensively a	nent Instrument (RAI) etion of the resident	F6	336			
F 641 SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status.	of Assessments. st accurately reflect the	F6	541	4/18/19		
	by: Based on record rev facility failed to accur Data Set in the areas #87) and diagnoses (residents reviewed. I 1. Resident #87 was 2/14/19 with the diagn obstructive uropathy. A review of Resident Set (MDS) dated 2/19 unable to be complet deficit. The resident	admitted to the facility on noses of dementia and #87's 5-day Minimum Data 9/19 revealed cognition was ed secondary to memory required minimal assistance ing. The active diagnoses		Address how corrective ad accomplished for those res have been affected by the practice; The MDS coordinator com Modification assessment for dated 2/19/19 on 3/29/19, coding for injections for Re The MDS coordinator com Modification assessment for dated 2/19/19 on 3/29/19, coding of the diagnosis of Resident # 35. The Director of Clinical Re provided education for the coordinator on 4/2/19, rega	sidents found to deficient pleted a or the MDS to correct the esident # 87. pleted a or the MDS to include the dementia for imbursement MDS		
	1 injection. A review of Resident administration record	entia. The resident received #87's medication for February 2019 revealed he resident had not received		coding of the MDS accordi RAI guidelines, to include of injections and diagnosis of Alzheimers/dementia. Address how the facility wi	coding of		

Event ID: YQDZ11

Facility ID: 923320

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (CONSTRUCTION	(X3) DATE SURVEY	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		СОМ	PLETED
		045477					С
		345177	B. WING	OT	REET ADDRESS, CITY, STATE, ZIP CODE	03	/21/2019
NAIVIE OF PI	ROVIDER OR SUPPLIER				5 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER			NEHURST, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 641	Continued From page	ə 14	F 64	11			
		n (test for tuberculosis)		•	residents having the potential to be		
		mented as "completed at the			affected by the same deficient practice	e;	
	previous facility." The			Current facility residents with orders for			
	injections ordered.				injections and diagnosis of		
		//=0			Alzheimers/Dementia have the potent	ial to	
		#78's nurses' note dated that the resident had not			be affected by the alleged deficient practice.		
	received his tuberculi				The MDS coordinator completed an a	udit	
					4/04/19, of current residents MDS	aan	
	The resident was not	available for an interview.			assessment from 01/01/19 through		
					3/31/19, to identify residents that were		
		On 3/20/19 at 9:20 am an interview was conducted with the MDS Coordinator who stated			coded as receiving injections within th		
		nt #87's chart and incorrectly			MDS lookback period. There were 3 residents that were coded as receiving		
		eived an injection on the			injections during the lookback period of	-	
	5-day MDS dated 2/1	-			their MDS assessments. The MDS		
					coordinator reviewed the MDS		
	On 3/20/19 at 3:30 pr				assessments for those residents ident		
		irector of Nursing who stated Stated scourately.			to validate that the MDS was accurate coded. The MDS coordinator complete	-	
		admitted to the facility on			a corrected MDS for those residents	eu	
		ses that included dementia.			identified as inaccurate coding for injections.		
		ted 1/7/19 indicated that			The MDS coordinator completed an a		
	Resident #35 had a c	liagnosis of dementia.			on 4/4/19, of current residents diagnos	sis,	
					to identify residents with diagnosis of		
		ractitioner's note dated sident #35 was receiving			Alzheimers/dementia. The MDS coordinator completed an audit 4/4/19	a	
		tic medication) for vascular			for the last MDS assessment complete		
	dementia with behavi	-			for the residents identified with	-	
					Alzheimers/dementia diagnosis, to		
	The quarterly Minimu				validate that the diagnosis was include	ed in	
		21/19 indicated Resident			the MDS assessment. There 28		
	-	everely impaired, and she c medication on 7 of 7 days			residents identified with diagnosis of Alzheimers/dementia and the last MD	s	
		w period. Resident #35 was			assessment that was completed for ea		
		osis of dementia on the			resident was coded correctly.		
	1/21/19 MDS.		1		-		1

Facility ID: 923320

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/30/2019 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345177	B. WING			0:	C 3/21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 641	quarterly MDS for Red diagnosis of dementia MDS Coordinator. The revealed this MDS was Resident #35. She selectronic medical red all active diagnoses of reported that she was of dementia was not a Resident #35's 1/21/2 Coordinator confirme diagnosis for Resider 1/21/19 MDS. An interview was con Nursing on 3/21/19 at	ducted with the MDS 19 at 4:50 PM. The 1/21/19 sident #35 that included no a was reviewed with the ne MDS Coordinator as coded inaccurately for tated that normally, the cords system auto-populated lirectly onto the MDS. She is not sure why this diagnosis	F	641	Address what measures will be put int place or systemic changes made to ensure that the deficient practice will r recur; The Director of Clinical Reimbursement provided education for the MDS coordinator on 4/2/19, regarding accu- coding of the MDS according the MDS RAI guidelines, to include coding of injections and diagnosis of Alzheimers/dementia. The MDS coordinator will review phys orders, medication administration reco- and progress notes during the look ba- period of the MDS to validate when injections are given to the resident and code accurately on the MDS. The MD coordinator will review the residents medical record to validate that active diagnosis□ are included on the MDS assessment that is being completed. Indicate how the facility plans to monit its performance to make sure that solutions are sustained; The Director of Nursing (DON) will aud MDS assessments completed each w for 4 weeks then 20 MDS assessment monthly for 2 months , prior to submis to the state, to validate that injections coded accurately and diagnosis of Alzheimer's/dementia is included as applicable. The DON will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. DON will review the plan during month QAPI and will continue audits at the discretion of the QAPI committee.	not nt irrate ician ords ck d will DS cor dit eek sion are	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	MPLETED
					С	
		345177	B. WING		0	3/21/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER		95 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 16	F 656			
F 656 SS=D		Comprehensive Care Plan	F 656			4/18/19
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.1 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, include treatment under §483.2 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the resider (iv)In consultation wit resident's representaa (A) The resident's pre- future discharge. Fac- whether the resident's	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 I mental and psychosocial ied in the comprehensive mprehensive care plan must Q - are to be furnished to attain ent's highest practicable 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 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-				

Facility ID: 923320

If continuation sheet Page 17 of 89

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG				
		345177	B. WING			03/2	C 21/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 001		
				20	05 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PI	NEHURST, 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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	o 17		050				
F 000			F	656				
	entities, for this purpo							
		in the comprehensive care						
		in accordance with the						
	section.	h in paragraph (c) of this						
		Γ is not met as evidenced						
	by:	is not met as evidenced						
		iew, observation and staff			F 656			
	interview, the facility				Address how corrective action will be			
		plan for the indwelling			accomplished for those residents found	d to		
	-	idents #74 & 53) and for			have been affected by the deficient			
		#50 & 35). The facility also			practice;			
	-	ne care plan for nutrition for			,			
		vas evident for 4 of 17			The MDS coordinator developed a car	e		
	sampled residents re	viewed.			plan for indwelling catheter on 3/19/19			
					Resident #74.	,		
	Findings included:				The MDS coordinator developed a car	e		
					plan for indwelling catheter on 3/19/19			
	1. Resident #74 was	admitted to the facility on			Resident # 53.			
	2/14/19 with multiple	diagnoses including urinary			The Social Service Director (SSD)			
	retention. The admis	sion Minimum Data Set			developed a care plan on 3/19/19, for			
	(MDS) assessment d	ated 2/24/19 indicated that			specific behaviors and interventions			
		emory and decision making			related to Resident #35, to include yell	ing		
	•	d an indwelling urinary			out related to Behavioral and			
	catheter.				Psychological Symptoms of Dementia			
	Posidont #74 had a	loctor's order on admission			(BPSD).			
					The Director of Nursing (DON) comple	tod		
		elling urinary catheter.			The Director of Nursing (DON) comple in service education on 3/26/19, for the			
	The Care Area Asses	sment (CAA) for the			certified nursing assistants (CNA)	-		
		heter dated 2/26/19 revealed			regarding following care plan intervent	ions		
		velling urinary catheter in			as noted on the resident Kardex for			
		Resident needs assistance			assistance with eating for Resident #3	5		
	•	ee activity of daily living			The MDS coordinator had resolved the			
		n. Staff will provide catheter			Sexual behavior care plan for Residen			
	care per facility proto	-			#50 on 11/21/18, due to resident not	-		
		loctor and family will be			exhibiting sexual behaviors. The MDS			
		as needed. Will proceed to			coordinator initiated a History of Sexua			
	care plan".	····			behavior care plan on 3/29/19. The SS			

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If continuation sheet Page 18 of 89

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/30/2019 DRM APPROVED NO. 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C 03/21/2019	
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				20	05 RATTLESNAKE TRAIL			
THE GREE	INS AT PINEHURST REF	HAB & LIVING CENTER		P	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 656	Continued From page	e 18	F	656				
					initiated a care plan on 4/04/19, for			
	Resident #74 did not	have a comprehensive care			Resident #50, specific to behaviors of	f		
		e use of the urinary catheter			anger that is not easily redirected.			
					Address how the facility will identify of	other		
		M and at 4:30 PM, Resident			residents having the potential to be			
		bed with an indwelling			affected by the same deficient practic	ce;		
	urinary catheter in pla	ace.			Current facility residents with indwelli	20		
	On 3/10/10 at 3:40 P	M, the MDS Nurse was			catheters, feeding assistant needs ar			
		ified that Resident #74 had			behaviors have the risk to be affected			
		catheter and she had			the deficient practice. The DON ident	•		
		care plan for the urinary			current facility residents with indwelling			
	catheter.				catheters on 3/22/19, to validate that	a		
					care plan had been initiated for those	;		
		M, the Director of Nursing			residents. There were 9 residents			
		ed. The DON stated that			identified, and all residents had a car			
	she expected a comp				plan for indwelling catheter. The SSE			
	developed when a re-	sident has a urinary			completed an audit on 4/04/19, of cu			
	catheter.				facility residents receiving psychoact medications, to validate that a care p			
					for behaviors had been initiated for the			
	2 Resident #53 was	originally admitted to the			residents identified. There were 35	1030		
		d was readmitted on 2/18/19			residents identified, and 34residents	had		
		es including congestive			a behavior care plan to include reside			
	heart failure.				specific behaviors and appropriate			
					interventions. The SSD implemented			
	The quarterly Minimu	. ,			behavior care plans for the remaining	y 1		
	assessment dated 2/				resident to include resident specific			
	-	tion was intact and she did			behaviors and appropriate intervention	ons.		
	not have an indwellin	g unnary cameter.			The DON completed an audit on 3/28	2/10		
	Resident #53 had an	order for the urinary			of current facility residents to identify			
		readmission) due to urinary			residents that require assistance with			
	retention.				eating. The DON validated that resid			
					identified to need assistance with eat			
	Resident #53 did not	have a comprehensive care			were included on the care plan and	2		
	plan developed for th	e use of the urinary catheter			Kardex. There were no other			
	as of 3/19/19.				discrepancies identified.			

Facility ID: 923320

If continuation sheet Page 19 of 89

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM AP OMB NO. 09	938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345177	B. WING		C 03/21/2	2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	E, ZIP CODE	
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE CC ED TO THE APPROPRIATE FICIENCY)	(X5) DMPLETIC DATE
F 656	Continued From page 19		F 6	56		
	On 3/19/19 at 9:53 Al	M and at 4:35 PM, Resident		Address what measu	res will be put into	
i		bed with a urinary catheter		place or systemic cha ensure that the deficie recur;	anges made to	
	interviewed. She ver an indwelling urinary readmitted from the h	M, the MDS Nurse was ified that Resident #53 had catheter when she was iospital on 2/18/19 and she		The DON, ADON, and coordinator will review during morning clinica	v physician orders al meeting at least 5	
	plan for the urinary ca	p a comprehensive care atheter. M, the Director of Nursing		times a week, to ident indwelling catheter, part medications and assist and will implement ca	sychoactive stance with feeding,	
		ed. The DON stated that orehensive care plan		Care plan interventior the care Kardex for re the CNA to be aware each resident.	ns will be included on esidents to enable	
	3a. Resident #35 was	s admitted to the facility on		The CNA will review t	he Kardex at the	
	•	ses that included dementia bance and anxiety disorder.		beginning of each shi nurse will notify the C that may occur throug	NA of any changes	
	#35 had anxiety, rang	11/14/18 indicated Resident the call bell every 5- 10		IDT will review and up quarterly, annually an	odate care plans id significant change.	
	When staff entered th	y yelled out, "Nurse, Nurse". he room to see what l, she stated that she had		The Director of Nursir an in-service education certified nursing assis	on on 3/27/19, for the	
	forgotten and didn't k or ringing the call bell	now why she was yelling out		regarding following ca as noted on the reside education will be prov	ent Kardex. The	
	#35 rang the call bell with yelling out for sta			during orientation. The Reimbursement provite the MDS coordinator	e Director of Clinical ided education for and SSD on 4/2/19,	
	#35 what she needed	oom and asked Resident I, she would state that she and she stated that she just be room with her		regarding implementa care plans specific to diagnosis.		
		11/16/18 indicated Resident		Indicate how the facili its performance to ma		

Facility ID: 923320

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/30/20 [,] 1 APPROVE). 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	LETED
		345177	B. WING			_ 21/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 656	physician was in the finoted to order an Ser medication) for Resided #35 was yelling out the with visual and auditor A nursing note dated #35 was yelling out a medication that was ge The admission Minim assessment dated 11 #35' s cognition was a vas assessed with ha 7 day look period. Re behavioral symptoms rejection of care. She antipsychotic medicat a Gradual Dose Redu antipsychotic medicat The behavioral sympt (CAA) for Resident #3 MDS indicated she had disorder and Behavio Symptoms of Demen to yell out and then for Resident #35's comp the focus area, initiator revised on 11/26/18, of	or staff this morning while the facility. The physician was roquel (antipsychotic lent #35. 11/19/18 indicated Resident nat morning and was noted ory hallucinations. 11/20/18 indicated Resident nd stating that the given to her was poison. 11/20/18 indicated Resident moderately impaired. She allucinations during the MDS esident #35 had other on 4-6 days and no was administered tions on 4 of 7 days and had uction (GDR) of the tion on 11/19/18. tom care area assessment 35's 11/20/18 admission ad diagnoses of anxiety	F 656	solutions are sustained; The DON, and/or ADONs will ob residents weekly for 4 weeks, th residents monthly for 2 months is that residents requiring assistance resident's care plan. The Director of nursing, Assistant of nursing and/or MDS coordina 100% of identified incoming ord/ ensure compliance within 72 ho receipt of orders to include care updates and Kardex updates. Le presented monthly X 3 months the QAPI program with the plan adjusted/extended as deemed r by QAPI Program to ensure sign compliance is maintained. Dates When The Corrective Act completed April 18th, 2019	nen 10 to validate ice with per the nt Director itor will log ers to urs of plan og will be to the necessary nificant	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>				PLETED
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			5	1 00/	21/2013	
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	focus area: 1) Admini medications as ordered monitor for side effect shift; 2) Monitor/docur adverse reactions of p These interventions w and last revised on 12 no specific behaviors non-pharmacological the comprehensive ca focus areas related to and/or BPSD. A review of nursing no s behavior of frequent 11/24/18, 11/26/18, 12 2/1/19, 2/10/19, 2/16/ An interview was com 3/19/19 at 4:40 PM. If Resident #35 yelled of indicated that this ber since Resident #35 's An interview was com Supervisor #1 on 3/20 Supervisor #1 stated the behavior of screat She reported that whe #35's room in respons stated that she had no Supervisor #1 stated ordered Seroquel for behavior.	wo interventions for this ster psychotropic ed by the physician and ts and effectiveness each ment/report as needed any osychotropic medications. were initiated on 11/26/18 1/28/18. This care plan had noted and contained no interventions. In addition, are plan included no other o Resident #35 ' s behaviors of the serve aled Resident #35 ' t yelling out occurred on 1/28/18, 11/29/18, 12/5/18, 1/27/18, 12/29/18, 1/26/19, 19, and 3/3/19. ducted with Nurse #8 on Nurse #8 stated that but all the time. She havior had been ongoing is admission. ducted with Nurse that Resident #35 exhibited ming/yelling out for staff. en staff entered Resident se to her yelling, the resident of needed anything. Nurse that Resident #35 was BPSD to manage the ducted with the MDS	F	656			
	An interview was con	ducted with the MDS 19 at 4:50 PM. She stated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE		
		345177	B. WING				C 21/2019	
NAME OF PI	ROVIDER OR SUPPLIER							
	ENS AT PINEHURST REF			205 RATTLESNAKE TRAIL				
					PINEHURST, NC 28374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 22	Í F	656	6			
	· · · · · · · · · · · · · · · · ·	oonsible for completing care		000				
	Worker (SW) on 3/19, that she was auditing (3/19/19) and noticed in place to address R She explained that th Resident #35's antips care plan had not incl non-pharmacological behaviors. An interview was con Nursing on 3/21/19 at she expected care pla based on the resident indicated that Resident with dementia-related	that there was no care plan esident #35's behaviors. ere was a care plan for sychotic medication, but this luded any interventions to address ducted with the Director of t 10:25 AM. She stated that ans to be comprehensive t's assessed needs. She nt #35 had been assessed						
	11/13/18 with diagnos On 1/3/19 Resident #	s admitted to the facility on ses that included dementia. 35's comprehensive care h the initiation of the focus						
	area of nutrition/dehy							
	#35's cognition was s required the supervisi	21/19 indicated Resident everely impaired, and she						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	, í				LETED		
							0		
		345177	B. WING			03/21/2019			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL					
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER							
(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)				(X5) COMPLETION DATE		
F 656	Continued From page weight loss with a cur pounds. A dietary communicat indicated a recommen- be assisted with eatin On 2/1/19 Resident # nutrition/dehydration of the resident was to be meals and snacks. A physician's order sig Resident #35 was to be all meals. A family interview was #35 on 3/18/19 at 12: Resident #35 had sor couple of months and facility staff were prov A review was conduct (NA) Activities of Daily documentation for the provided to Resident 3/19/19. There was a documentations comp Resident #35 was pro 12 out of 96 times. The from independent with extensive assistance An observation was conduction at the provide of the provided to Resident a documentation for the provided to Resident a signal a documentation for the provided to Resident a signal a documentation scomp Resident #35 was provided to a signal a documentati	e 23 rent body weight of 124 ion form dated 1/31/19 ndation for Resident #35 to g for all meals. 35's care plan related to risk was revised to indicate e assisted with eating for all gned on 2/5/19 indicated be assisted with eating for s conducted for Resident 21 PM. She stated that ne weight loss over the past she was unsure if the riding assistance with eating. ted of the Nursing Assistant y Living (ADL) e eating assistance level #35 from 2/6/19 through total of 96 NA bleted which revealed ovided with total assistance he remaining times ranged in no set up assistance to of 1.		650	DEFICIENCY)				
	over-the-bed table wit	and it was placed on her thin her reach. Resident I was not easily roused.							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	There was no staff pro- room to provide her a Resident #35's nutrition meal at this time was A second observation #35 during the breakff AM. Resident #35 was breakfast meal tray re- position as on the firs There was no staff pro- room to provide her a appeared to be no fur what was observed do observation. On 3/20/19 at 9:15 AI remove Resident #35 room. An interview w #4. She stated that R 0-25% of her breakfas Resident #35 required A second interview wa 3/20/19 at 10:50 AM. nutrition/dehydration of indicated she needed and snacks was revie revealed she had not care plan included thi An interview was con Nursing on 3/21/19 at she expected the care implemented. 4. Resident #50 was a	esent in Resident #35's ssistance with eating. onal intake of the breakfast 0-25 percent (%). was conducted of Resident ast meal on 3/20/19 at 9:00 as sleeping, and her emained in the same t observation at 8:40 AM. esent in Resident #35's ssistance with eating. Their ther nutritional intake than uring the 8:40 AM M NA #4 was observed to ' s breakfast tray from her ras then conducted with NA tesident #35 had eaten st meal. NA #4 stated that d no assistance with eating. as conducted with NA #4 on The care plan related to risk for Resident #35 that assistance with all meals wed with NA #4. NA #4 known that Resident #35's	F	656			

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		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	
		345177	B. WING				
	ROVIDER OR SUPPLIER	AB & LIVING CENTER	-1	:	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL DINIEUURST, NC, 28224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PINEHURST, NC 28374 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 656	A review of Resident dated 12/19/18 revea judgement and was of resident's mood durin depression, and sadm diagnosis of Sexual E psychotherapist was thought patterns into documented in the re A review of Resident Data Set dated 2/7/19 a hearing aid and had The resident had an i behaviors, psychosis diagnoses were non-/ seizure, anxiety, and Resident #50's care p revised on 11/14/18 r anti-psychotic mediat behavior managemer anxiety, and dementia will remain free of me The interventions wer effects, psych service approaches, and beh the person (there wer to behaviors documen On 3/20/19 at 2:00 pr conducted with Nurse familiar with and assig resident had a history sexual where she kiss mouth about a year a another incident. The staff for behaviors. M	 #50's psychotherapy notes led the resident had poor onfused at times. The g therapy was anger, uess. The resident had the behavior Disorder. The working to change negative positive (last note visit cord). #50's quarterly Minimum Prevealed the resident wore at minimal difficulty hearing. Intact cognition with no or depression. Active Alzheimer's dementia, depression blan initiated on 11/2/18 and evealed a focus of ion administration for nt related to depression, a. The goal was the resident dication complication(s). The goal was the resident avior symptoms not usual to re no interventions specific nted). 	F	656	5		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	she had a new roomn The resident had the communication and a verbalized that she di The resident had a ca behaviors, but the nur interventions did not r On 3/20/19 at 2:10 pr of Resident #50 who verbally aroused. The styled, wearing make On 3/21/19 at 8:30 ar conducted with Resid seizures all her life. T by her facial expressi was fixed on her body conversation. The re- re-directed. When as roommate, the reside say" and frowned. Th complaint and did not On 3/21/19 at 8:30 ar of the resident who w bed eating breakfast. oriented to time, situa was noted. The reside on her somatic sympt On 3/21/19 at 8:45 ar conducted with Nurse familiar with Resident the resident can be no Nurse #8 was aware	nate placed 3 weeks ago. verbal behaviors of negative nger. The resident had d not want a roommate. are plan goal for no rse was not aware that reflect the sexual behavior. In an observation was done was sleeping and not e resident was clean, hair up. In an interview was ent #50 who stated she had The resident appeared angry on and tone of voice and r symptoms during sident was not easily ked about her new int stated, "what is there to be resident did not have any want to talk any further. In an observation was done as sitting at the side of her The resident was alert and tion, and self. No confusion dent appeared to be fixated oms and her past.	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED C	
		345177	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 657 SS=D	On 3/21/18 at 8:55 ar conducted with Nurse regularly assigned to added that the resider less angry with staff s #5 has not observed of resident nor concerns assistants. Nurse #5 plan interventions with On 3/20/19 at 4:00 pr conducted with the far remembered Residen resident had received behaviors and psychic The physician was aw behaviors, including s the past. On 3/20/19 at 4:00 pr conducted with the Di she expected the resi developed to reflect th required. Care Plan Timing and CFR(s): 483.21(b)(2)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy	n an interview was #5 who stated she was the resident. Nurse #5 int was more relaxed and he was familiar with. Nurse recent behaviors from the socied from the nursing was not sure of the care hout looking. In an interview was cility physician who it #50 and stated that the psychotherapy for her atry followed as needed. ware of the resident's sexual behavior sometime in in an interview was frector of Nursing who stated dent's care plan to be heir preferences and care I Revision (i)-(iii) ensive Care Plans prehensive care plan must if days after completion of asessment. erdisciplinary team, that ited to rsician. e with responsibility for the		656			4/18/19

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/21/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GREI	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 657	 (E) To the extent pract the resident and the r An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and o assessments. This REQUIREMENT by: Based on record rev resident, and physicia failed to revise the re- of activities of daily liv 17 residents reviewed Resident #50 was ad 12/3/13 with the diagrand atrial fibrillation. A review of Resident Data Set dated 2/7/19 a hearing aid and had The resident had an i behaviors, psychosis required set up and s dressing and physica Active diagnoses wer and seizure. 	d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the	F 65	 7 The MDS coordinator reviewed a revised Resident #50 □ s Activities Living (ADL) care plan on 3/29/19 reflect the residents current ADL on needs. Address how the facility will idention residents having the potential to be affected by the same deficient practice of failure to revisor residents ADL care plan to reflect residents current ADL care needs. Address ADL care plan to reflect residents current ADL care needs. The Director of Nursing (DON), AD Director of Nursing (ADON), and coordinator completed an audit or 3/28/19, of current facility residents current facility resident care plan to validate that the ADL plan reflects the residents current care needs. 	s of Daily b, to care ify other be actice; e eged se the the s. issistant MDS n its ADL . care t ADL

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/30/2019 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING			03	C 6/21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REI	AB & LIVING CENTER					
				F	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page	e 29	F	657			
	 F 657 Continued From page 29 revealed a focus for self-care performance deficit related to limitations. The goal was the resident will maintain her current level of functioning. Interventions for all activities of daily living was independent initiated on 1/3/19. On 3/20/19 at 2:00 pm an interview was conducted with Nurse #1 who stated he was familiar with and assigned to Resident #50. The resident had a care plan for activities of daily living assistance and was not completely independent. The resident required assistance with bathing and set up for meals. On 3/20/19 at 2:10 pm an observation was done of Resident #50 who was sleeping and not verbally aroused. The resident was clean, hair styled, wearing makeup. On 3/21/19 at 8:30 am an interview was conducted with Resident #50 who stated she has had seizures all her life. The resident commented that the nursing assistant helped her 				care plans that were revised to reflect residents current ADL care needs. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will recur; The DON, ADON and/or the MDS coordinator will implement ADL care p within 21 days of admission for new admissions and will review and updat ADL care plans quarterly, annually ar significant change, to reflect the resid current ADL care needs. Indicate how the facility plans to moni its performance to make sure that solutions are sustained; The DON and/or the ADON s will au resident ADL care plans weekly for 4 weeks then 10 resident ADL care plan month for 2 months to validate that th ADL care plan reflects the residents current ADL care needs. The DON will review audits monthly	to not blans e nd ents tor udit 5 ns a e	
	shower by herself and needs for her meal. On 3/21/19 at 8:30 ar of the resident who w bed. She was eating On 3/21/18 at 8:55 ar conducted with Nurse assigned to Resident	e #5 who was regularly #50. She stated that the ndependent but required e assistance with her t preferred to be as			identify patterns/trends and will adjus plan as necessary for continued compliance. The DON will review the during monthly QAPI and will continue audits at the discretion of the QAPI committee.	e plan	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/201 FORM APPROVE OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/21/2019
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	•
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 657	Continued From page	e 30	F 657		
E 050	she expected the rest revised to reflect their required.	irector of Nursing who stated ident's care plan to be r preferences and care	E 050		
F 658 SS=D	CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 658		4/18/19
	as outlined by the con must- (i) Meet professional	d or arranged by the facility, mprehensive care plan,			
	resident and staff inter monitor and documer with an order for fluid	iews, observations, and erviews, the facility failed to nt fluid intake on resident restriction for 2 of 2 Resident #26 and #42).		F 658 F658 failed to monitor and document intake on a resident with a fluid restrict resident 26 and 42	ion
	A review of the facility and Restricting Fluids read in part, "be accu	/ policy titled Encouraging s and dated October 2010, rate when recording fluid d intake on the intake side of		Address how corrective action will be accomplished for those residents found have been affected by the deficient practice;	d to
	the intake and output in milliliters (ml)".	record. Record fluid intake		In regard to the deficient practice of the facility to monitor and document intake a resident with a fluid restriction for	
	The findings included	:		resident # 26 and resident # 42, the fail initiated an I and O (intake and output)	,
	4/2/18 with diagnoses	admitted to the facility on s that included congestive nd chronic kidney disease		monitoring system for both affected residents on 3/20/19. The facility place monitoring parameters on the resident medication administration record (MAF properly record and monitor intake of	d s'
		recent Minimum Data Set arterly assessment and		resident number 26 and resident numb 42 on 3/20/19. Non-compliance of	ber

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345177	B. WING			C 3/21/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		5/21/2019
				205 RATTLESNAKE TRAIL	0002	
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	a 31	F 65	50		
1 000	dated 1/15/19 revealed		FUL	resident's Intake restriction	ons are reported	
		eived supervision with her		to residents' physician fo		
	Activities of Daily Livi	•		modification of the reside	-	
		als. Active diagnoses were		as deemed necessary by	•	
		etes. The resident received 7		attending physician.		
		insulin injections over the 7				
	day look back period			Address how the facility		
	A review of Resident	#26's care plan dated		residents having the pote affected by the same def		
		d restrictions as ordered.		anected by the same der	icient practice,	
				An audit of all current res	sidents was	
	A review of the most	recent Registered Dietician		completed 3/19/19, by th		
		ated 2/12/19 indicated the		Director of Nursing (ADC		
		nue with the 1200ml per day		other residents who have	-	
	fluid restriction for CH	1F.		deficient practice of mon	-	
	A review of Resident	#26's February 2019 and		documenting fluid intake with a fluid restriction. For		
		on Administration Record		as having the deficient p		
	(MAR) revealed no m			to monitor and document		
	. ,	d intake until 3/18/19 which		In-service education was		
	-	e fluids provided from		by 3/19/19, to all current		
	nursing with medicati	ions.		upon receipt of any fluid		
	A review of the ment	aly physician orders dated		resident's care plan and		
		nly physician orders dated d restriction of 1200 ml in a		administration record (M. reviewed and updated as		
		lietary providing 240ml at		include I & O(intake and	-	
		dinner and nursing staff		and fluid restriction para		
		ach shift with medications.		personnel will be respon		
				that residents fluid intake		
		n an observation was made		and record of all fluid cor	-	
	cup of coffee only.	eakfast tray which included a		resident as reasonably a fluids throughout their sh		
		d with Resident #26 on		In-service education will		
		ho stated she was aware of		newly hired licensed nur	÷ ·	
	the fluid restriction ar			during orientation and pr		
	beverages throughou unopened diet Pepsi	-		care for a resident that u any fluid restriction order		
		ed that the staff did not ask		plan and Medication adm		

Event ID: YQDZ11

Facility ID: 923320

If continuation sheet Page 32 of 89

		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURV COMPLETE	
			A. BUILDING	3	С	
		345177	B. WING		03/21/2	010
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	019
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE	ACTION SHOULD BE COM	(X5) MPLETIO
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED DEFICI		DATE
F 658	Continued From page	e 32	F 65	58		
	her about the fluids s			(MAR) will be reviewed	and updated as	
		······································		necessary to include I 8		
	On 3/19/19 at 2:25pm	n an interview was		output) records and fluid		
	conducted with Nursi	ng Aide (NA) #2. She		parameters. Licensed p	ersonnel will be	
	-	as aware Resident #26 was		responsible to ensure th	nat residents fluid	
		and that she only provided		intake records reflect ar		
		ent on the meal tray. She		fluid consumed by resid	2	
		record any intake for the		able to include all fluids	throughout their	
	resident or provide ac	dditional fluids to her.		shifts.		
	On 3/19/19 at 2:30pm	n an interview occurred with		Address what measures	s will be put into	
		ssigned to the resident. After		place or systemic change		
	reviewing the MAR, N			ensure that the deficien		
		ml of fluids provided with		recur;		
	medications as order	ed on each shift but did not				
	document the additio	nal amounts of fluid		Physician order review	will occur 5 x's per	
	consumed by the res	ident.		week of all newly writter		
				by Unit coordinators (AI		
		vith the Director of Nursing		and/or MDS coordinator		
		8:15am, she stated she was		any fluid restriction orde		
		et was not being utilized as		plan and Medication ad		
		ut would expect the nursing		(MAR) will be reviewed		
		d intake on the MAR to		necessary to include 1 8	-	
		ved on meal trays, provided vell as any additional fluids		output) records and fluid parameters.	restriction	
	consumed by the res	-		parameters.		
				Indicate how the facility	plans to monitor	
	On 3/20/19 at 1:00pm	n Resident #26 was		its performance to make		
		of tea provided by dietary on		solutions are sustained;		
	· ·	big styrofoam cup of bubbly,				
	dark fluid on her beds	side table.		The director of nursing,		
	An interview was con	ducted with Nurse #7 on		of nursing and/or MDS of 100% of identified incom	-	
		She stated she documented		ensure compliance with		
	-	ovided with medications as		receipt of orders. Log w		
		but did not document any		monthly X 3 months to t		
		f fluid consumed by the		with the plan adjusted/e		
	resident.			deemed necessary by C		
				ensure significant comp		

Facility ID: 923320

If continuation sheet Page 33 of 89

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/30/2019 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C / 21/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL		
				P	INEHURST, NC 28374		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	<u>- 33</u>	F	658			
	During an interview w	vith the DON on 3/20/19 at		550	maintained.		
	2:05pm, she indicated as of today, nursing staff were to question the alert and oriented residents about fluids consumed and document all fluid intake on the MAR. On 3/21/19 at 10:25am during an interview with the DON, she stated it was her expectation for fluid intake to be monitored and documented.				Indicate dates when corrective action be completed;	will	
					04/18/2019		
	1/23/19 with diagnose	admitted to the facility on es that included Heart tructive Pulmonary Disease ellitus (DM) and					
	A review of the most recent MDS coded as an admission assessment and dated 1/30/19 revealed the resident was cognitively intact, received extensive assistance from staff for						
	diagnoses were hear diabetes. The resider	up with meals. Active					
	A review of Resident revealed fluid restrict	#42's care plan dated 2/4/19 ions as ordered.					
		#42's February 2019 and realed no monitoring and d intake.					
	3/1/19 revealed fluid 24-hour period with d	nly physician orders dated restriction of 1500 ml in a lietary providing 240ml at dinner and nursing staff					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GREI	ENS AT PINEHURST REF	AB & LIVING CENTER			05 RATTLESNAKE TRAIL NINEHURST, 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 658	of Resident #42's brecup of coffee. An interview occurred 3/19/19 at 2:15pm, withe fluid restriction and throughout the day or members. On 3/19/19 at 2:25pm conducted with NA #2 was aware Resident is and that she assisted provided on the meal didn't record any intal any additional fluids the On 3/19/19 at 2:30pm Nurse #6 who was as reviewing the MAR, N documented the 260r medications as ordered document the addition consumed by the resident members. During an interview with (DON) on 3/20/19 at 3 was aware the intake as stated in the policy nursing staff to docum to include the fluid record provided with medical	ach shift. an an observation was made akfast tray which included a with Resident #42 on ho stated he was aware of id did consume extra fluids brought in by family an an interview was 2. She explained that she #42 was on a fluid restriction with the fluids that were tray. She added that she ke for the resident or provide o him. an interview occurred with esigned to the resident. After Jurse #6 stated that she min of fluids provided with ed on each shift but did not nal amounts of fluid ident or brought in by family with the Director of Nursing 8:15am, she stated that she sheet was not being utilized y but would expect the nent fluid intake on the MAR ceived on meal trays,	F	358			
		ducted with Nurse #7 on					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/20 FORM APPROVI OMB NO. 0938-03	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		345177	B. WING	C 03/21/2019		
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER		RATTLESNAKE TRAIL EHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO	
F 658 F 690 SS=D	the 260ml of fluids pro- ordered on each shift additional amounts of resident. During an interview w 2:05pm, she indicated staff were to question residents about fluids all fluid intake on the On 3/21/19 at 10:25a the DON, she stated fluid intake to be mon Bowel/Bladder Incont CFR(s): 483.25(e)(1) §483.25(e) Incontiner §483.25(e)(1) The fac resident who is contin admission receives so maintain continence of condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter or is assessed for remove	She stated she documented ovided with medications as to but did not document any f fluid consumed by the with the DON on 3/20/19 at d as of today, the nursing the alert and oriented to consumed and document MAR. m during an interview with it was her expectation for intored and documented. tinence, Catheter, UTI -(3) mce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that	F 658		4/18/19	

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		ID HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COMPLE	(X3) DATE SURVEY COMPLETED C	
		345177	B. WING			1/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER		05 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 690	Continued From page	e 36 theterization is necessary;	F 690				
	receives appropriate prevent urinary tract i continence to the ext §483.25(e)(3) For a r incontinence, based comprehensive asses ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on record rev interview, the facility care by not securing catheter tubing to pre- to prevent accidental failed to perform a vo- per hospital recomme of 4 sampled residen urinary catheter. Findings included: 1. Resident #74 was 2/14/19 with multiple retention. The admiss (MDS) assessment d	esident with fecal on the resident's ssment, the facility must it who is incontinent of bowel treatment and services to		Address how corrective action w accomplished for those residents have been affected by the deficie practice; In regard to deficient practice of p securing and anchoring catheter prevent excessive tension and to accidental removal for resident n 74, catheter tubing was secured 03/19/19 by C.N.A assigned to re In regard to deficient practice of performing a toileting trial and if to void, refer to urology. Resident # declined a voiding trail, and the p doesn t want the catheter remov this time. Residents care plan w	s found to ent properly tubing to p prevent number on esident. unable to #53 physician ved at		
	problems and she ha catheter. Resident #74 had a c	d an indwelling urinary loctor's order on admission velling urinary catheter.		updated to reflect a comprehensi of care for the use of a urinary ca 3/19/19. Education was provided to all cu working C.N.A□s on the securen urinary catheters on 3/19/19 by E nursing (DON). All other C.N.A□	atheter on rrently nent of Director of		

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						0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
			A. DOILDING	J	с	
		345177	B. WING			1/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 690	Continued From page	o 27		20		
F 090			F 69		na and advection	
		have a comprehensive care the use of the urinary catheter		to the securement of uring		
	as of 3/19/19.	to use of the unitary calleter		or by 3/28/19, by the DC	-	
				C.N.A s will be provide		
	On 3/19/19 at 9:50 A	M and at 4:30 PM, Resident		education during new hi		
	#74 was observed in	bed. She had an indwelling		to caring for residents w	ho have an	
	urinary catheter and	the catheter was not secured		indwelling catheter.		
	or anchored to her th	igh.		Address how the facility		
				residents having the pot		
		M, Nurse Aide (NA) #3 was		affected by the same de	-	
		ed that she just worked part		An audit was completed		
	time at the facility. N	A #3 also stated that lled her catheter out once.		DON and Assistant Dire	•	
		she would inform the Nurse		(ADON), of all residents have a catheter for curre	-	
		device on the resident's		voiding trials to ensure of		
	catheter.			properly carried out. The		
				residents identified as de		
	On 3/19/19 at 4:35 P	M, Nurse #8 was		An audit was completed	3/22/19, by	
	interviewed. She sta	ted that she expected the NA		Director of Nursing (DOI		
		sident's catheter had no		Director of Nursing (ADC		
		n it. She indicated that		residents who currently		
		that Resident #74's catheter		ensure that they were pr		
	was not secured or a	nchored to her thigh.		prevent excessive tension		
	On 3/21/10 at 8:45 A	M, the Director of Nursing		accidental removal. The residents identified as d		
		ed. The DON stated that she		Address what measures		
	. ,	catheters to be secured or		place or systemic chang		
		securement device and NAs		ensure that the deficient		
		orm the nurse when the		recur;	-	
	urinary catheter did n	ot have a securement		Education was provided	-	
	device.			working C.N.A s on the		
				urinary catheters on 3/1		
	2 Decident #52 was	originally admitted to the		Director of Nursing (DOI		
		originally admitted to the dwas readmitted on 2/18/19		C.N.A s received in-ser education to the securer	-	
	-	es including congestive		catheters on or by 3/28/	-	
	heart failure.			Newly hired C.N.A s wi		
				in-service education dur	-	
	The quarterly Minimu			orientation prior to caring	•	

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME				PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	B. WING		C 03/21/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
THE GREENS AT PINEHURST REHA	B & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
not have an indwelling uThe hospital discharge arevealed that in and outperformed on Resident ashe continued to have re(ml). An indwelling urinaIt was recommended tothe facility with the indwelling urinalto void and to empty heaurology.Resident #53 had doctor(readmission) for the indexand recommend voidingvoid, refer to urology.Resident #53 did not haplan developed for the uas of 3/19/19.On 3/19/19 at 9:53 AM a#53 was observed in bein place.On 3/20/19 at 11:58 AMwas interviewed. She snurse who wrote the ordindwelling urinary catherecommendation from thtrials and if not voiding,Nursing Supervisor indicthe Nurse to follow throuvoiding trial. The Nursirthe resident's records at	 /19 indicated that n was intact and she did urinary catheter. summary dated 2/18/19 catheterization was #53 at the hospital and esidual up to 800 milliliter ary catheter was inserted. discharge the resident to relling urinary catheter and at the facility and if unable r bladder, to refer her to or's orders dated 2/18/19 dwelling urinary catheter and at 4:35 PM, Resident ed with a urinary catheter 1, Nursing Supervisor #1 tated that she was the ders dated 2/18/19 for the ter and the he hospital for the voiding to refer to urology. The cated that she expected ugh with the order for the hg Supervisor reviewed	F 6	 90 who have an indwelling cate Education was provided to working Licensed nurses of the DON, for completing version of the DON, for completion of as ordered. All other licensed personnel received in-service ducation for completion of as ordered on or by 3/28/19. Newly hired licensed nursing will be provided with in-service during new hire orientation ensuring resident sorders out in regards to a voiding caring for residents who had indwelling catheter. Physician order review will per week of all newly writter orders and new admission Assistant Director of Nursin DON, and/or MDS coordinate receipt of any residents ide catheter upon admission of ordered catheter, the reside and orders will be reviewed as necessary to ensure all (including voiding trials and catheter care) are carried of appropriately. Residents with catheters worder on their Medication ARecord(MAR) for the nurset that catheter is appropriate prevent excessive tension accidental removal. 	all currently n 3/19/19 by biding trials as I nursing ice training and f voiding trials 9, by the DON. ng personnel vice education to include s are carried trial prior to ave an occur 5 x s en physician orders by the ng(ADON), ator. Upon entified with a r a newly ent s care plan d and updated orders d/or other but rill include an administration es to ensure d/y secured to and to prevent

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/3 FORM APPF OMB NO. 0938	ROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 03/21/201	19
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GREE	ENS AT PINEHURST REP	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP	K5) LETION ATE
F 690	F 690 Continued From page 39 Resident #53. On 3/20/19 at 3:05 PM, Nurse #9 was interviewed. She stated that she was assigned to Resident #53 when readmitted from the hospital. Nurse #9 stated that the Nursing Supervisor wrote the admission orders and she didn't know about the order for the voiding trial. She revealed that she had not performed the voiding trial for Pagident #52		F 690	its performance to make sure that solutions are sustained; The DON, ADON and/or MDS coordir will log 100% of identified incoming or to ensure compliance within 72 hours receipt of orders. Log will be presente monthly X 3 months to the QAPI prog with the plan adjusted/extended as deemed necessary by QAPI Program	ders of ed ram	
F 692 SS=D	(DON) was interviewed expected the nursing discharge summary a recommendation and voiding trial. The DO order and the hospital urinary catheter and to on the physician's ord the Medication Admir therefore the voiding	tatus Maintenance	F 692	ensure significant compliance is maintained. The DON will audit 3 of residents who have an order for a catheter per week weeks, then 10 residents with a cathe monthly per month X 2 months to ens that all residents have their catheter□ properly secured. Findings will be reported to QAPI committee with adjustment to plan as necessary to achieve and maintain significant compliance.	X 4 ter ure	19
	(Includes naso-gastri both percutaneous er percutaneous endosc enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Mainta of nutritional status, s desirable body weigh balance, unless the re	ssment, the facility must				

Facility ID: 923320

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/30/2019 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l í í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING				C 21/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ENS AT PINEHURST REF			20	05 RATTLESNAKE TRAIL		
				Ρ	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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	preferences indicate of §483.25(g)(2) Is offerences indicate of §483.25(g)(3) Is ofference there is a nutritional poper hydra §483.25(g)(3) Is ofference there is a nutritional poper orders a there This REQUIREMENT by: Based on observation interviews with family, staff, the facility failed order to provide Reside eating for all meals for for nutrition. The findings included Resident #35 was add 11/13/19 Resident # plan was updated with area of nutrition/dehydinterventions included meals as needed. The quarterly Minimum assessment dated 1/2 #35's cognition was so required the supervisi Resident #35 was asso weight loss with a cur pounds. A Registered Dietician	otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care rapeutic diet. is not met as evidenced n, record review, and , Registered Dietician, and to follow the physician's dent #35 assistance with r 1 of 5 residents reviewed : mitted to the facility on ses that included dementia. 35's comprehensive care h the initiation of the focus dration risk. The d assisting Resident #35 with m Data Set (MDS) 21/19 indicated Resident everely impaired, and she on of 1 with eating. sessed with significant rent body weight of 124	F	592	F 692 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; The Director of Nursing (DON) provide service education beginning on 3/19/19 for the licensed nurses and certified nursing assistants (CNA) regarding following physician orders and care pla interventions and as noted on the resid Kardex for assistance with eating for Resident #35. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice The DON completed an audit on 3/28/7 of current facility residents to identify residents that require assistance with eating. The DON validated that reside identified to need assistance with eatin were included on the care plan and Kardex. There were no discrepancies identified.	d in), n ent er ; 19,	
	pounds. A Registered Dieticiar 1/25/19 indicated Res				were included on the care plan and Kardex. There were no discrepancies	-	

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						10.0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		FE SURVEY MPLETED	
						С	
		345177	B. WING		0	3/21/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 692	Continued From page	e 41	F 69	2			
		ls. Resident #35's intake		place or systemic changes made	de to		
	was noted as 0-50%	and she was independent		ensure that the deficient practic			
	with set up assistance			recur;			
	indicated Resident #3 nutritional supplement			The DON, ADON, and/or MDS			
		115.		coordinator will review physicia	n orders		
	A dietary communica	tion form dated 1/31/19		during morning clinical meeting			
	•	ndation for Resident #35 to		times a week, to identify orders			
	be assisted with eatir	ng for all meals.		indwelling catheter, psychoactiv			
				medications and assistance wit	-		
		[£] 35's care plan related to risk was revised to indicate		and will implement care plan ac Care plan interventions will be			
	-	e assisted with eating for all		the care Kardex for residents to			
	meals and snacks.			the CNA to be aware of interve			
				each resident. The CNA will rev	/iew the		
		35's Nursing Assistant (NA)		Kardex at the beginning of each			
	-	as updated to indicate the		the licensed nurse will notify the			
	meals and snacks.	sisted with eating for all		any changes that may occur th the shift. The IDT will review ar			
				care plans quarterly, annually a			
	A physician's order si	igned on 2/5/19 indicated		significant change.			
		be assisted with eating for		The Director of Nursing (DON)			
	all meals.			in service education on 3/28/1			
	An PD note dated 3/1	15/19 indicated Resident #35		certified nursing assistants (CN regarding following physician o			
		ht was 120.8 pounds as of		care plan interventions as note			
		24 pounds on 1/18/19).		resident Kardex. The education			
	Resident #35 was no	ted to be totally dependent		provided to new hires during or			
	on staff for assistance	e with eating.		The Director of Clinical Reimbu			
	A family interview	a conducted for Decident		provided education for the MDS			
	-	s conducted for Resident 21 PM. The family member		coordinator and SSD on 4/2/19 implementation and updating o			
		#35 had some weight loss		plans specific to resident needs			
		of months and she was		diagnosis.			
		taff were assisting the					
	resident to eat.			Indicate how the facility plans to			
		tod of the NIA Activitiesf		its performance to make sure the	nat		
	A review was conduc Daily Living (ADL) do	ted of the NA Activities of		solutions are sustained.			

Facility ID: 923320

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	OMPLETED
						С
		345177				03/21/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 692	1.0		F 69			
		ided to Resident #35 from		The DON, and/or ADONs		
	NA documentations of	19. There was a total of 96		residents weekly for 4 wee residents monthly for 2 mo		
		h revealed Resident #35		that residents requiring as		
	was provided with tot	al assistance 12 out of 96		eating are receiving assist		
	times. The remaining			to the residents care plan.		
	independent with no	•				
	extensive assistance	of 1.		The Director of nursing, A of nursing and/or MDS co		
	An observation was o	conducted of Resident #35		100% of identified incomir		
	during the breakfast r	meal on 3/20/19 beginning at		ensure compliance within	-	
		35's breakfast meal tray had		receipt of orders to include	•	
		d and it was placed on her		updates and Kardex upda		
		ithin her reach. Resident d was not easily roused.		QAPI program with the pla		
		resent in Resident #35's		adjusted/extended as dee		
	-	assistance with eating.		by QAPI Program to ensu	•	
		onal intake of the breakfast		compliance is maintained.		
	meal at this time was	o-25%.		Data When Corrective Act	ien will be	
		n was conducted of Resident		Date When Corrective Act Completed	ion will be	
		fast meal on 3/20/19 at 9:00		Completed		
	AM. Resident #35 w			April 18th, 2019		
	breakfast meal tray re					
		st observation at 8:40 AM.				
		esent in Resident #35's assistance with eating. Their				
	•	rther nutritional intake than				
	what was observed d					
	observation.					
	On 3/20/19 at 9.15 A	M NA #4 was observed to				
		5's breakfast tray from her				
	room. An interview w	vas then conducted with NA				
		Resident #35 had eaten				
		st meal. NA #4 was asked				
		sident needed assistance orted that this information				
	was listed on the NA					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 04/30/2019 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345177	B. WING			03/21/2019
	ROVIDER OR SUPPLIER	HAB & LIVING CENTER		STREET ADDRESS, CITY, STAT 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 692	#35 had not required A second interview w 3/20/19 at 10:50 AM. Resident #35 that ind assistance with all me #4. NA #4 revealed s Resident #35's karde assistance with all me was familiar with Res resident had fluctuation	NA #4 stated that Resident assistance with eating. as conducted with NA #4 on The NA kardex for licated she needed eals was reviewed with NA she had not known that x indicated she needed eals. She reported that she ident #35 and that the ons in her eating abilities e thought the resident was	F 6	92		
F 608	3/20/19 at 11:55 AM. indicated Resident #3 staff for assistance w She stated that she re well as the NA docum level of assistance a The RD indicated she assistance to Resider ordered. An interview was con Nursing on 3/21/19 a she expected physici	ducted with the RD on The 3/15/19 RD note that 85 was totally dependent on ith eating was reviewed. eviewed the NA kardex as nentation to determine what resident requires with eating. e expected staff to provide int #35 with eating as ducted with the Director of t 10:25 AM. She stated that an's orders to be followed.	Eß	08		4/18/19
F 698 SS=E	require dialysis receiv with professional star	ure that residents who ve such services, consistent ndards of practice, the on-centered care plan, and	F 6	98		4/18/19

Facility ID: 923320

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/30/2019 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA1	E SURVEY IPLETED
		345177	B. WING			C 03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	05 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		Р	INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 698	Continued From page	o 44	F	698			
				030			
	the residents' goals a	Γ is not met as evidenced					
	by:						
	-	iew, resident interview, and			Address how corrective action will b	be	
		cility failed to maintain			accomplished for those residents for	und to	
	ongoing routine comr				have been affected by the deficient		
	hemodialysis center f	for 1 of 1 resident reviewed			practice;		
	for dialysis (Resident	: #2).			The facility will maintain ongoing effe		
					communication with the hemodialys		
	The findings included	1:			center through written communication	-	
					utilizing a communication notebook		
		nitted to the facility on			will accompany residents to/from dia	-	
		ently readmitted on 1/28/19 ncluded End Stage Renal			center(s). This deficient practice wa noted for one resident Resident #2.		
		dependence on renal			where the nurse was unable to verif		
	dialysis.				written communication to and from t	-	
					hemodialysis center had occurred.		
	The quarterly Minimu	ım Data Set (MDS)			Dialysis center was contacted by the	Э	
		24/19 indicated Resident			assistant director of nursing on 3/20		
	#2's cognition was int	tact, and she received			to verify no other communication to	the	
	dialysis.				facility in regard to Resdient #2 had	l not	
					been communicated.		
	A review of Resident	-			Address how the facility will identify	other	
		ea of the need for dialysis is area was initiated on			residents having the potential to be	ico :	
		ed active as of 3/18/19. The			affected by the same deficient pract All other residents who receive serv		
		itiated on 10/25/18, included			provided by hemodialysis center(s)		
	dialysis as ordered by				risk for this deficient practice.	u. 0 ut	
		· · · · · · · · · · · · · · · · · · ·			All dialysis residents will utilize writt	en	
	An interview was con	iducted with Resident #2 on			communication notebooks to		
	3/18/19 at 12:00 PM.	She stated she went to			communicate information, validating	I	
	dialysis three times a	week.			verbal conversations between dialys	sis	
					center(s) and the facility staff.		
		ducted with Nurse #5 on			Communication notebooks are		
l		Nurse #5 reported she			maintained and transported to and f		
		Resident #2 and confirmed			dialysis centers by the transportation		
		l dialysis three times a week.			All other identified residents dialys		
		ere was no system in place			centers were contacted on or before 2, 2019 to verify that all information		
		ommunication with the			2, 2019 to verify that all information	nau	

Event ID: YQDZ11

Facility ID: 923320

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/21/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
				205 RATTLESNAKE TRAIL	
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 698 F 732 SS=C	explained that the fac "communication book communication that w facility staff and the d was no longer in place known why this was of been several months Nurse #5 indicated the normal occurred that called the facility staff An interview was con 3/20/19 at 3:35 PM. #5's interview that the for ongoing routine co dialysis center's staff An interview was con Supervisor #1 on 3/2 verified there was no routine communication staff for Resident #2. An interview was con Nursing (DON) on 3/2 indicated she expected for ongoing communication staff or nogoing communication staff for Resident #2.	for Resident #2. She cility used to have a c' that contained routine vas shared between the lialysis center's staff, but this ce. She stated she had not discontinued, but that it had since it had been in place. the dialysis center staff f or vice versa. aducted with Nurse #1 on Nurse #1 confirmed Nurse ere was no system in place communication with the for Resident #2. aducted with Nurse 0/19 at 3:40 PM. She system in place for ongoing on with the dialysis center's aducted with the Director of 21/19 10:25 AM. The DON ed a system to be in place cation, coordination, and in the facility staff and the	F 698	 been appropriately communicated to facility and services were coordinate Address what measures will be put if place or systemic changes made to ensure that the deficient practice will recur; Facility transportation driver receiver in-service education provided by Dir of Nursing in regards to the communication process to coordinate services with the dialysis centers on 3/27/19. All current licensed nursing personn were provided in-service education protocordinate services with the dialy centers. New licensed nursing personnel will provided training to communication of dialysis provider(s) to properly coordinate services upon hire. Indicate how the facility plans to modify performance to make sure that solutions are sustained; Administrator, Director of nursing will aud dialysis communication notebooks to ensure appropriate coordination and communication occurs 5 x sperwer 4 weeks, 2 X per week for 3 weeks a weekly X 2, reporting results to QAF program and re-evaluating and adju plan to maintain compliance as need. 	ed. into into Il not d rector te nel on or ursing be with dinate nitor r it o d seek X and Pl sting

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345177	B. WING				21/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 732	§483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must po specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readabh (B) In a prominent pla residents and visitors §483.35(g)(3) Public a staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by:	and the actual hours worked opries of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. I nurses or licensed defined under State law). des. g requirements. bot the nurse staffing data in (g)(1) of this section on a inning of each shift. ed as follows: le format. ince readily accessible to access to posted nurse cility must, upon oral or e nurse staffing data c for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of uired by State law, whichever	F	732			
	posted daily nurse sta 18 months, or as requ is greater. This REQUIREMENT by:	affing data for a minimum of uired by State law, whichever			Address how corrective action will be		

Facility ID: 923320

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE	
ND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345177	B. WING	C		
NAME OF P	ROVIDER OR SUPPLIER	040177		STREET ADDRESS, CITY, STATE, ZIP CODE	03/21/201	19
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	X5) PLETION ATE
F 732	Continued From page	e 47	F 732			
	facility failed to post in the area of actual hou during the survey. The Observation of the po 3/18/19, 3/19/19, 3/20 the column titled "Act blank for licensed and An interview was con Nursing (DON) on 3/2 stated that the column Worked" on the poste completed by the third previous shifts at mid She reported that after in the column on the previous day a current date's posting Hours Worked" again she was unaware tha staffing information w the beginning of each it was her expectation	aurse staffing information in urs worked for 4 of 4 days he findings included: basted nurse staffing form on 0/19, and 3/21/19 revealed ual Hours Worked" was d unlicensed nursing staff. ducted with the Director of 21/19 at 9:30 AM. The DON in titled "Actual Hours ed nurse staffing form was d shift nurse for all 3 night at the end of the day. er the third shift nurse filled nurse staffing form for d", she removed that posting and replaced it with the y with the column for "Actual being blank. She indicated		 accomplished for those residents have been affected by the deficie practice; The staffing sheets for dates 3/1 3/20 and 3/21 were updated at the each day to reflect actual hours we Address how the facility will ident residents having the potential to be affected by the same deficient practice of failure to poss staffing information with actual dat were to occur, providing actual hours worked, adjusting from those sch hours posted. Address what measures will be p place or systemic changes made ensure that the deficient practice of recur; To ensure that deficient practice of reoccur, nursing personnel will actual hours worked by the completed during the shift transition, providing accurate information of actual hours worked Director of nurses completed in-s training for the current licensed recurs that will impact the listed m hours, thereby posting actual hours worked. All newly hired licensed nurses will be recurrent and the deficient practice of the providing actual hours worked. 	nt 8, 3/19, e end of vorked. fy other be actice; b this to a site ours eduled at into to will not to will not to be not by the construction of the	

Event ID: YQDZ11

Facility ID: 923320

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	S FUR MEDICARE C	MEDICAID SERVICES			OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C 03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER			1 00/21/2013		
THE GRE	ENS AT PINEHURST RE	EHAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 732	Continued From pag	je 48	F 732	Indicate how the facility plans to moni- its performance to make sure that solutions are sustained; Director of nursing, ADON, or administrator will ensure postings are correctly adjusted reflecting actual how worked by completing audits 5 X □ s pe week X 4 weeks, 3 X per week X 4 weeks, and Monthly X 1 to ensure tha appropriate and timely adjustments ar postings are made to reflect actual ho worked per shift. Findings will be report to the QAPI committee and program v be re-evaluated and adjusted as need to maintain compliance.	urs er it nd urs orted vill	
F 744 SS=E	CFR(s): 483.40(b)(3 §483.40(b)(3) A resident diagnosed with deman appropriate treatment maintain his or her homological mental, and psychological This REQUIREMENT by: Based on observation facility failed to deven centered intervention residents with dement (Residents #35 and care. The findings in 1. Resident #35 was 11/13/18 with diagno	dent who displays or is eentia, receives the nt and services to attain or nighest practicable physical, social well-being. IT is not met as evidenced on, record review, and lent, staff, and physician, the elop and implement person ns to address the needs of ntia for 2 of 4 residents #50) reviewed for dementia	F 744	F 744 Address how corrective action will be accomplished for those residents four have been affected by the deficient practice; The Social Service Director (SSD) developed a care plan on 3/19/19, for specific behaviors and interventions related to Resident #35, to include yel out related to Behavioral and Psychological Symptoms of Dementia	lling	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	MPLETED	
			A. BOILDING			с	
		345177	B. WING			3/21/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
				205 RATTLESNAKE TRAIL			
THE GRE	THE GREENS AT PINEHURST REHAB & LIVING CENTER			PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 744	Continued From page	e 49	F 74	4			
	1.0	g the call bell every 5- 10	F /4				
		ly yelled out, "Nurse, Nurse".		The MDS coordinator had res	olved the		
	When staff entered th			Sexual behavior care plan for			
	Resident #35 needed	d, she stated that she had		#50 on 11/21/18, due to reside			
	forgotten and didn't k	now why she was yelling out		exhibiting sexual behaviors.			
	or ringing the call bel	I.		coordinator initiated a History			
				behavior care plan on 3/29/19			
		11/15/18 indicated Resident		initiated a care plan on 4/04/1			
	with yelling out for sta	every 5-10 minutes along		Resident #50, specific to beha anger related to dementia that			
		pom and asked Resident		easily redirected.			
		d, she would state that she					
		and she stated that she just		Address how the facility will id	lentify other		
	wanted someone in t	-		residents having the potential			
				affected by the same deficient	t practice;		
		11/16/18 indicated Resident					
		or staff this morning while the		The MDS coordinator complete			
		facility. The physician was		on 4/4/19, of current resident's	•		
	noted to order Seroque	lent #35. Resident #35 ' s		to identify residents with diagr Alzheimers/dementia, and val			
		as reduced after one dose of		Dementia specific care plan w			
	the Seroquel.			centered interventions were in			
				There were 28 residents ident			
	A nursing note dated	11/19/18 indicated Resident		Alzheimers/dementia diagnos			
		nat morning and was noted		Dementia care plans were dev			
	with visual and audito	ory hallucinations.		4/4/19 for residents identified.			
	A nursing note dated	11/20/18 indicated Resident		Address what measures will b	e nut into		
	#35 was yelling out a			place or systemic changes ma			
		given to her was poison.		ensure that the deficient pract			
				recur;			
	The admission Minim						
		1/20/18 indicated Resident		The licensed nurse and/or the			
	-	moderately impaired. She		initiate a baseline care plan u			
		allucinations during the MDS		admission to identify care nee			
	behavioral symptoms	esident #35 had other		specifically related to dementi needs.	a care		
	rejection of care. She			The SSD will review new adm	ission		
	antipsychotic medica			resident records to identify dia			

Facility ID: 923320

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		MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		345177	B. WING	C		
		345177			03/21/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST RE	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL		
				PINEHURST, NC 28374		
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		
PREFIX TAG	· · ·	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
F 744	Continued From pag	e 50	F 74	4		
				Alzheimers/dementia and will devel	lop a	
	The behavioral symp	otom Care Area Assessment		resident centered dementia care pla	•	
		² 35 ' s 11/20/18 admission		within 21 days of admission. The S	SD will	
		ad diagnoses of anxiety		review and update as necessary,		
		oral and Psychological		dementia care plans quarterly, annu	-	
		ntia (BPSD). She was noted		and significant change to assure ca		
	-	orget why she was yelling.		plans remain resident centered and		
		be assisted as needed, offer reassurance, explain		effective.		
		cipated needs. This CAA		The Director of Clinical Reimburser	ment	
		was to be developed.		provided education for the MDS	nont	
				coordinator and SSD on 4/2/19, reg	arding	
	Resident #35's com	prehensive care plan included		implementation and updating of car	-	
		ted on 11/23/18 and last		plans specific to resident needs and		
	revised on 11/26/18,	of the use of antipsychotic		diagnosis.		
	medications related	to behavior management and				
		s for Resident #35 to remain		Indicate how the facility plans to mo	onitor	
		drug related complications.		its performance to make sure that		
		ventions for this focus area:		solutions are sustained;		
		otropic medications as				
		cian and monitor for side		The MDS coordinator and/or the DC		
	effects and effective	port as needed any adverse		review new admission resident care weekly for 12 weeks to validate that		
		ropic medications. These		dementia specific care plan has bee		
		itiated on 11/26/18 and last		initiated as applicable within 21 day		
		This care plan had no		admission and will review care plan		
		l interventions to address		quarterly, annually and significant c		
	resident #35's deme	ntia related behaviors. In		to validate that dementia care plans	shave	
	addition, the compre	hensive care plan included		been reviewed and updated.		
		related to Resident #35's				
	behaviors, dementia	, and/or BPSD.		The MDS coordinator and/or the DO		
				review audits to identify patterns/tre		
		notes revealed Resident		and will adjust plan as necessary fo	or	
		quent yelling out occurred on 11/28/18, 11/29/18, 12/5/18,		continued compliance. The MDS coordinator and/or DON will review	the	
		2/27/18, 12/29/18, 1/26/19,		plan during monthly QAPI and will		
	2/1/19, 2/10/19, 2/16			continue audits at the discretion of	the	
				QAPI committee.		

Facility ID: 923320

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED		
						С		
		345177	B. WING			3/21/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
THE GREI	ENS AT PINEHURST REI	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 744	Continued From page	e 51	F 74	4				
	on 3/19/19 at 11:35 A	M. Staff were present for Resident #35 was noted to		Date When Corrective Action V Completed	Will be			
	behaviors were observed. Resident #35 was not interviewable.			4/18/19				
		conducted of Resident #35 M. She was sleeping in her ily roused.						
		conducted of Resident #35 M. She was sleeping in her ily roused.						
	3/19/19 at 4:40 PM. Resident #35 yelled of indicated that this bel since Resident #35's she was not sure if R included any non-pha							
	Supervisor #1 stated the behavior of screa She reported that wh #35's room in respon stated that she had n Supervisor #1 stated ordered Seroquel for behavior. She indica Resident #35's care	0/19 at 10:13 AM. Nurse that Resident #35 exhibited ming/yelling out for staff. en staff entered Resident se to her yelling, the resident ot needed anything. Nurse that Resident #35 was BPSD to manage the ted she was not sure if olan included any interventions to address						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING _				C / 21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 744	that the SW was resp plans to address dem She reported that her plan to be developed person-centered, non interventions to addre related behaviors. An interview was con Worker (SW) on 3/19, that she was auditing (3/19/19) and noticed in place to address R related behaviors. Sh care plan for Residen medication, but this c any non-pharmacolog the dementia related An interview was con Nursing on 3/21/19 at that her expectation v interventions to be de comprehensive care p a resident's dementia 2. Resident #50 was 12/3/13 with the diagn A review of Resident dated 12/19/18 revea judgement and was c resident's mood durin depression, and sadm diagnosis of Sexual E psychotherapist was thought patterns into documented in the re	onsible for completing care entia related behaviors. expectation was for a care that included -pharmacological ess a resident's dementia ducted with the Social /19 at 4:25 PM. She stated her care plans today that there was no care plan esident #35's dementia e explained that there was a t #35's antipsychotic are plan had not included gical interventions to address behaviors. ducted with the Director of t 10:25 AM. She reported vas for person-centered eveloped through the planning process to address -related behaviors. admitted to the facility on nosis of dementia. #50's psychotherapy notes led the resident had poor onfused at times. The g therapy was anger, tess. The resident had the behavior Disorder. The working to change negative positive (last note visit	F	744			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED	
	ΓED
345177 B. WING C 03/21/20	/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GREENS AT PINEHURST REHAB & LIVING CENTER 205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
F 744 Continued From page 53 F 744 Data Set dated 27/19 revealed the resident wore a hearing aid and had minimal difficulty hearing. The resident had an initiated cognition with no behaviors, psychosis or depression. Active diagnoses were non-Alzheimer's dementia, anxiety, and depression F 744 Resident #50's care plan initiated on 11/2/18 and revised on 11/14/18 revealed a focus of anti-psychotic mediation administration for behavior management related to depression, anxiety, and dementia. The goal was the resident will remain free of medication complication(s). The interventions were to report medication side effects, psych services as needed, consistent approaches, and behavior symptoms not usual to the person (there were no interventions specific to behaviors documented). On 3/20/19 at 2:00 pm an interview was conducted with Nurse Supervisor #2 who stated he was familiar with and assigned to Resident #50. The resident had a history of behaviors including sexual where she kissed another resident on the mouth about a year ago. There has not been another incident. The resident was observed by staff for behaviors. Most recently the resident was having anxiety and verbal behaviors because she had a new roommute placed 3 weeks ago. The resident had a care plan goal for no behaviors. but the nurse was not aware that interventions did not reflect sexual and verbal behaviors. On 3/20/19 at 2:10 pm an observation was done of Resident #50 who was steeping and not	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345177	B. WING _				C 21/2019	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			5 RATTLESNAKE TRAIL NEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 744	styled, wearing make On 3/21/19 at 8:30 ar conducted with Resid seizures all her life. T by her facial expressi was fixed on her body conversation. The re re-directed. When as roommate, the reside say" and frowned. Th complaint and did not On 3/21/19 at 8:30 ar of the resident who w bed eating breakfast. oriented to time, situal was noted. On 3/21/19 at 8:45 ar conducted with Nurse familiar with Resident the resident can be no Nurse #8 was aware aggression that cause not aware of prior sex On 3/21/18 at 8:55 ar conducted with Nurse regularly assigned to added that the reside less angry with staff s #5 has not observed resident nor concerns	e resident was clean, hair up. m an interview was lent #50 who stated she had The resident appeared angry on and tone of voice and y symptoms during sident was not easily sked about her new nt stated, "what is there to ne resident did not have any t want to talk any further. m an observation was done as sitting at the side of her The resident was alert and ation, and self. No confusion m an interview was t #50 and commented that egative and aggressive. of the resident's anger and ed verbal behavior but was was the resident. Nurse #5 nt was more relaxed and she was familiar with. Nurse recent behaviors from the a voiced from the nursing was not sure of the care hout looking.	F	744				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345177	B. WING		C 03/21/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 744 F 756 SS=D	resident had received behaviors and psychi The physician was av behaviors, including s the past. On 3/20/19 at 4:00 pr conducted with the D she expected the resi and a plan to address needs. Drug Regimen Revier CFR(s): 483.45(c)(1) §483.45(c) Drug Reg §483.45(c)(1) The dru must be reviewed at I licensed pharmacist. §483.45(c)(2) This re of the resident's media §483.45(c)(4) The ph irregularities to the at facility's medical direct and these reports mu (i) Irregularities included drug that meets the c (d) of this section for (ii) Any irregularities report attending physician a director and director of minimum, the resident	cility physician who th #50 and stated that the d psychotherapy for her atry followed as needed. vare of the resident's current sexual behavior sometime in m an interview was irector of Nursing who stated ident to have interventions individual and specific w, Report Irregular, Act On (2)(4)(5) imen Review. ug regimen of each resident least once a month by a view must include a review ical chart. armacist must report any tending physician and the ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. hoted by the pharmacist st be documented on a	F 7		4/18/19

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/30/2019 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345177	B. WING			03/21/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	THE GREENS AT PINEHURST REHAB & LIVING CENTER			2	205 RATTLESNAKE TRAIL		
				F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	resident's medical red irregularity has been action has been taken be no change in the r physician should doc the resident's medical §483.45(c)(5) The fac 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 Consultant interviews failed to identify and a Abnormal Involuntary assessment (an asse involuntary movemen antipsychotic medical reviewed for unneces #62). The findings included Resident #62 was ad 11/13/18 with diagnos anxiety disorder, dep syndrome and polyar	ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in al record. cility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take ifies an irregularity that in to protect the resident. T is not met as evidenced iew and staff and Pharmacy is, the Pharmacy Consultant address an incomplete Movement Scale essment utilized to monitor its for persons on tions) for 1 of 5 residents asary medications (Resident it: mitted to the facility on ses that included dementia, ression, restless leg thritis.	F	756	Address how corrective action will be accomplished for those residents four have been affected by the deficient practice; An abnormal involuntary movement si assessment (AIMS) was completed of resident number 62 on 03/20/2019 by licensed nurse. Address how the facility will identify of residents having the potential to be affected by the same deficient practic An audit was conducted by the Direct Nursing and Assistant director of nurs on 04/02/2019 of all other residents w are on antipsychotic medications to ensure that their AIMS had been completed within the most recent qua identifying 10 residents who were affected	nd to cale n the ther e; or of es ho rter,	
	assessment dated 11				of the deficient practice of having a complete AIMS upon admission and within the most recent quarter. The	Ma	
	A review of the comp	rehensive Minimum Data			licensed nurses updated/completed A	11112	

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		MEDICAID SERVICES			OMB NO.	0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345177	B. WING		C	C 03/21/2019	
	ROVIDER OR SUPPLIER	343177		STREET ADDRESS, CITY, STATE, ZIF		1/2019	
	ROVIDER OR SUFFLIER			205 RATTLESNAKE TRAIL	CODE		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE	
F 756	Continued From non	- 57					
F 750	1.0		F 75				
	. ,	an Admission assessment		assessment for identified	i residents on		
	cognitive impairment			4/4/19. Address what measures	will be put into		
		tion 7 days out of the 7 day		place or systemic change	-		
	look back period.			ensure that the deficient			
	•			recur;			
	A review of the most	recent MDS coded as a		The director of nursing pr	rovided education		
	quarterly assessment			to the pharmacy consulta	-		
		t had cognitive impairment		regarding the routine more	-		
	-	osychotic medication 7 days		completion of the Involun	-		
	out of the 7 day look	back period.		scale assessment (AIMS	-		
	A roview of Posident	#62's March 2019 physician		conducting the monthly re Additionally, the director			
	orders revealed an or			completed inservice educ	-		
	antipsychotic medica			current licensed nursing			
				completion of the AIMS q			
	An interview was con	npleted with Nurse #3 on		upon admission for all ap			
	3/20/19 at 2:55pm wł	no stated she was unsure		residents (those who rec			
	why the AIMS assess	sment was not completed at		medications) on 3/27/19.			
		 She further explained that 		nursing personnel will be			
	-	pleted an AIMS assessment		upon hire to the completi			
	for any new admissio			assessment upon admiss			
	antipsychotic medica	tion.		for all applicable resident	-		
	An interview was con	ducted with the Director of		receive antipsychotic me	dications).		
		20/19 at 3:05pm who stated		Indicate how the facility p	lans to monitor		
	the AIMS assessmen			its performance to make			
	admission and every	•		solutions are sustained;			
				The Director of nursing w	vill review monthly		
	On 3/20/19 at 4:10pn	n a phone interview occurred		reports provided by the c	2		
	-	onsultant. She stated she		pharmacist review and re			
		ssessment when a resident		recommendations includi	•		
		otic medication, but only		missing AIMS within 30 d	•		
		s marked complete in the		recommendations. Reco			
		ctronic Medical Record		follow up will be presente			
		that the 11/13/18 AIMS marked with an Error in the		QAPI meeting with re-eva adjustment to plan to ma			
	status bar was an ov			compliance. Additionally			
		oroignt.		nursing, assistant directo			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/30/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	THE GREENS AT PINEHURST REHAB & LIVING CENTER				05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756 F 758	the DON, she stated i the Pharmacy Consul any AIMS assessmen completed.	m during an interview with it was her expectation for ltant to identify and address its that needed to be chotropic Meds/PRN Use		756	MDS coordinator will conduct audits to ensure the completion of the Involunta movement scale Assessment (AIMS) residents per week X 4 weeks, followe by 4 residents per month X 3 months verifying the completion of the AIMS to done upon admission and quarterly. Findings will be presented to the mont QAPI meeting to review and adjust pla maintain compliance.	ary of 3 od o be hly	4/18/19
SS=E	§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio	ppic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented nts who use psychotropic I dose reductions, and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345177	B. WING_				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	05 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER		F	PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	59	F	758			
	unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN or	ursuant to a PRN order n is necessary to treat a undition that is documented and rders for psychotropic drugs					
	§483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he of	er believes that it is RN order to be extended or she should document their ent's medical record and					
	drugs are limited to 14 renewed unless the a prescribing practitione the appropriateness of This REQUIREMENT by:	ttending physician or er evaluates the resident for of that medication. is not met as evidenced					
	try non pharmacologic prior to the initiation a dosage of an antipsyd #54 & #35), failed to re target behavior and s a resident on antipsyd #54) and failed to ass antipsychotic medicat symptoms (EPS), a d disorder (Resident # 0	terview, the facility failed to cal interventions/approaches and prior to the increase in chotic medication (Residents monitor and to document the ide effects of medication for chotic medication (Resident tess a resident on tion for extrapyramidal rug induced movement			Monitor and document target behavior and side effects of medications on antipsychotic medication (54) and faile and assess for EPS for resident # 62 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; In regard to deficient practice of non-pharmacological interventions/approaches prior to initiat or increase in dosage of antipsychotic medications for resident number 54 an 35; the residents□ physician was notifit on 3/20/19 by the Director of Nursing	d to d to tion d	

Event ID: YQDZ11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/30/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING _				C / 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				20	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REI	HAB & LIVING CENTER		P	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758		s admitted to the facility on	F7	758	antipsychotic medications. At that tim		
		diagnoses including ors. The significant change ata Set (MDS) assessment			the physician chose to maintain curre dosage of prescribed antipsychotic medications. On 3/19/19, care plan w		
	memory and decision	d that Resident #54 had making problems and had c medication for 7 days			added by the Social Service Director (SSD) to monitor for increased or changed targeted behaviors specific t	0	
	during the assessme	nt period.			resident # 54 and resident #35 with non-pharmacological interventions		
	reviewed. One of the	blan dated 2/8/19 was care plan problems was the or adverse reaction related			specific to resident # 54 and resident to prevent, improve or intercede with targeted behaviors. Instructions to re		
	would be free of adve	he goal was the resident erse drug reactions through The approaches included			affects of non-pharmacological interventions for targeted behaviors to recorded in the resident medical reco		
	to monitor for possible adverse drug reaction	e signs and symptoms of n, review resident's			review with resident⊡s physician prior initiation or increase in dosage of		
	medications with the pharmacist for duplica prescriptions, proper				antipsychotic medication. The Director of nursing (DON) completing inservice training for all current license		
	frequency of administ supporting diagnoses	tration, adverse reactions, and review as needed			personnel on 3/27/19, for introducing resident specific care plans which pro	vide	
	(PRN) in the process A doctor's progress n	ote dated 2/26/18 revealed			targeted behavior documentation and non-pharmacological interventions pri the initiation or increase dosage of		
	that Resident #54 wa to altered in mental s	s referred to the doctor due tatus. The note indicated			antipsychotic medications. Education training to all newly hired licensed nur		
		ntinued to express he has had hallucinatory ble who were not there. She			staff will occur during orientation to include introducing resident specific c plans which provide targeted behavio		
	was not hearing any she appeared to be p	voices apparently. At times, ossibly at harm to herself.			documentation and non-pharmacolog interventions and reviewing with the	ical	
	medication) and follow	Seroquel (antipsychotic w up for results.			resident physician prior to the initiatio increase dosage of antipsychotic medications.		
		der for Seroquel 25 nouth twice a day was e dementia with behaviors			In Regards to the deficient practice of Monitor and document target behavio and side effects of medications on		
		d Psychological Symptoms			antipsychotic medication (54) and fail	ed to	

Facility ID: 923320

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		MEDICAID SERVICES				0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			LETED
		345177	B. WING		03/2	C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From pag	e 61	F 75	8		
	of Dementia (BPSD). Review of Resident # February 2018 was of documentation that m intervention had been Seroquel. A nurse's note dated Resident #54 continu- ordered. She was no agitation/anxiety. She incontinence care was being transferred and turned. She noted to attempting to have a noted to have emotion evening. She was lat then crying and callin She has had as need medication) and Xan in the past, both were anxiety/agitation. The to address in the mode A doctor's progress m that Resident #54 was The note revealed th	4/3/18 at 8 PM revealed that an tried prior to the initiation of 4/3/18 at 8 PM revealed that and the prior to the initiation of 4/3/18 at 8 PM revealed that and with Seroquel as beed to have episodes of a was screaming out when as provided, when she was d when she was being o dig in her stools when bowel movement. She was anal lability more so in the ughing in one minute and ag out for "mama/granny". ded (PRN) Ativan (antianxiety ax (antianxiety medication) e effective for e physician was aware and ming.		assess for EPS for resident # 6 3/21/19, the director of nursing resident # 54 and resident # 62 effects of medications and (no) effects were noted. Physician contacted 3/21/19, by the DON changes to current medication were received. On 4/1/19 direc nursing and assistant director of placed on each residents Medi administration record (MAR) to targeted behaviors and monito adverse effects of use of antips medications to include extrapy symptoms(EPS). Inservice tra current licensed staff was com the director of nursing on 3/27/ include the daily monitoring for behaviors on the Medication administration record(MAR) an monitoring of adverse effects of antipsychotic medications to in extrapyramidal symptoms(EPS) newly hired licensed nursing st receive education during new- orientation to include the daily for target behaviors on the Medication administration record(MAR) an monitoring of adverse effects of antipsychotic medications to in extrapyramidal symptoms(EPS newly hired licensed nursing st receive education during new- orientation to include the daily for target behaviors on the Medication administration record(MAR) an monitoring of adverse effects of antipsychotic medications to in	assessed 2 for side) side was I, and no regimen ctor of of nursing cation monitor for ring of sychotic ramidal ining to all pleted by 19, to target d f use of clude b). All aff will hire monitoring dication d f use of	
	episodes occur. The altered mental status ongoing dementia. T	emely anxious when these assessment indicated probably secondary to The plans were treatment as nue to monitor with recheck		Address how the facility will ide residents having the potential t affected by the same deficient All current facility residents wh antipsychotic medications were to be at risk for the deficient pr	o be practice; o receive e identified	

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,	i	COMPL	ETED
					C	;
		345177	B. WING		03/2	1/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER		205 RATTLESNAKE TRAIL		
				PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE
F 758	Continued From page	e 62	F 75	8		
	Seroquel 25 mgs twice			not having non-pharma	cological	
		M and 50 mgs in PM.		interventions/approache		
		0 -		or increase in dosage o		
	Review of Resident #			medication and failure t	o monitor and	
	including the nurse's			document target behavi		
	documentation to indi			of medications on antip	-	
		rvention/approach had been		medication and failed to	and assess for	
	Seroquel.	o the increase in dosage of		EPS for resident.	1 on 2/29/10 by the	
	Seloquel.			An audit was completed DON and/or ADON to it		
	A doctor's progress n	ote dated 4/5/18 revealed		who receive antipsycho	-	
		s referred due to altered in		were identified to be at		
	mental status. She wa	as becoming more confused		deficient practice of not	having	
	and disoriented and w	was becoming more agitated		non-pharmacological		
	-	navior. She had no fever,		interventions/approache		
		ough, no shortness of breath		or increase in dosage o		
		ominal pain, no nausea or		medication and failure t		
		uency, dysuria or urgency. ease Seroquel, would like to		document target behave of medications on antip		
	try to avoid sedation a			medication and failed to		
	pending response to			EPS for resident. 17 re		
	p 5 5 - p			affected by deficient pra		
	On 4/5/18, there was	another order to discontinue		In regard to deficient pr	actice of	
		in AM and 50 mgs in PM		non-pharmacological		
	and to start Seroquel	50 mgs twice a day.		interventions/approache		
	Deview of Deside 14			or increase in dosage o		
	Review of Resident #			medications the resider		
	including the nurse's documentation to indi			notified on 4/01/19 by th current orders for antips		
		rvention/approach had been		medications. At that tin	-	
		o the increase in dosage of		reviewed dosage of pre		
	Seroquel.			antipsychotic medicatio		
				care plan was added by		
		Director of Nursing (DON)		to monitor for increased		
		20/19 at 8:50 AM. The DON		targeted behaviors spec		
	-	ted the nurses to try non		with non-pharmacologic		
		roaches and to document in		specific to prevent, imp		
	the nurse's notes the	approaches that had been		with targeted behaviors		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLI	
					с	
		345177	B. WING			1/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				205 RATTLESNAKE TRAIL		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		PINEHURST, NC 28374		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE A	CTION SHOULD BE	(X5) COMPLETIO DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED T DEFICIE		5/112
F 758	Continued From page	e 63	F 75	58		
	1.0	ychotropic medications.		interventions for targeted	hehaviors to be	
				recorded in the resident		
	An interview was con	ducted with Nurse #5 on		review with resident⊡s p		
		The Nurse stated that she		initiation or increase in d		
		ident #54 and she had		antipsychotic medication	•	
	-	admission. Resident #54		On 3/27/19, director of n		
	was quiet when left a			inservice training to all c		
		vhen staff was providing		personnel for introducing		
		e, turning, bathing). Nurse #5		care plans which provide		
		nt #54 was on PRN Ativan		behavior documentation	-	
		d PRN Xanax (antianxiety		non-pharmacological inte		
		they were effective, but the		the initiation or increase	-	
		led them. She also stated		antipsychotic medication	-	
	that nurses were sup			training to all newly hired		
	-	rventions and to document		staff will occur during ori	-	
		the nurse's notes when		include introducing resid		
	residents were displa	ying behaviors. Nurse #5		plans which provide targ		
	had reviewed the Res	sident #54's medical records		documentation and non-		
		notes and she was unable to		interventions and review		
	•	f any non pharmacological		resident physician prior t	-	
		re tried prior to the initiation		increase dosage of antip		
		losage of Seroquel. She		medications.	,	
		the Nurse who carried out		In Regards to the deficie	nt practice of	
		the Seroquel on 4/4/18 and		Monitor and document ta	-	
		an employee of the facility.		and side effects of medic	•	
		· · ·		antipsychotic medication		
	An interview with Res	sident #54's physician was		assess for EPS for resid	•	
		at 9:58 AM. He stated that		the director of nursing as		
	he was made aware	of Resident #54's behavior		identified resident for sid	e effects of	
	by the nursing staff.	He indicated that Resident		medications and any sid	e effects were	
		cinations and outburst in		noted. Physician was co	ontacted 4/1/19,	
		ed the Seroquel. He also		by the DON, to review n		
	stated that he was av	vare of the increase in		regimen were received.	On 4/1/19, the	
	dosage of Seroquel in	n one day (4/4/18 and		director of nursing and a	ssistant director	
		I that the nursing staff had		of nursing placed an ord		
		ent's behavior was out of		residents Medication adr		
	control.			record (MAR) to monitor	for targeted	
				behaviors and monitoring	-	
		with the DON was		effects of use of antipsyd		

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		MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	G			
				WINC			С
		345177	B. WING			03	/21/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REI	HAB & LIVING CENTER		205	5 RATTLESNAKE TRAIL		
				PIN	NEHURST, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 758	Continued From page	e 64	F 75	58			
		9 at 10:31 AM. The DON			to include extrapyramidal		
		expect dose increase of			symptoms(EPS). Inservice training to	all	
	Seroquel to happen t	-			current licensed staff was completed b		
		o clarify the order with the			the director of nursing on 3/27/19 to	-	
	Physician or Practitioner. She also indicated that				include the daily monitoring for target		
	she expected the nur	rses to try non			behaviors on the Medication		
		rventions and to document			administration record(MAR) and		
		the nurse's notes before			monitoring of adverse effects of use of	f	
		orders for any psychotropic			antipsychotic medications to include		
	medications.				extrapyramidal symptoms(EPS). All		
					newly hired licensed nursing staff will		
					receive education during new-hire		
		as admitted to the facility on			orientation to include the daily monitor	-	
	7/14/17 with multiple	iors. The significant change			for target behaviors on the Medication administration record(MAR) and		
		ata Set (MDS) assessment			monitoring of adverse effects of use of	F	
		d that Resident #54 had			antipsychotic medications to include		
		n making problems and had			extrapyramidal symptoms(EPS).		
		ic medication for 7 days					
	during the assessme				Address what measures will be put int	0	
					place or systemic changes made to		
	Resident #54's care	plan dated 2/8/19 was			ensure that the deficient practice will r	ot	
		care plan problems was the			recur;		
		or adverse reaction related			Physician order review will occur 5 x		
		The goal was the resident			per week of all newly written physician		
		erse drug reactions through			orders by Unit coordinators(ADON), D		
		The approaches included			and/or MDS coordinator. Upon receip	t of	
		e signs and symptoms of			any antipsychotic medication orders,		
	adverse drug reaction	n, review resident's physician and consulting			resident⊡s care plan and Medication administration record (MAR) will be		
	pharmacist for duplic				reviewed and updated as necessary to	.	
	prescriptions, proper				include targeted behavior monitoring,		
		tration, adverse reactions,			non-pharmacological interventions of		
		s and review as needed			targeted behaviors and review of		
	(PRN) in the process				unnecessary medication or duplicative	;	
	, , , , , , , , , , , , , , , , , , , ,				therapy. Any findings will be reported		
	A doctor's progress n	ote dated 2/26/18 revealed			resident physician.		
		as referred to the doctor due					
	to altered in mental s	tatus. The note indicated			Indicate how the facility plans to monit	or	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/30/2019 M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C / 21/2019	
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE GRE	ENS AT PINEHURST REF	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 758	that Resident #54 cor behavioral issues. Sl issues of seeing peop was not hearing any y she appeared to be p The plan was to add a results. On 2/26/18, a new or milligrams (mgs) by n started for progressiv and for Behavioral an of Dementia (BPSD). A nurse's note dated Resident #54 continu ordered. She was not agitation/anxiety. She incontinence care wa being transferred and turned. She noted to attempting to have a noted to have emotio evening. She was lat then crying and callin She has had as need medication) and Xana in the past, both were anxiety/agitation. The to address in the mor A doctor's progress n that Resident #54 wa The note revealed tha stage dementia had to behavior outburst. Sl supervision so as to p also was getting extre	htinued to express he has had hallucinatory ble who were not there. She voices apparently. At times, ossibly at harm to herself. Seroquel and follow up for der for Seroquel 25 nouth twice a day was e dementia with behaviors ad Psychological Symptoms 4/3/18 at 8 PM revealed that ed with Seroquel as ted to have episodes of e was screaming out when s provided, when she was I when she was being dig in her stools when bowel movement. She was nal lability more so in the ughing in one minute and g out for "mama/granny". led (PRN) Ativan (antianxiety ax (antianxiety medication) e effective for e physician was aware and ning. ote dated 4/4/18 revealed s referred due to behaviors. at Resident #54 with end peen having issues with	F	758	its performance to make sure that solutions are sustained; The director of nursing, assistant dire of nursing and/or MDS coordinator wi 100% of identified incoming orders as they occur to ensure compliance with hours of receipt of orders. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed neces by QAPI Program to ensure significant compliance is maintained.	ll log s in 72 e sary		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345177	B. WING				C / 21/2019
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	ongoing dementia. T ordered and to contin in one week. A doctor's progress m that Resident #54 wa mental status. She wa and disoriented and w with hallucinatory ber sweats or chills, no co or wheezing, no abdo vomiting and no frequ. The plan was to incre- try to avoid sedation a pending response to a On 4/4/18, there was Seroquel 25 mgs twic Seroquel 25 mgs in A On 4/5/18, there was the Seroquel 25 mgs and to start Seroquel Review of the Reside including the nurse's October 2018, Noven January 2019, Februa 2019)revealed no door resident's behavior or had been monitored. An interview was con 3/20/19 at 2:50 PM. T was assigned to Resi	probably secondary to he plans were treatment as ue to monitor with recheck ote dated 4/5/18 revealed s referred due to altered in as becoming more confused vas becoming more agitated havior. She had no fever, bugh, no shortness of breath minal pain, no nausea or hency, dysuria or urgency. ase Seroquel, would like to and further treatment above. an order to discontinue is a day and to start M and 50 mgs in PM. another order to discontinue in AM and 50 mgs in PM 50 mgs twice a day. nt #54's medical records notes for the last 6 months (her 2018, December 2018, ary 2019 and March cumentation to indicate that is side effects of medication ducted with Nurse #5 on 'he Nurse stated that she dent #54 and she had	F	758			
	3/20/19 at 2:50 PM. T was assigned to Resi known her since her a was quiet when left a	he Nurse stated that she dent #54 and she had admission. Resident #54					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	care (incontinent care stated that nurses we to document behavior medication in the nurs reviewed the resident the nurse's notes and documentation to indi and side effects of me monitored for the last An interview with the 3/21/19 at 10:31 AM. expected the nurses f resident's behaviors a medication in the nurs on psychotropic medi reviewed the medical nurse's notes of Resid able to find one behar nurse's note dated 11 The DON was unable indicate that side effe monitored. 2. Resident #35 was 11/13/18 with diagnos with behavioral distur A nursing note dated #35 had anxiety, rang minute, and frequent! When staff entered th Resident #35 needed forgotten and didn't ki or ringing the call bell A nursing note dated Nurse #11 indicated F	e, turning, bathing). She also re supposed to monitor and rs and side effects of se's notes. Nurse #5 had 's medical records including I she was unable to find icate that resident's behavior edication had been 6 months. DON was conducted on The DON stated that she to monitor and to document and side effects of se's notes for all residents cations. The DON had records including the dent #54. The DON was vior documented in the /8/18 for the last 6 months. e to find documentation to cts of medication had been admitted to the facility on ses that included dementia bance and anxiety disorder. 11/14/18 indicated Resident g the call bell every 5- 10 y yelled out, "Nurse, Nurse". the room to see what I, she stated that she had now why she was yelling out	F	758	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345177	B. WING				C 21/2019
NAME OF PROVIDER	OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GREENS AT	PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
night. "screat for the room "oh no "A nurs #35 ra with y When #35 w didn't wante physic and h medic deme Resid her av new c Resid that s medic deme Resid that s medic deme Resid ber av new c Resid that s medic deme Resid that s medic deme Resid that s medic deme Resid that s medic deme Resid that s medic Seroo A phy	aming" of family and asked what of much" or "not sing note dated ang the call bell elling out for sta staff entered ro hat she needed need anything, d someone in the cian was aware e ordered Name ation) 10 milligr ntia. The nurse ent #35's Response vare of Residen rder for Namen ent #35 had the ne had previous ation) for anxiet sician's order da nda 10 mg twice sing note dated as yelling out for cian was in the f to order Seroqu ation) 25 mg nor vioral and Psych ntia (BPSD). Re or and stopped y uel.	I with anxiety and frequent members' names or calling staff entered Resident #35's t she needed she replied, hing important". 11/15/18 indicated Resident every 5-10 minutes along iff. bom and asked Resident I, she would state that she and she stated that she just he room with her. The of Resident #35's behaviors enda cognition-enhancing ams (mg) twice daily for indicated she contacted onsible Party (RP) and made t #35's behaviors and the da. The RP indicated se behaviors in the past and kly taken Xanax (antianxiety	F	758			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/30/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345177	B. WING			-		C 21/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 758	Continued From page BPSD for Resident #3 A nursing note dated #35 had a decrease in Seroquel on 11/16/18 times that shift. A nursing note dated #35 was yelling out th with visual and audito #35 was educated se the call bell when she had not done so. A physician's note dat Resident #35 continue out to staff. She was disorientation. The pl Resident #35 included behavioral issues. Re a trial of Seroquel with response. A physician's order dat discontinuation of Ser A psychotherapy note Resident #35 was see evaluation. Resident	e 69		758				
	new community. She cognitive impairment, to person only, her me anxious and her attitu as irritable. Resident a appropriate for psycho	de/behavior was assessed #35 was noted to not be						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345177	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	 #35 was yelling out, h sense, and she was s was given to her was The admission Minim assessment dated 11 #35's cognition was n was assessed with ha 7 day look period. Re behavioral symptoms rejection of care. She antipsychotic medicat a Gradual Dose Redu antipsychotic medicat The behavioral sympt (CAA) for Resident #3 MDS indicated she ha disorder and BPSD. and then forget why s #35 was to be assiste calmly, offer reassura and anticipated needs The psychotropic drug #35's 11/20/18 admis ordered Seroquel for medication was causi the physician disconti 11/19/18. Resident #35's compu- the focus area, initiate revised on 11/26/18, o medications related to BPSD. The goal was free of antipsychotic of 	ter words were not making stating that the medicine that poison. um Data Set (MDS) /20/18 indicated Resident noderately impaired. She allucinations during the MDS esident #35 had other on 4-6 days and no was administered tions on 4 of 7 days and had uction (GDR) of the tion on 11/19/18. for care area assessment ad diagnoses of anxiety She was noted to yell out the was yelling. Resident ed as needed, approached ince, explain procedures, s. g use CAA for Resident sion MDS indicated she was BPSD on 11/16/18, but the ng "severe side effects" so nued the Seroquel on rehensive care plan included ed on 11/23/18 and last of the use of antipsychotic o behavior management and for Resident #35 to remain drug related complications. ventions for this focus area:	F	758			

Facility ID: 923320

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	-	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	SURVEY PLETED	
		345177	B. WING				C /21/2019	
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 758	ordered by the physic effects and effectiven Monitor/document/rep reactions of psychotro interventions were ini revised on 11/28/18. non-pharmacological A physician's note da Resident #35 continu disoriented, and shou be placed on Seroque sedation and was sub The Seroquel was no Resident #35 again w The physician indicate was to be initiated. A physician's order da Seroquel 12.5 mg twi Resident #35. A nursing note dated Nurse #11 indicated F where she became an called out "nurse" rep improvement with her previous week. A nursing note dated Nurse #11 indicated F "nurse, nurse" at the f had requested the nu her television and/or f	cian and monitor for side ess each shift; 2) port as needed any adverse opic medications. These tiated on 11/26/18 and last This care plan had no interventions. ted 11/21/18 indicated ed to be confused, iting out. She was noted to el which caused some osequently discontinued. ted to have worn off and vas yelling and screaming. ed a small dose of Seroquel ated 11/21/18 indicated ce daily for BPSD for 11/24/18 completed by Resident #35 had episodes invious, demanding, and eatedly. There was noted behaviors from the 11/26/18 completed by Resident #35 was yelling out beginning of the shift. She rse to turn the volume up on turn the television on. 11/28/18 indicated Resident tically throughout the shift. the room to ask what she	F	758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345177	B. WING				C / 21/2019	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG				IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 758	remember or that she stay in the room with A nursing note dated Nurse #11 indicated F agitated, screaming of attempting to get out call the police and sta at the facility against noted to be very conf redirected. Nurse #1 other residents and fa disrupted by Residen A physician's note da Resident #35 continu the day and night, co Namenda was noted physician indicated S had been tried but ha sedation". The current twice daily was noted The physician indicated Seroquel of 25 mg tw	e just wanted someone to her. 11/29/18 completed by Resident #35 was extremely but for the nurse and of bed. She requested to ated that she was being kept her will. Resident #35 was used and not easily 1 indicated that several amily members had been t #35 ' s behavior. ted 11/29/18 indicated ed with outbursts throughout nstantly calling out for staff. with no benefit. The eroquel at 25 mg twice daily d caused "excessive nt Seroquel dose of 12.5 mg to not be of any benefit. ed a trial of increased ice daily was to be initiated. ated 11/29/18 indicated an 12.5 mg twice daily to 25 mg	F	75				
	discussion was had w The family reported the them throughout the reported that they we were becoming increa physician indicated it resident 's behaviors more rest, be calmer,	ted 12/3/18 indicated a vith Resident #35's family. hat Resident #35 called hight. The family member re not getting any rest and asingly frustrated. The was his goal to control the so that she was able to have and have a better quality of indicated he wanted to						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345177	B. WING _				C 21/2019	
NAME OF PI	ROVIDER OR SUPPLIER		ľ		TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 758	behaviors were causi residents in the facility he was going to conti accordingly in order to down and not be do s that this would require Seroquel and adjustry medication). A review of the medic #35 was not ordered 12/3/18 physician's no Ativan while at the face A nursing note dated #35 was yelling out at immediately after staf Resident #35 was as stated either that she she just wanted the p A physician note date Resident #35 continu behaviors, called her long, and yelled out for that he was attemption with a combination of "judicious" Ativan, but success. He indicate Seroquel and noted to be necessary. A review of the medic #35 was not ordered 12/5/18 physician's no Ativan while at the face	 disruption Resident #35's ng the staff and other y. The physician wrote that nue to adjust medications to have the resident calm to disruptive. He indicated a probable increase in the time of the inters in Ativan (antianxiety) al record indicated Resident Ativan at the time of the ote nor had she received cility. 12/5/18 indicated Resident and pressing the call light if exited her room. When ked what she needed she didn't need anything or that erson in the room. d 12/5/18 indicated ed to have outbursts of family member all night or staff. The physician wrote g to control this behavior Namenda, Seroquel, and t was not having a lot of d the plan was to adjust that other medications may 	F	758				

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CENTER STATEMENT (-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		FORM OMB NC (X3) DATE	0: 04/30/2019 MAPPROVED 0: 0938-0391 SURVEY LETED
		345177	B. WING				0
		343177				03/	21/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER		205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	mg in the morning and Resident #35. A nursing note dated #11 indicated Resider crying, and was yellin stated she wanted to expressed that she had daughter put her in th not easily redirected, console. Nurse #11 in Resident #35 for about reassurance until the able to fall asleep. A nursing note dated #35 was heard yelling nurse entered the root floor on the side of the someone was in her re keys. A physician's note dated Resident #35 continue screaming and attempt non-stop. The physic changes were made it these behavior issues going to continue to a attempt to keep her b cause sedation. A nursing note dated #35 continued to yell call bell and then star	from 25 mg twice daily to 25 d 50 mg at night for 12/9/18 completed by Nurse nt #35 was very upset, g out of for the nurse. She call her daughter and ad not known why her e facility. Resident #35 was and she was difficult to ndicated she sat with ut 30 minutes providing she calmed down and was 12/10/18 indicated Resident g "help me" and when the m she was found on the e bed. She stated that toom and had taken her ted 12/10/18 indicated ed to act out with continuous pting to phone her family ian wrote that medication n an attempt to deal with a. He indicated he was djust medications in an ehaviors down and not 12/13/18 indicated Resident out for staff. She rang the ted yelling. Resident #35 r wheelchair, but then yelled	F 758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345177	B. WING				21/2019	
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 758	A physician's note da Resident #35 continue disoriented, and had I shouting out and calli he would continue to Resident #35 less and A nursing note dated #35 was yelling out for A physician's note da Resident #35 ' s famil psychiatric consultation believed Resident #33 events that led to her and needed a psycho- also indicated they be one compassion visiti loss. The physician in was resistant to accept dementia. A physician's order da psychiatric consultation #35. A Psychiatric Nurse P 1/14/19 Resident #35 psychiatric medication stabilization of demen- out, and possible dep Nursing staff reported change in mental stat out since her admissi she was left alone. S memory and repetitive current psychiatric medication 25 mg in the morning	ted 12/23/18 indicated ed to be confused, behaviors of continually ng her family. He wrote that modify medications to make xious. 12/29/18 indicated Resident or staff and family. ted 1/7/19 indicated ly member requested a on. They indicated they 5 was depressed over the being admitted to the facility ological evaluation. They elieved she needed one on ing to help her deal with indicated this family member pting that Resident #35 had ated 1/9/19 indicated a on was ordered for Resident Practitioner (PNP) note dated is was seen for an initial in management visit for itia with behavior of yelling	F	758				

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DEPART CENTER		FORM	APPROVED 0. 0938-0391					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING _				C 21/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 758	distressing delusions yelling out. The PNP's dementia with behavii indicated Resident #3 expected to the Seroo start Remeron (antide mg at night for sleep a sleep difficulties were regular sleep/wake cy with naps during the o PNP indicated that fol in 4-5 weeks and if Re Seroquel would be re possible to manage d family and nursing sta out behavior was the delusions. Delusions the resident. A physician's order da Remeron 7.5 mg at ni Resident #35. The quarterly MDS as indicated Resident #3 impaired. She had no behaviors, and no reju administered antipsyo antidepressant medic A physician's order da discontinuation of Ser and 50 mg at night ar 50 mg in the morning A nursing note dated #35 was yelling out for	but had not helped with a diagnosis was vascular oral disturbance. She 5 was not responding as quel. She noted a plan to pressant medication) at 7.5 and appetite noting that the likely due to dementia. A vcle was to be encouraged day being discouraged. The low up was to be continued emeron was helping, the duced to the lowest dose elusions. Resident #35's aff reported that the yelling biggest concern, rather than were noted to not distress ated 1/17/19 indicated ght for disordered sleep for assessment dated 1/21/19 .5's cognition was severely o symptoms of psychosis, no ection of care. She was chotic medication and ation on 7 of 7 days. ated 1/25/19 indicated a roquel 25 mg in the morning in the initiation of Seroquel	F 7	758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345177	B. WING				C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE GREE	ENS AT PINEHURST REF	HAB & LIVING CENTER			05 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	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 77	F	758			
	A physician's order dated 1/31/19 indicated a discontinuation of Seroquel.						
	Seroquel was discont had an increase in be continuously yelled or #35 was asked what had not remembered.	ed 2/1/9 indicated that since tinued, and Resident #35 thaviors and had ut for staff. When Resident she needed she stated she . She was also noted with nd was easily agitated.					
	increasing sleepy/dro otherwise indicating the bouts of behaviors the despite medications. going to reduce sedar staff were to monitor	had reported she was wsy, but staff had reported hat she continued to have roughout the day and night The physician wrote he was ting type medications, but and report if behaviors both disruptive to Resident					
	#35 yelled out for help bell. She was provide	2/10/19 indicated Resident p rather than using her call ed with education to use the ut 20 minutes she yelled out					
	Nurse #11 indicated F for staff continuously. disruptive to other res members. When Res she needed, she requ member. She was cr	d 2/16/19 completed by Resident #35 was yelling out She was noted to be sidents and their family sident #35 was asked what uested to call her family ying and yelling at the family e asking, "how could you do					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED	
		345177	B. WING				C 21/2019	
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	21/2019	
_					205 RATTLESNAKE TRAIL			
THE GREE	ENS AT PINEHURST REF	AB & LIVING CENTER			PINEHURST, NC 28374			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG					DEFICIENCY)			
F 750								
F 758			F	758				
		ated 2/19/19 indicated						
	#35.	e daily for BPSD for Resident						
	A pursing note dated	3/3/19 indicated Resident						
	•	hollering out for staff, most						
		ng any assistance. Resident						
		come angry and accused						
	staff of ignoring her.							
	An observation was c	onducted of Resident #35						
		M. Staff were present for						
		Resident #35 was noted to						
	be awake, but kept he	-						
		ved. Resident #35 was not						
	interviewable.							
	An observation was c	onducted of Resident #35						
		 A. She was sleeping in her 						
	bed and was not easi	ly roused.						
	An observation was c	onducted of Resident #35						
	on 3/20/19 at 10:00 A	M. She was sleeping in her						
	bed and was not easi	ly roused.						
	An interview was con	ducted with MDS						
	Coordinator on 3/20/1							
		e CAA for Resident #35's						
		IDS that indicated she was						
	· ·	BPSD on 11/16/18, but the				l		
		ing "severe side effects" so				ľ		
	11/19/18 was reviewe	inued the Seroquel on				l		
		oorted that Resident #35				l		
		se in yelling behaviors when				l		
	-	rted, but then on 11/19/18				l		
	she was yelling out a					l		
		oted to sedate Resident #35.				l		
		r was unable to explain why						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C	IRVEY	
	(X3) DATE SURVEY COMPLETED	
345177 B. WING 03/21/20	/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREENS AT PINEHURST REHAB & LIVING CENTER 205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
	(X5) COMPLETION DATE	
F 758 Continued From page 79 F 758 the Seroquel was re-initiated despite its noted "severe side effects". F 758 An interview was conducted with Nurse #8 on 3/19/19 at 4:40 PM. Nurse #8 stated that Resident #35 yelled out all the time. She indicated that this behavior had been ongoing since Resident #35's admission. She reported that Resident #35's behavior of yelling out normally ceased if someone sat with her and talked to her. She explained that she believed Resident #35 needed companionship with verbal interaction for her yelling to stop. A phone interview was conducted with Nurse #11 on 3/20/19 at 4:28 PM. She stated that these was familiar with Resident #35 and had worked with her since admission. She reported that Resident #35 moved to the facility from a different state to be closer to family. She indicated she believed Resident #35 had the early stages of dementia at the time of admission and that she became disoriented, confused, anxious, and faerful after admission. She stated that generally. Resident #35 was able to be redirected or calmed with companionship, but occasionally there were times where she became very angry with her family members for placing her in the facility and she was unable to be redirected during those times. Nurse #11 indicated that there were times when the Seroquel had setated Resident #35. She also stated that the resident #35. She also stated that thereid Resident the behavior of screaming/yelling out f		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 04/30/2019 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		345177	B. WING			C 03/21/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP C		
			2	05 RATTLESNAKE TRAIL		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER	F	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 758	stated that she had no she just wanted some her. Nurse Superviso #35 was ordered Sero the behavior. She rep caused some sedatio instances when hallud when she was on the #1 was unable to exp re-initiated despite its She stated that staff r physician and it was u with pharmacological A phone interview wa #35's physician on 3/2 physician indicated he was unable to review familiar with Resident made aware of Resid frequent yelling out by her family members th phone all night long a hallucinations that she job as a school bus du Seroquel for Resident behaviors and hallucin discontinuation of the 11/21/19 physician 's Seroquel had been di and the re-initiation of was reviewed with the the nursing staff had i behavior had increase discontinued so he re staff had implemented	se to her yelling, the resident of needed anything or that eone to stay in the room with or #1 stated that Resident oquel for BPSD to manage borted that the Seroquel had in and that there were cinations occurred even Seroquel. Nurse Supervisor lain why the Seroquel was noted "severe side effects". eported behaviors to the up to him how to proceed approaches. s conducted with Resident 20/19 at 3:50 PM. The e was out of the country and his records, but that he was #35. He stated that he was ent #35's behavior of y staff and was informed by hat she called them on the nd that she had e was working at her former river. He stated he initiated t #35 to manage the nations. The Seroquel on 11/19/19, the note that indicated the scontinued due to sedation, f the Seroquel on 11/21/19 e physician. He indicated informed him the yelling ed when the Seroquel was -initiated it. He was asked if d any non-pharmacological	F 758			
	was reviewed with the the nursing staff had i behavior had increase discontinued so he re staff had implemented interventions for Resid	e physician. He indicated nformed him the yelling ed when the Seroquel was -initiated it. He was asked if d any non-pharmacological				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345177	B. WING				C / 21/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	AB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 758	was not sure if non-pl had been implemente that staff informed him constantly yelling, she was disrupting her livi other residents and fa behavior had to be ac notes dated 12/3/18 a Resident #35 was be reviewed with the phy was not able to review had noted Resident # was not, but that he g utilize benzodiazepine Ativan. An interview was con Nursing (DON) on 3/2 stated that she expect non-pharmacological initiation and/or increa medication. She repor medications that caus to not be utilized. 3) Resident #62 was 11/13/18 with diagnos anxiety disorder, depor syndrome and polyart A review of assessme Abnormal Involuntary assessment dated 11 A review of the most of Minimum Data Set (Massessment and date resident had cognitive	harmacological interventions ad by the staff. He reported in Resident #35 was a had hallucinations, and she ing environment as well as amily members and this ddressed. The physician's and 12/5/18 that indicated ing treated with Ativan were vsician. He indicated that he w his records to see why he i35 was on Ativan when she generally preferred not to e medications such as ducted with the Director of 21/19 at 10:25 AM. The DON ted the nurses to try approaches prior to the ase in an antipsychotic orted that she expected that sed side effects of sedation admitted to the facility on ses that included dementia, ression, restless leg thritis. ents revealed an incomplete Movement Scale (AIMS) /13/18. recent comprehensive IDS) coded as an Admission ed 11/20/18 indicated the e impairment and received ication 7 days out of the 7	F	758	8		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345177	B. WING				21/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL VINEHURST, 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 758	Continued From page	82	F	758			
	quarterly assessment indicated the resident	had cognitive impairment sychotic medication 7 days					
	A review of Resident orders revealed an or antipsychotic medicat						
	3/20/19 at 2:55pm wh why the AIMS assess the time of admission						
F 849 SS=B	the DON, she stated i the AIMS assessment Hospice Services	m during an interview with t was her expectation for ts to be completed correctly. •(4)	F	349			4/18/19
	do either of the follow (i) Arrange for the pro through an agreemen Medicare-certified hos (ii) Not arrange for the	term care (LTC) facility may ing: vision of hospice services t with one or more spices.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/30/2019 APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345177	B. WING				03/	C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
THE GREE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 849	when a resident reque §483.70(o)(2) If hospi LTC facility through an paragraph (o)(1)(i) of the LTC facility must requirements: (i) Ensure that the hosp professional standard to individuals providin to the timeliness of the (ii) Have a written agret that is signed by an a the hospice and an authe LTC facility before any resident. The write at least the following: (A) The services the hospice's resist the appropriate hospic in §418.112 (d) of this (C) The services the hospice the appropriate hospic in §418.112 (d) of this (C) The services the hospice and that the needs of the hospice and that the needs of the hospice and (1) A significant changemental, social, or emo (2) Clinical complicatiant alter the plan of care.	ospice and assist the g to a facility that will ion of hospice services ests a transfer. ce care is furnished in an n agreement as specified in this section with a hospice, neet the following spice services meet s and principles that apply g services in the facility, and e services. eement with the hospice uthorized representative of thospice care is furnished to tten agreement must set out hospice will provide. ponsibilities for determining ce plan of care as specified a chapter. LTC facility will continue to h resident's plan of care. process, including how the e documented between the ospice provider, to ensure resident are addressed and e LTC facility immediately bout the following: ge in the resident's physical,	F	849				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345177	B. WING _			C 03/21/2019		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	THE GREENS AT PINEHURST REHAB & LIVING CENTER			205 RATTLESNAKE TRAIL PINEHURST, NC 28374				
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 849	responsibility for dete course of hospice can determination to chan provided. (G) An agreement tha responsibility to furnis care, meet the resider nursing needs in coor representative, and e provided is appropriat resident's needs. (H) A delineation of th including but not limite direction and manage counseling (including bereavement); social supplies, durable meet necessary for the pall associated with the te conditions; and all oth necessary for the card illness and related coo (I) A provision that wh personnel are respon of prescribed therapie determined appropria delineated in the hosp facility personnel may where permitted by S the LTC facility. (J) A provision stating report all alleged viola mistreatment, neglect and physical abuse, in	th. that the hospice assumes rmining the appropriate e, including the ge the level of services at it is the LTC facility's th 24-hour room and board ht's personal care and dination with the hospice nsure that the level of care tely based on the individual the hospice's responsibilities, ed to, providing medical ment of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs iation of pain and symptoms rminal illness and related ter hospice services that are te of the resident's terminal nditions. then the LTC facility sible for the administration te by the hospice and bice plan of care, the LTC r administer the therapies tate law and as specified by g that the LTC facility must	F	349				

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	MENT OF HEALTH AN					FORM	APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED				
		345177	B. WING				C 21/2019		
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
					205 RATTLESNAKE TRAIL				
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER		PINEHURST, NC 28374					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION			
F 849	by hospice personnel administrator immedia becomes aware of the (K) A delineation of th hospice and the LTC bereavement services §483.70(o)(3) Each L provision of hospice of agreement must desig facility's interdisciplina for working with hosp coordinate care to the LTC facility staff and h interdisciplinary team clinical background, fi scope of practice act, assess the resident of that has the skills and resident. The designated interor responsible for the fol (i) Collaborating with and coordinating LTC the hospice care plan residents receiving th (ii) Communicating with and other healthcare provision of care for th conditions, and other of care for the patient (iii) Ensuring that the with the hospice med attending physician, a participating in the pro as needed to coordina medical care provided	, to the hospice ately when the LTC facility a alleged violation. The responsibilities of the facility to provide to LTC facility staff. TC facility arranging for the are under a written gnate a member of the ary team who is responsible for representatives to the resident provided by the hospice staff. The member must have a unction within their State and have the ability to thave access to someone thave access to someone thave access the lisciplinary team member is lowing: hospice representatives facility staff participation in ning process for those ese services. th hospice representatives providers participating in the ne terminal illness, related conditions, to ensure quality and family. LTC facility communicates facil director, the patient's and other practitioners povision of care to the patient ate the hospice care with the	F	849	9				

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	FORM): 04/30/2019 / APPROVED					
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	05 RATTLESNAKE TRAIL		
THE GREI	ENS AT PINEHURST REF	IAB & LIVING CENTER	PINEHURST, NC 28374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 849	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	205 RATTLESNAKE TRAIL PINEHURST, NC 28374 ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO		an ces	

Facility ID: 923320

					CONSTRUCTION			
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·			(X3) DATE SURVEY COMPLETED			
	345177		A. BUILDIN	с				
			B. WING					
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE			- 03/21/2019		
	ROVIDER OR SUFFLIER				05 RATTLESNAKE TRAIL			
THE GRE	ENS AT PINEHURST RE	HAB & LIVING CENTER			INEHURST, NC 28374			
				F	,			
(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) COMPLETIC DATE	
F 849	Continued From page	e 87	F 84	49				
					the resident #54 s medical record or	n		
	Resident # 54 was ad	dmitted to the facility on			March 25,2019.			
		7/14/17 with multiple diagnoses including						
		ors. The significant change			Address how the facility will identify o	ther		
		ata Set (MDS) assessment			residents having the potential to be			
		d that Resident #54 had			affected by the same deficient practic			
		making problems and she			An audit was completed on March 28			
	had received hospice	care.			2019 of the 3 other residents receivin Hospice services by the Director of	g		
	Resident #54 had a d	loctor's order dated 2/1/19			Nursing to ensure that all other reside	onte		
	for hospice services.				receiving Hospice services had			
					appropriate and signed certifications,			
	Resident #54's care p	blan dated 2/8/19 was			recertifications, medication lists, hosp	ice		
		e care plan problems was the			election form and plan of care were			
	resident has a termin			signed and received by the facility as	part			
	the resident's comfor			of the resident medical record. No ot	her			
	-	The approaches included to			residents were found to be affected.			
		ely for signs of pain and			Address what measures will be put in	to		
		cation as ordered, notify			place or systemic changes made to			
		y for breakthrough pain, to			ensure that the deficient practice will	not		
		ith hospice team to ensure I, emotional, intellectual,			recur; Director of nurses provided notificatio	n to		
		eeds were met and to work			all hospice providers that the facility v			
		rovide maximum comfort for			expect all hospice documentation to b			
	the resident.				signed by the provider within 5 days of			
					initiation of services on or before April			
	Review of the nursing	g facility hospice services			2019. Social services director and			
		2018 was conducted. The			assistant director(s) of nursing were			
	•	that hospice should provide			in-serviced on 3/21/19, by director of			
		ne most recent hospice plan			nursing to ensure that appropriate an			
		hospice resident, the			complete documentation of the hospic			
		and any advance directives			services are completed within 5 days			
	specific to the hospic	e resident, Physician			initiation of hospice services. This will monitored through audits of new physical services of the service of			
		e resident and the hospice			orders of Hospice referrals are review			
		ic to the hospice resident.			in morning standup meeting by Assist			
					directors of nursing and social service			
	Review of Resident #	54's medical records on			director to ensure that once order is	-		
		nospice information filed in			received, appropriate and signed			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/30/2019 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345177	B. WING			C 03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT PINEHURST REF	IAB & LIVING CENTER			05 RATTLESNAKE TRAIL INEHURST, NC 28374		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 849	AVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 the records including the most recent hospice plan of care, hospice election form, Physician certification and recertification of terminal illness and hospice medication list. On 3/19/19 at 3:40 PM, the Hospice Nurse was interviewed. She stated that she had not filed the required forms in Resident #54's medical records because the Physician had not signed the forms yet. On 3/20/19 at 2:21 PM, the Social Worker (SW) was interviewed. She stated that she was the facility coordinator with hospice. The SW stated that the hospice staff was responsible for filing the required forms in the resident's medical records. She indicated that she was not aware the required information/forms were not in Resident #54's medical records. On 3/21/19 at 10:31 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the hospice staff to file the required forms in resident's medical records as soon as the Physician had signed the forms and the hospice care had started but not after a month the hospice care had started.		F	349	paperwork is received within 5 days a placed on residents medical record. Indicate how the facility plans to moni its performance to make sure that solutions are sustained; Director of nursing or administrator wi monitor audits monthly X 3 months to ensure substantial compliance is achieved. Findings will be reported to QAPI committee and program will be re-evaluated and adjusted as needed maintain compliance.	tor II the	

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